House Engrossed Senate Bill

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JANICE K. BREWER
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CHAPTER 97

SENATE BILL 1100

AN ACT

AMENDING SECTIONS 3-662, 8-105, 8-134, 8-822, 11-821, 13-3612, 14-5310, 14-5314, 14-5315, 15-346, 15-843, 15-871, 15-872, 15-873, 20-142, 20-826, 20-826.03, 20-833, 20-841.04, 20-1051, 20-1057, 20-1057.01, 20-1057.10, 20-1342, 20-1342.05, 20-1376, 20-1402, 20-1402.02, 20-1404, 20-1404.02, 20-1406, 20-1631, 20-2323, 20-2327, 20-2332, 21-202, 28-447, 28-909, 28-2409, 28-3005, 28-3167, 36-2907.01, 36-2912.03, 44-133.01 AND 46-454, ARIZONA REVISED STATUTES; RELATING TO REGISTERED NURSE PRACTITIONERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 3-662, Arizona Revised Statutes, is amended to read:

3-662. Manufacture or sale not prohibited

This article does not prohibit the manufacture or sale of:

1. Trade products complying with this chapter.

2. Proprietary foods containing milk or skim milk to which have been added any fat or oil other than milk fat ~~when such~~ IF THESE foods are clearly labeled to show their composition and the fact that they are to be sold exclusively for use as directed by ~~physicians~~ A PHYSICIAN OR A REGISTERED NURSE PRACTITIONER for the feeding of invalids and children.

3. Real products flavored with chocolate or cocoa, with the presence of cocoa fat in an amount not exceeding that which is naturally present in the chocolate or cocoa used.

4. Real products the vitamin content of which is increased with the presence of a food oil as a carrier of such vitamins, ~~where~~ IF the quantity of such food oil does not exceed one one-hundredth per cent of the weight of the finished real products.

Sec. 2. Section 8-105, Arizona Revised Statutes, is amended to read:

8-105. Preadoption certification; investigation; central adoption registry

A. Before any prospective adoptive parent may petition to adopt a child the person shall be certified by the court as acceptable to adopt children. A certificate shall be issued only after an investigation conducted by an officer of the court, by an agency or by the division. A written application for certification shall be made directly to the court, to an agency or to the division, in the form and content required by the court, agency or division.

B. The division is not required to accept every application for certification. In determining which applications to accept the division may give priority to applications filed by adult residents of this state who wish to adopt a child who has any of the special needs described in section 8-141.

C. After receiving and accepting the written and completed application of the prospective adoptive parent or parents, which shall include a financial statement and a physician's OR A REGISTERED NURSE PRACTITIONER'S statement of each applicant's physical health, the division, the agency or an officer of the court shall conduct or cause to be conducted an investigation of the prospective adoptive parent or parents to determine if they are fit and proper persons to adopt children.

D. The division shall not present for certification a prospective adoptive parent unless that person has a valid fingerprint clearance card issued pursuant to title 41, chapter 12, article 3.1 or provides to the division documentation of the person's application for a fingerprint clearance card. The prospective adoptive parent must certify on forms that are provided by the division and that are notarized whether the prospective

adoptive parent is awaiting trial on or has ever been convicted of any of the criminal offenses listed in section 41-1758.03, subsections B and C in this state or similar offenses in another state or jurisdiction.

E. An officer of the court may obtain a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

F. This investigation and report to the court shall consider all relevant and material facts dealing with the prospective adoptive parents' fitness to adopt children and shall include:

1. A complete social history.

2. The financial condition of the applicant.

3. The moral fitness of the applicant.

4. The religious background of the applicant.

5. The physical and mental health condition of the applicants.

6. Any court action for or adjudication of child abuse, abandonment of children, dependency or termination of parent-child relationship in which the applicant had control, care or custody of the child who was the subject of the action.

7. Whether the person or persons wish to be placed on the central registry established in subsection M of this section.

8. All other facts bearing on the issue of the fitness of the prospective adoptive parents that the court, agency or division may deem relevant.

G. The investigator shall not reveal to the prospective adoptive parents the identity of a child or the child's parent or parents and shall not reveal to the child or the child's parent or parents the identity of the prospective adoptive parents if these facts are not already known.

H. Within ninety days after the original application prescribed by subsection A of this section has been accepted, the division or the agency or a person or agency designated by the court to conduct an investigation shall present to the juvenile court the written report required by subsection F of this section, which shall include a definite recommendation for certifying the applicant as being acceptable or nonacceptable to adopt children with the reasons for the recommendation.

I. Within sixty days after receiving the investigation report required by subsections F and H of this section, the court shall certify the applicant as being acceptable or nonacceptable to adopt children based on the investigation report and recommendations of the report. A certification remains in effect for eighteen months from the date of its issuance and may be extended for additional one year periods if after review the court finds that there have been no material changes in circumstances ~~which~~ THAT would adversely affect the acceptability of the applicant to adopt.

J. The court may require additional investigation if it finds that additional information is necessary on which to make an appropriate decision regarding certification.

K. Any applicant who has been certified as nonacceptable may petition the court to review such certification. Notice shall be given to all interested parties and the matter shall be heard by the court, which may affirm or reverse the certification.

L. If the applicant is certified as nonacceptable, the applicant may not reapply for certification to the court, to any agency or to the division for one year.

M. The division shall maintain a central adoption registry that includes the names of all prospective adoptive parents currently certified by the court as acceptable to adopt children, except those who request that their names not be included, the names of all children who are under the jurisdiction of the division and who are currently available for adoption, the names of any other children who are currently available for adoption and whose names are voluntarily entered in the registry by any agency, parent or other person that has the right to give consent to the child's adoption, and other information as the division may elect to include in aid of adoptive placements. Access to information in the registry shall be made available on request to any agency under assurances as the division may require that the information sought is in furtherance of adoptive placements and that confidentiality of the information is preserved.

N. This section does not apply if:

1. The prospective adoptive parent is the spouse of the birth or legal parent of the child to be adopted or is an uncle, aunt, adult sibling, grandparent or great-grandparent of the child of the whole or half-blood or by marriage or adoption.

2. The birth or legal parent is deceased but at the time of death the parent had legal and physical custody of the child to be adopted and the child had resided primarily with the spouse of the birth or legal parent during the twenty-four months before the death of the parent.

3. The grandparent, great-grandparent, aunt, adult sibling or uncle is deceased but at the time of death that person had legal and physical custody of the child to be adopted and the child had resided primarily with the spouse of the grandparent, great-grandparent, aunt, adult sibling or uncle during the twenty-four months before the death of the grandparent, great-grandparent, aunt, adult sibling or uncle.

O. If the applicant has adopted a child within three years preceding the current application and is applying to adopt another child or is a foster parent who is licensed by this state, the division or agency or a person designated by the court to conduct an investigation shall only provide an update report on any changes in circumstances that have occurred since the previous certification or licensing report. If the applicant has adopted a child more than three years before the current application and is applying to

adopt another child, the division or agency or a person designated by the court to conduct an investigation may provide an updated report on any changes in circumstances that have occurred since the previous certification or licensing report. The court shall certify the applicant as acceptable to adopt unless there are changes in circumstances that adversely affect the applicant's parenting ability. In making this determination, the court shall consider information from the prior certification or licensing report.

Sec. 3. Section 8-134, Arizona Revised Statutes, is amended to read:

8-134. Confidential intermediary

A. Any of the following persons may use the services of a confidential intermediary who is listed with the court:

1. The adoptive parents of an adoptee who is at least eighteen years of age or, if the adoptive parents are deceased, the adoptee's guardian.

2. An adoptee if the adoptee is at least eighteen years of age.

3. If an adoptee is deceased, the adoptee's spouse if the spouse is the legal parent or guardian of any child of the adoptee.

4. If an adoptee is deceased, any progeny of the adoptee who is at least eighteen years of age.

5. Either of the birth parents of an adoptee.

6. If the birth parent of an adoptee is deceased, the parent of the birth parent.

7. A biological sibling of the adoptee if the sibling is at least eighteen years of age.

B. An adoption agency licensed by this state, the division or an individual who meets the requirements adopted pursuant to subsections F and G of this section may serve as a confidential intermediary.

C. Notwithstanding sections 8-120 and 8-121, a confidential intermediary may inspect documents compiled pursuant to this article. Documents include the court records, division records, agency records and maternity home records. The confidential intermediary shall keep confidential all information obtained during the course of the investigation. The intermediary shall use confidential information only to arrange a contact or share information between the person who initiates the search and the person who is the subject of the search. A confidential intermediary shall review the court record before making any contact with an adoptee to determine if an affidavit has been filed pursuant to subsection E of this section. Except as provided pursuant to subsection A, paragraphs 1, 2, 4 and 7 and subsection G of this section, a confidential intermediary shall not contact persons under twenty-one years of age.

D. The confidential intermediary shall obtain written consent from the person who initiated the search and the person who is the subject of the search before arranging for the sharing of identifying information or a contact between them. If the confidential intermediary discovers the subject of the search is deceased or that the identity of the birth father was unknown to or not revealed by the birth mother, the confidential intermediary

1 shall share this information with the person initiating the search. If the
2 confidential intermediary, after a diligent effort, is unable to locate the
3 subject of the search to obtain written consent to share information, the
4 confidential intermediary shall share this information with the person
5 initiating the search and prepare and place with the compiled documents a
6 written report describing search efforts. If the person who initiated the
7 search petitions the court to release identifying information, the court
8 shall review the report prepared by the confidential intermediary and shall
9 decide if the information may be released and in what manner the information
10 may be released if the court determines there is good cause.
11 E. An adoptive parent who has not informed an adoptee that the adoptee
12 was adopted may file an affidavit so stating with the court where the
13 adoption took place. The affidavit may be withdrawn at any time by the
14 adoptive parent. If an affidavit is a part of the court record, the
15 confidential intermediary shall not make contact with the adoptee unless the
16 adoptive parent withdraws the affidavit and grants permission in writing or
17 the adoptee has filed an affidavit stating that the adoptee knows about the
18 adoption and wishes to make contact with the birth parent.
19 F. A birth parent who has not informed the parent's biological
20 offspring of the existence of the adoptee may file an affidavit so stating
21 with the court where the adoption took place. The affidavit may be withdrawn
22 at any time by the birth parent. If an affidavit is a part of the court
23 record, the confidential intermediary shall not make contact with the
24 biological sibling unless the birth parent withdraws the affidavit and grants
25 permission in writing or the biological sibling has filed an affidavit
26 stating that the biological sibling knows about the adoptee and wishes to
27 make contact with the adoptee.
28 G. On receipt of a written statement from a physician OR A REGISTERED
29 NURSE PRACTITIONER that explains in detail how a health condition may
30 seriously affect the health of the adoptee or a direct descendant of the
31 adoptee, the court shall order the confidential intermediary program to
32 appoint a confidential intermediary. The confidential intermediary shall
33 make a diligent effort to notify an adoptee who has attained eighteen years
34 of age, an adoptive parent or guardian of an adoptee who has not attained
35 eighteen years of age or a direct descendant of a deceased adoptee that the
36 nonidentifying information is available and shall be provided on written
37 request.
38 H. On receipt of a written statement from a physician OR A REGISTERED
39 NURSE PRACTITIONER that explains in detail why a serious health condition of
40 the adoptee or a direct descendant of the adoptee should be communicated to
41 the birth parent or biological sibling to enable the birth parent or
42 biological sibling to make an informed medical decision, the court shall
43 order the confidential intermediary program to appoint a confidential
44 intermediary. The confidential intermediary shall make a diligent effort to

notify those individuals that the nonidentifying information is available and shall be provided on written request.

I. The Arizona supreme court shall administer the confidential intermediary program. The court shall adopt rules and procedures necessary to implement the program, including qualifications, required fees, minimum standards for certification, training and standards of conduct of confidential intermediaries, and shall establish the fees that may be charged by a confidential intermediary.

J. A person shall not act as a confidential intermediary unless the person possesses a confidential intermediary certificate issued by the supreme court. In order to be certified as a confidential intermediary a person shall meet and maintain the minimum standards prescribed by this section and the rules adopted by the supreme court.

K. In carrying out the provisions of this section the supreme court shall require applicants for a confidential intermediary certificate to furnish fingerprints and the supreme court shall obtain criminal history record information pursuant to section 41-1750. The applicant for certification shall pay a fee to the department of public safety to reimburse the department of public safety for the cost of obtaining the applicant's criminal history record information required by this section. The fee shall not exceed the actual cost of obtaining the applicant's criminal history record information.

L. The actual and reasonable cost to the agency, division or court of providing information pursuant to the confidential intermediary program shall be paid by the person requesting the services of a confidential intermediary. If the juvenile court of a county is supplying the information, the actual and reasonable costs shall be paid to the clerk of the court of that county who shall transmit the monies to the county treasurer of that county for deposit in the juvenile probation services fund to be utilized by the juvenile court of that county for reimbursing the court for costs associated with providing information pursuant to the confidential intermediary program. If the division is supplying the information, the actual and reasonable costs shall be paid to the division. If an agency is supplying the information, the actual and reasonable costs shall be paid to the agency.

Sec. 4. Section 8-822, Arizona Revised Statutes, is amended to read:

8-822. <u>Removal of child from home; review; review teams</u>

The department shall adopt rules and establish clear policies and procedures, where appropriate, to:

1. Determine the circumstances under which it is appropriate to remove a child from the custody of the child's parents, guardian or custodian.

2. Ensure the immediate notification of the child's parents, guardian or custodian regarding the removal of the child from home, school or child care and the timely interview of the child and the child's parent, guardian or custodian.

3. Review each removal of a child that is expected to result in a dependency petition to assess options other than continued out-of-home placement including in-home services to the family. Such reviews shall be conducted before the dependency petition is filed. The review team shall consist of a protective services worker, a worker's supervisor and two members of the local foster care review board. If the child has a medical need or a chronic illness, the review team shall include the child's physician OR REGISTERED NURSE PRACTITIONER. If all reasonable efforts to reach the child's physician OR REGISTERED NURSE PRACTITIONER have been made and the physician OR REGISTERED NURSE PRACTITIONER is not available, the team shall include 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 and who is familiar with children's health care. IF THE CHILD SUFFERS FROM A CHRONIC ILLNESS, AT LEAST ONE MEMBER OF THE TEAM SHALL BE A PHYSICIAN LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17. A child shall not be removed unless a majority of the members of the review team agree that removal is necessary. If a majority of the members of the review team do not agree that removal is necessary, the child shall not be removed or, if the child has already been removed, the child shall be returned to the home.

Sec. 5. Section 11-821, Arizona Revised Statutes, is amended to read:

11-821. <u>County plan; definitions</u>

A. The commission shall formulate and the board of supervisors shall adopt or readopt a comprehensive long-term county plan for the development of the area of jurisdiction in the manner prescribed by this article. The planning commission shall coordinate the production of the county plan with the creation of the conceptual state land use plans under title 37, chapter 2, article 5.1. The county plan, with the accompanying maps, plats, charts and descriptive matter, shall show the commission's recommendations for the development of the area of jurisdiction together with the general zoning regulations. The county plan shall be made with the general purpose of guiding and accomplishing a coordinated, adjusted and harmonious development of the area of jurisdiction. In the preparation of the county plan the commission shall make surveys and studies of the present conditions and prospective future growth of the area of the jurisdiction. The planning commission shall cooperate with the state land department regarding integrating the conceptual state land use plans into the county plan. The county plan shall include provisions that identify changes or modifications that constitute amendments and major amendments to the plan.

B. In addition to the other matters that are required or authorized under this section and article 1 of this chapter, the county plan:

1. Shall provide for zoning, shall show the zoning districts designated as appropriate for various classes of residential, business and industrial uses and shall provide for the establishment of setback lines and other plans providing for adequate light, air and parking facilities and for expediting traffic within the districts.

2. May establish the percentage of a lot or parcel ~~which~~ THAT may be covered by buildings, and the size of yards, courts and other open spaces.

3. Shall consider access to incident solar energy.

4. May provide for retirement community zoning districts.

5. May provide for the regulation and use of business licenses, adult oriented business manager permits and adult service provider permits in conjunction with the establishment or operation of adult oriented businesses and facilities, including adult arcades, adult bookstores or video stores, cabarets, adult live entertainment establishments, adult motion picture theaters, adult theaters, massage establishments and nude model studios. With respect to cabarets, the plan shall not conflict with specific statutory or valid regulatory requirements applicable to persons licensed to dispense alcoholic beverages, but the plan may include regulation of the age and conduct of erotic entertainers in a manner at least as restrictive as rules adopted under title 4.

C. In addition to the other matters that are required or authorized under this section and article 1 of this chapter, for counties having a population of more than one hundred twenty-five thousand persons according to the most recent United States decennial census, the county plan shall include, and for other counties the county plan may include:

1. Planning for land use that designates the proposed general distribution and location and extent of uses of the land for housing, business, industry, agriculture, recreation, education, public buildings and grounds, open space and other categories of public and private uses of land appropriate to the county. The land use plan shall include:

(a) A statement of the standards of population density and building intensity recommended for the various land use categories covered by the plan.

(b) Specific programs and policies that the county may use to promote compact form development activity and locations where those development patterns should be encouraged.

(c) Consideration of air quality and access to incident solar energy for all general categories of land use.

(d) Policies that address maintaining a broad variety of land uses including the range of uses existing in the county at the time the plan is adopted, readopted or amended.

2. Planning for circulation consisting of the general location and extent of existing and proposed freeways, arterial and collector streets, bicycle routes and any other modes of transportation as may be appropriate, all correlated with the land use plan under paragraph 1 of this subsection.

3. Planning for water resources that addresses:

(a) The known legally and physically available surface water, groundwater and effluent supplies.

(b) The demand for water that will result from future growth projected in the county plan, added to existing uses.

(c) An analysis of how the demand for water that will result from future growth projected in the comprehensive plan will be served by the water supplies identified in subdivision (a) of this paragraph or a plan to obtain additional necessary water supplies.

D. In addition to the other matters that are required or authorized under this section and article 1 of this chapter, for counties having a population of more than two hundred thousand persons according to the most recent United States decennial census, the county plan shall include, and for other counties the county plan may include:

1. Planning for open space acquisition and preservation. The open space plan shall include:

(a) A comprehensive inventory of open space areas, recreational resources and designations of access points to open space areas and resources.

(b) An analysis of forecasted needs, policies for managing and protecting open space areas and resources and implementation strategies to acquire additional open space areas and further establish recreational resources.

(c) Policies and implementation strategies designed to promote a regional system of integrated open space and recreational resources and a consideration of any existing regional open space plan.

2. Planning for growth areas, specifically identifying those areas, if any, that are particularly suitable for planned multimodal transportation and infrastructure expansion and improvements designed to support a planned concentration of a variety of uses, such as residential, office, commercial, tourism and industrial uses. The mixed use planning shall include policies and implementation strategies that are designed to:

(a) Make automobile, transit and other multimodal circulation more efficient, make infrastructure expansion more economical and provide for a rational pattern of land development.

(b) Conserve significant natural resources and open areas in the growth area and coordinate their location to similar areas outside the growth area's boundaries.

(c) Promote the public and private construction of timely and financially sound infrastructure expansion through the use of infrastructure funding and financing planning that is coordinated with development activity.

3. An environmental planning element that contains ~~analysis~~ ANALYSES, policies and strategies to address anticipated effects, if any, of plan elements on air quality, water quality and natural resources associated with proposed development under the comprehensive plan. The policies and strategies to be developed under this element shall be designed to have countywide applicability and shall not require the production of an additional environmental impact statement or similar analysis beyond the requirements of state and federal law.

4. A cost of development element that identifies policies and strategies that the county will use to require development to pay its fair share toward the cost of additional public facility needs generated by new development, with appropriate exceptions when in the public interest. This element shall include:

(a) A component that identifies various mechanisms that are allowed by law and that can be used to fund and finance additional public services necessary to serve the development, including bonding, special taxing districts, development fees, in lieu fees and facility construction, dedications and privatization.

(b) A component that identifies policies to ensure that any mechanisms that are adopted by the county under this element result in a beneficial use to the development, bear a reasonable relationship to the burden imposed on the county to provide additional necessary public facilities to the development and otherwise are imposed according to law.

E. The water resources element of the comprehensive plan does not require:

1. New independent hydrogeologic studies.

2. The county to be a water service provider.

F. To carry out the purposes of this article, the board may adopt overlay zoning districts and regulations applicable to particular buildings, structures and land within individual zones. For the purposes of this subsection, "overlay zoning district" means a special zoning district that includes regulations ~~which~~ THAT modify regulations in another zoning district with which the overlay zoning district is combined. Overlay zoning districts and regulations shall be adopted pursuant to section 11-829. The provisions of overlay zoning shall apply retroactively to authorize overlay zoning districts and regulations adopted before April 20, 1993.

G. The policies and strategies to be developed under these elements shall be designed to have regional applicability.

H. This section does not authorize:

1. The imposition of dedications, exactions, fees or other requirements that are not otherwise authorized by law.

2. The regulation or restriction of the use or occupation of land or improvements for railroad, mining, metallurgical, grazing or general agricultural purposes, if the tract concerned is five or more contiguous commercial acres.

I. For the purposes of this section:

1. "Adult arcade" means any place to which the public is permitted or invited and in which coin-operated or slug-operated or electronically, electrically or mechanically controlled still or motion picture machines, projectors or other image producing devices are maintained to show images involving specific sexual activities or specific anatomical areas to persons in booths or viewing rooms.

2. "Adult bookstore or video store" means a commercial establishment that offers for sale or rent any of the following as one of its principal business purposes:

(a) Books, magazines, periodicals or other printed matter, photographs, films, motion pictures, videocassettes or reproductions or slides or other visual representations that depict or describe specific sexual activities or specific anatomical areas.

(b) Instruments, devices or paraphernalia that are designed for use in connection with specific sexual activities.

3. "Adult live entertainment establishment" means an establishment that features either:

(a) Persons who appear in a state of nudity.

(b) Live performances that are characterized by the exposure of specific anatomical areas or specific sexual activities.

4. "Adult motion picture theater" means a commercial establishment in which for any form of consideration films, motion pictures, videocassettes, slides or other similar photographic reproductions that are characterized by the depiction or description of specific sexual activities or specific anatomical areas are predominantly shown.

5. "Adult oriented business" means adult arcades, adult bookstores or video stores, cabarets, adult live entertainment establishments, adult motion picture theaters, adult theaters, massage establishments that offer adult service or nude model studios.

6. "Adult oriented business manager" means a person on the premises of an adult oriented business who is authorized to exercise overall operational control of the business.

7. "Adult service" means dancing, serving food or beverages, modeling, posing, wrestling, singing, reading, talking, listening or other performances or activities conducted for any consideration in an adult oriented business by a person who is nude or seminude during all or part of the time that the person is providing the service.

8. "Adult service provider" or "erotic entertainer" means any natural person who provides an adult service.

9. "Adult theater" means a theater, concert hall, auditorium or similar commercial establishment that predominantly features persons who appear in a state of nudity or who engage in live performances that are characterized by the exposure of specific anatomical areas or specific sexual activities.

10. "Cabaret" means an adult oriented business licensed to provide alcoholic beverages pursuant to title 4, chapter 2, article 1.

11. "Discernibly turgid state" means the state of being visibly swollen, bloated, inflated or distended.

12. "Massage establishment" means an establishment in which a person, firm, association or corporation engages in or permits massage activities, including any method of pressure on, friction against, stroking, kneading,

rubbing, tapping, pounding, vibrating or stimulating of external soft parts of the body with the hands or with the aid of any mechanical apparatus or electrical apparatus or appliance. This paragraph does not apply to:

(a) Physicians WHO ARE licensed pursuant to title 32, chapter 7, 8, 13, 14 or 17.

(b) Registered nurses, licensed practical nurses or technicians who are acting under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17.

(c) REGISTERED NURSE PRACTITIONERS WHO ARE LICENSED PURSUANT TO TITLE 32, CHAPTER 15.

~~(c)~~ (d) Persons who are employed or acting as trainers for a bona fide amateur, semiprofessional or professional athlete or athletic team.

~~(d)~~ (e) Persons who are licensed pursuant to title 32, chapter 3 or 5 if the activity is limited to the head, face or neck.

13. "Nude model studio" means a place in which a person who appears in a state of nudity or who displays specific anatomical areas is observed, sketched, drawn, painted, sculptured, photographed or otherwise depicted by other persons who pay money or other consideration. Nude model studio does not include a proprietary school that is licensed by this state, a college, community college or university that is supported entirely or in part by taxation, a private college or university that maintains and operates educational programs in which credits are transferable to a college, community college or university that is supported entirely or in part by taxation or a structure to which the following apply:

(a) A sign is not visible from the exterior of the structure and no other advertising appears indicating that a nude person is available for viewing.

(b) A student must enroll at least three days in advance of a class in order to participate.

(c) No more than one nude or seminude model is on the premises at any time.

14. "Nude", "nudity" or "state of nudity" means any of the following:

(a) The appearance of a human anus, genitals or A female breast below a point immediately above the top of the areola.

(b) A state of dress that fails to opaquely cover a human anus, genitals or A female breast below a point immediately above the top of the areola.

15. "Principal business purposes" means that a commercial establishment derives fifty per cent or more of its gross income from the sale or rental of items listed in paragraph 2 of this subsection.

16. "Seminude" means a state of dress in which clothing covers no more than the genitals, pubic region and female breast below a point immediately above the top of the areola, as well as portions of the body that are covered by supporting straps or devices.

17. "Specific anatomical areas" means any of the following:

(a) A human anus, genitals, THE pubic region or a female breast below a point immediately above the top of the areola that is less than completely and opaquely covered.

(b) Male genitals in a discernibly turgid state even if completely and opaquely covered.

18. "Specific sexual activities" means any of the following:

(a) Human genitals in a state of sexual stimulation or arousal.

(b) Sex acts, normal or perverted, actual or simulated, including acts of human masturbation, sexual intercourse, oral copulation or sodomy.

(c) Fondling or other erotic touching of the human genitals, pubic region, buttocks, anus or female breast.

(d) Excretory functions as part of or in connection with any of the activities under subdivision (a), (b) or (c) of this paragraph.

Sec. 6. Section 13-3612, Arizona Revised Statutes, is amended to read:

13-3612. Definitions; contributing to dependency or delinquency

For the purposes of sections 13-3613 through 13-3618, unless the context otherwise requires:

1. "Delinquency" means any act ~~which~~ THAT tends to debase or injure the morals, health or welfare of a child.

2. "Delinquent person" includes any person under the age of eighteen years who violates a law of this state, or an ordinance of a county, city or town defining crime.

3. "Dependent person" means a person under the age of eighteen years:

(a) Who is found begging, receiving or gathering alms, whether actually begging or under the pretext of selling or offering anything for sale.

(b) Who is found in a street, road or public place with the intent of begging, gathering or receiving alms.

(c) Who is a vagrant.

(d) Who is found wandering and WHO DOES not ~~having~~ HAVE a home, or a settled place of abode, or a guardian or any visible means of subsistence.

(e) Who has no parent or guardian willing to exercise, or capable of exercising, proper parental control over ~~him~~ THE DEPENDENT PERSON.

(f) Who is destitute.

(g) Whose home, by reason of neglect, cruelty or depravity of ~~his~~ THE DEPENDENT PERSON'S parents, or either of them, or on the part of ~~his~~ THE DEPENDENT PERSON'S guardian, or on the part of the person in whose custody or care ~~he~~ THE DEPENDENT PERSON may be, is an unfit place for such person.

(h) Who frequents the company of reputed criminals, vagrants or prostitutes.

(i) Who is found living or being in a house of prostitution or assignation.

(j) Who habitually visits, without A parent or guardian, a saloon~~,~~ or place where spirituous, vinous or malt liquors are sold, bartered or given away.

(k) Who persistently refuses to obey the reasonable orders or directions of ~~his~~ THE DEPENDENT PERSON'S parent or guardian.

(l) Who is incorrigible~~, that~~ AND WHO is~~,~~ beyond the control and power of ~~his~~ THE DEPENDENT PERSON'S parents, guardian or custodian by reason of the vicious conduct or nature of the person.

(m) Whose father or mother is dead, or has abandoned the family, or is an habitual drunkard, or whose father or mother does not provide for ~~such~~ THE person, and it appears that ~~such~~ THE person is destitute of a suitable home or adequate means of obtaining an honest living, or who is in danger of being brought up to lead an idle, dissolute and immoral life, or when both parents are dead, or the mother or father, if living, is unable to provide proper support and care of ~~such~~ THE person.

(n) Who~~,~~ habitually uses intoxicating liquor as a beverage, ~~or~~ habitually smokes cigarettes~~,~~ or uses opium, cocaine, morphine or other similar drugs without direction of a competent physician OR A QUALIFIED REGISTERED NURSE PRACTITIONER.

(o) Who from any cause is in danger of growing up to lead an idle, dissolute or immoral life.

Sec. 7. Section 14-5310, Arizona Revised Statutes, is amended to read:

14-5310. Temporary guardians; appointment; notice; court appointed attorney hearings; duties

A. If an alleged incapacitated person has no guardian and an emergency exists or if an appointed guardian is not effectively performing the duties of a guardian and the welfare of the ward is found to require immediate action, the alleged incapacitated person, the ward or any person interested in the welfare of the alleged incapacitated person or the ward may petition for a finding of interim incapacity and for the appointment of a temporary guardian. No finding and appointment may be made without notice, pursuant to section 14-5309, except as provided in subsection B of this section.

B. The court may enter a finding of interim incapacity and may appoint a temporary guardian without notice to the proposed ward or the proposed ward's attorney only if all of the following conditions are met:

1. It clearly appears from specific facts shown by an affidavit or by the verified petition that immediate and irreparable injury, loss or damage will result before the proposed ward or the proposed ward's attorney can be heard in opposition.

2. The petitioner or the petitioner's attorney certifies to the court in writing any efforts that the petitioner or the petitioner's attorney has made to give the notice or the reasons supporting the claim that notice should not be required.

3. The petitioner files with the court a request for a hearing on the petition for the appointment of a temporary guardian.

4. The petitioner or the petitioner's attorney certifies that that person will give notice of the petition, the order and all filed reports and affidavits to the proposed ward by personal service within the time period the court directs but not in excess of seventy-two hours following entry of the order of appointment.

5. The petitioner files a report from a physician, A REGISTERED NURSE PRACTITIONER or a psychologist detailing the need for a guardian and the basis for the emergency unless the report is waived by the court on a showing of good cause by a party to the action.

C. Unless the proposed ward is represented by independent counsel, the court shall appoint an attorney to represent the proposed ward in the proceeding on receipt of the petition for temporary appointment. The attorney shall visit the proposed ward as soon as practicable and shall be prepared to represent the interest of the proposed ward at any hearing on the petition.

D. Every order finding interim incapacity and appointing a temporary guardian granted without notice expires as prescribed by the court but within a period of not more than thirty days unless within that time the court extends it for good cause shown for the same period or unless the attorney for the ward consents that it may be extended for a longer period. The court shall enter the reasons for the extension on the record.

E. The court shall schedule a hearing on the petition for a finding of interim incapacity and the appointment of a temporary guardian within the time specified in subsection D of this section. If the petitioner does not proceed with the petition the court, on the motion of any party or on its own motion, may dismiss the petition.

F. If the court orders the appointment of a temporary guardian without notice, the ward may appear and move for its dissolution or modification on two days' notice to the petitioner and to the temporary guardian or on such shorter notice as the court prescribes. The court shall proceed to hear and determine that motion as expeditiously as possible.

G. The hearing on a petition for the appointment of a temporary guardian shall be held in the same manner as a hearing on a preliminary injunction. The court may order the hearing on the petition for appointment of a permanent guardian to be advanced and consolidated with the hearing of the petition for temporary appointment. If the court does not order this consolidation any evidence received on a petition for temporary appointment that would be admissible at the hearing on a petition for a permanent appointment becomes part of the record and need not be repeated at a later hearing. This subsection does not limit the parties to any rights they may have to trial by jury.

H. After notice and a hearing, if the court finds that a temporary guardian is necessary and the provisions of this section have been met, the court shall make an appointment of a temporary guardian for a specific

purpose and for a specific period of time of not more than six months unless the court extends this time period for good cause shown.

I. A temporary guardian is responsible to provide the care and custody of the ward. The authority of a permanent guardian previously appointed by the court is suspended as long as the temporary guardian has authority. A temporary guardian may be removed at any time. A temporary guardian shall make any report the court requires. In all other respects, the provisions of this title concerning guardians apply to temporary guardians.

Sec. 8. Section 14-5314, Arizona Revised Statutes, is amended to read:

14-5314. Compensation of appointees

A. If not otherwise compensated for services rendered, an investigator, accountant, lawyer, physician, REGISTERED NURSE PRACTITIONER, guardian or temporary guardian appointed pursuant to this article is entitled to reasonable compensation from the estate of the ward if the petition is granted, or from the petitioner if the petition is denied. If the court compensates the provider of a service the court may charge the estate for the reasonable cost of the service and shall deposit these monies in the probate fund pursuant to section 14-5433.

B. Notwithstanding subsection A of this section, if compensation by the ward or the petitioner is not feasible the court shall determine and pay reasonable compensation for services rendered by an investigator, accountant, lawyer, physician, REGISTERED NURSE PRACTITIONER, guardian or temporary guardian appointed in a guardianship proceeding.

Sec. 9. Section 14-5315, Arizona Revised Statutes, is amended to read:

14-5315. Guardian reports; contents

A. A guardian shall submit a written report to the court on each anniversary date of qualification as guardian, on resignation or removal as guardian and on termination of the ward's disability.

B. The guardian shall mail a copy of the report to:

1. The ward.

2. The ward's conservator.

3. The ward's spouse or the ward's parents if the ward is not married.

4. A court appointed attorney for the ward.

5. Any other interested person who has filed a demand for notice with the court.

C. The report shall include the following:

1. The type, name and address of the home or facility where the ward lives and the name of the person in charge of the home.

2. The number of times the guardian has seen the ward in the last twelve months.

3. The date the guardian last saw the ward.

4. The name and address of the ward's physician OR REGISTERED NURSE PRACTITIONER.

5. The date the ward was last seen by a physician OR A REGISTERED NURSE PRACTITIONER.

6. A copy of the ward's physician's OR REGISTERED NURSE PRACTITIONER'S report to the guardian or, if none exists, a summary of the physician's OR THE REGISTERED NURSE PRACTITIONER'S observations on the ward's physical and mental condition.

7. Major changes in the ward's physical or mental condition observed by the guardian in the last year.

8. The guardian's opinion as to whether the guardianship should be continued.

9. A summary of the services provided to the ward by a governmental agency and the name of the individual responsible for the ward's affairs with that agency.

Sec. 10. Section 15-346, Arizona Revised Statutes, is amended to read:

15-346. Policies and procedures concerning pupils with chronic health problems; definition

A. The governing board shall adopt policies and procedures concerning pupils with chronic health problems in consultation with parents, teachers and at least one health professional. The policies and procedures shall be designed to provide continuing learning for pupils with chronic health problems while they are absent from school and to provide for the integration of pupils with chronic health problems into the regular education program as much as possible. The policies and procedures shall include provisions for:

1. Homework availability to ensure that pupils with chronic health problems have the opportunity to keep up with assignments and avoid losing credit because of their absence from school.

2. Flexibility in physical education activity requirements so that pupils with chronic health problems may participate in the regular physical education program to the extent that their health permits.

B. For the ~~purpose~~ PURPOSES of this section, "pupils with chronic health problems" means:

1. Pupils who ARE NOT HOMEBOUND, BUT WHO are unable to attend regular classes for intermittent periods of one or more consecutive days because of illness, disease, pregnancy complications~~,~~ or accident ~~but who are not homebound. The chronic health problem shall be~~ AS certified by a person WHO IS licensed ~~under~~ PURSUANT TO title 32, chapter 7, 13 or 17 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO CHAPTER 15. IF THE CHILD SUFFERS FROM A CONDITION REQUIRING MANAGEMENT ON A LONG-TERM BASIS, THE CERTIFICATION SHALL BE MADE BY A PERSON LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17.

2. Pupils who have an infant with a severe health problem~~. The severe health problem of the infant shall be~~ AS certified by a person WHO IS licensed ~~under~~ PURSUANT TO title 32, chapter 7, 13 or 17 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO CHAPTER 15.

Sec. 11. Section 15-843, Arizona Revised Statutes, is amended to read:

15-843. Pupil disciplinary proceedings

A. An action concerning discipline, suspension or expulsion of a pupil is not subject to ~~the provisions of~~ title 38, chapter 3, article 3.1, except that the governing board of a school district shall post regular notice and shall take minutes of any hearing held by the governing board concerning the discipline, suspension or expulsion of a pupil.

B. The governing board of any school district ~~shall~~, in consultation with the teachers and parents of the school district, SHALL prescribe rules for the discipline, suspension and expulsion of pupils. The rules shall be consistent with the constitutional rights of pupils and shall include at least the following:

1. Penalties for excessive pupil absenteeism pursuant to section 15-803 including failure in a subject, failure to pass a grade, suspension or expulsion.

2. Procedures for the use of corporal punishment if allowed by the governing board.

3. Procedures for the reasonable use of physical force by certificated or classified personnel in self-defense, defense of others and defense of property.

4. Procedures for dealing with pupils who have committed or WHO are believed to have committed a crime.

5. A notice and hearing procedure for cases concerning the suspension of a pupil for more than ten days.

6. Procedures and conditions for readmission of a pupil who has been expelled or suspended for more than ten days.

7. Procedures for appeal to the governing board of the suspension of a pupil for more than ten days, if the decision to suspend the pupil was not made by the governing board.

8. Procedures for appeal of the recommendation of the hearing officer or officers designated by the board as provided in subsection F OF THIS SECTION at the time the board considers the recommendation.

C. Penalties adopted ~~under~~ PURSUANT TO subsection B, paragraph 1 OF THIS SECTION for excessive absenteeism shall not be applied to pupils who have completed the course requirements and whose absence from school is due solely to illness, disease or accident as certified by a person WHO IS licensed ~~under~~ PURSUANT TO title 32, chapter 7, 13, ~~or~~ 15 OR 17.

D. The governing board shall:

1. Support and assist teachers in the implementation and enforcement of the rules prescribed ~~in~~ PURSUANT TO subsection B OF THIS SECTION.

2. Develop procedures allowing teachers and principals to recommend the suspension or expulsion of pupils.

3. Develop procedures allowing teachers and principals to temporarily remove disruptive pupils from a class.

4. Delegate to the principal the authority to remove a disruptive pupil from the classroom.

E. If a pupil withdraws from school after receiving notice of possible action concerning discipline, expulsion or suspension, the governing board may continue with the action after the withdrawal and may record the results of such action in the pupil's permanent file.

F. In all action concerning the expulsion of a pupil, the governing board of a school district shall:

1. Be notified of the intended action.

2. Decide, in executive session, whether to hold a hearing or to designate one or more hearing officers to hold a hearing to hear the evidence, prepare a record and bring a recommendation to the board for action and whether the hearing shall be held in executive session.

3. Give written notice, at least five working days prior to the hearing by the governing board or the hearing officer or officers designated by the governing board, to all pupils subject to expulsion and their parents or guardians of the date, time and place of the hearing. If the governing board decides that the hearing is to be held in executive session, the written notice shall include a statement of the right of the parents or ~~legal~~ guardians or an emancipated pupil WHO IS subject to expulsion to ~~indicate their objection~~ OBJECT to the governing board's decision to have the hearing held in executive session. Objections shall be made in writing to the governing board.

G. If a parent~~, legal~~ OR guardian or AN emancipated pupil WHO IS subject to expulsion disagrees that the hearing should be held in executive session, ~~then~~ it shall be held in an open meeting unless:

1. If only one pupil is subject to expulsion and disagreement exists between that pupil's parents or ~~legal~~ guardians, the governing board, after consultations with the pupil's parents or ~~legal~~ guardians or the emancipated pupil, shall decide in executive session whether the hearing will be in executive session.

2. If more than one pupil is subject to expulsion and disagreement exists between the parents or guardians of different pupils, then separate hearings shall be held subject to the provisions of this section.

H. ~~Nothing in this section shall be construed to~~ THIS SECTION DOES NOT prevent the pupil who is subject to expulsion or suspension, and the pupil's parents or ~~legal~~ guardians and legal counsel, from attending any executive session pertaining to the proposed disciplinary action, from having access to the minutes and testimony of the executive session or from recording the session at the parent's or ~~legal~~ guardian's expense.

I. In schools employing a superintendent or a principal, the authority to suspend a pupil from school is vested in the superintendent, principal or other school officials granted this power by the governing board of the school district.

J. In schools that do not have a superintendent or principal, a teacher may suspend a pupil from school.

K. In all cases of suspension, it shall be for good cause and shall be reported within five days to the governing board by the superintendent or the person imposing the suspension.

L. A teacher who fails to comply with this section is guilty of unprofessional conduct and the teacher's certificate may be revoked.

M. The principal of each school shall insure that a copy of all rules pertaining to discipline, suspension and expulsion of pupils is distributed to the parents of each pupil at the time the pupil is enrolled in school.

N. The principal of each school shall ~~insure~~ ENSURE that all rules pertaining to the discipline, suspension and expulsion of pupils are communicated to students at the beginning of each school year, and to transfer students at the time of their enrollment in the school.

Sec. 12. Section 15-871, Arizona Revised Statutes, is amended to read:

15-871. Definitions

In this article, unless the context otherwise requires:

1. "Documentary proof" means written evidence that a pupil has been immunized or has laboratory evidence of immunity ~~which~~ THAT conforms with the standards promulgated pursuant to section 15-872.

2. "Dose" means the number in a series of immunizations ~~which~~ THAT may be prescribed pursuant to section 36-672.

3. "Health agency" means a local health department or similar governmental agency established pursuant to the laws of another state or country and its officers and employees.

4. "Homeless pupil" means a pupil who has a primary residence that is:

(a) A supervised publicly or privately operated shelter designed to provide temporary living accommodations.

(b) An institution that provides a temporary residence for individuals intended to be institutionalized.

(c) A public or private place not designed for, or ordinarily used as a regular sleeping accommodation for, human beings.

5. "Immunization" means the process of inoculation with a specific antigen to promote antibody formation in the body.

6. "Immunized" means the required initial immunization and boosters or reimmunization prescribed pursuant to section 36-672.

7. "Laboratory evidence of immunity" means written evidence of serologic confirmation of the presence of specific antibodies against an immunization-preventable disease ~~which~~ THAT is signed by a physician or an authorized representative of a health agency.

8. "Local health department" means a local health department established pursuant to title 36, chapter 1, article 4.

9. "Physician" means a person licensed pursuant to title 32, chapter 13, 17 or 29 or a person licensed to practice allopathic or osteopathic medicine under the laws of another state or country.

10. "Pupil" means a person who is eligible to receive instruction at a school and includes pre-kindergarten age children receiving either services for children with disabilities or day care on a school campus otherwise exempt from day care rules pursuant to section 36-884.

11. "REGISTERED NURSE PRACTITIONER" HAS THE SAME MEANING PRESCRIBED IN SECTION 32-1601.

~~11.~~ 12. "School" means a public, private or parochial school that offers instruction at any level or grade through twelfth grade, except for day care facilities regulated pursuant to title 36, chapter 7.1.

~~12.~~ 13. "School administrator" means the principal or person having general daily control and supervision of the school or that person's designee.

~~13.~~ 14. "Suspension" or "suspended" means:

(a) For a pupil attending a public school, the temporary withdrawal of the privilege of attending school pursuant to section 15-843.

(b) For a pupil attending a private or parochial school, the temporary withdrawal of the privilege of attending school pursuant to the policies and procedures of the private or parochial school.

Sec. 13. Section 15-872, Arizona Revised Statutes, is amended to read:

15-872. Proof of immunization; noncompliance; notice to parents; civil immunity

A. The director of the department of health services, in consultation with the superintendent of public instruction, shall develop by rule standards for documentary proof.

B. A pupil shall not be allowed to attend school without submitting documentary proof to the school administrator unless the pupil is exempted from immunization pursuant to section 15-873.

C. Each public school shall make full disclosure of the requirements and exemptions as prescribed in ~~sections 15-872~~ THIS SECTION and SECTION 15-873.

D. On enrollment, the school administrator shall suspend that pupil if the administrator does not have documentary proof and the pupil is not exempted from immunization pursuant to section 15-873.

E. Notwithstanding subsections B and D of this section, a pupil may be admitted to or allowed to attend a school if the pupil has received at least one dose of each of the required immunizations prescribed pursuant to section 36-672 and has established a schedule for the completion of required immunizations. The parent, guardian or person in loco parentis of a pupil shall present to the school administrator documentary proof of the immunizations received and a schedule prepared by the pupil's physician OR REGISTERED NURSE PRACTITIONER or a health agency for completion of additional required immunizations.

F. The school administrator shall review the school immunization record for each pupil admitted or allowed to continue attendance pursuant to subsection E of this section at least twice each school year until the pupil

receives all of the required immunizations and shall suspend a pupil as prescribed in subsection G of this section who fails to comply with the immunization schedule. Immunizations received by a pupil shall be entered in the pupil's school immunization record.

G. Unless proof of an exemption from immunization pursuant to section 15-873 is provided, a pupil who is admitted or allowed to continue to attend and who fails to comply with the immunization schedule within the time intervals specified by the schedule shall be suspended from school attendance until documentary proof of the administration of another dose of each appropriate immunizing agent is provided to the school administrator.

H. The provisions of subsections B, D and E of this section do not apply to homeless pupils until the fifth calendar day after enrollment.

I. A school and its employees are immune from civil liability for decisions concerning the admission, readmission and suspension of a pupil ~~which~~ THAT are based on a good faith implementation of the requirements of this article.

Sec. 14. Section 15-873, Arizona Revised Statutes, is amended to read:

15-873. Exemptions; nonattendance during outbreak

A. Documentary proof is not required for a pupil to be admitted to school if one of the following occurs:

1. The parent or guardian of the pupil submits a signed statement to the school administrator stating that the parent or guardian has received information about immunizations provided by the department of health services~~,~~ AND understands the risks and benefits of immunizations and the potential risks of nonimmunization and that due to personal beliefs, the parent or guardian does not consent to the immunization of the pupil.

2. The school administrator receives written certification ~~which~~ THAT is signed by the parent or guardian and by a physician OR A REGISTERED NURSE PRACTITIONER, ~~which~~ THAT states that one or more of the required immunizations may be detrimental to the pupil's health and ~~which~~ THAT indicates the specific nature and probable duration of the medical condition or circumstance ~~which~~ THAT precludes immunization.

B. An exemption pursuant to subsection A, paragraph 2 is only valid during the duration of the circumstance or condition ~~which~~ THAT precludes immunization.

C. Pupils who lack documentary proof of immunization shall not attend school during outbreak periods of communicable immunization-preventable diseases as determined by the department of health services or local health department. The department of health services or local health department shall transmit notice of this determination to the school administrator responsible for the exclusion of the pupils.

Sec. 15. Section 20-142, Arizona Revised Statutes, is amended to read:

20-142. Powers and duties of director; payment of examination and investigation costs; home health services

A. The director shall enforce the provisions of this title.

B. The director shall have powers and authority expressly conferred by or reasonably implied from the provisions of this title.

C. The director may conduct examinations and investigations of insurance matters, including examinations and investigations of adjusters, agents and brokers and any other persons who are regulated under this title, in addition to examinations and investigations expressly authorized, as the director deems proper in determining whether a person has violated any provision of this title or for the purpose of securing information useful in the lawful administration of any provision of this title. The examined party shall pay the cost of examinations that are conducted pursuant to this subsection except for examinations of adjusters, agents and brokers. The examined party shall pay the cost of examining adjusters, agents and brokers only if the party has violated any provision of this title. The state shall pay the cost of an investigation.

D. The director shall establish guidelines for insurers on home health services that shall be used by the director pursuant to sections 20-826, 20-1342, 20-1402 and 20-1404. The director may use home health services as defined in section 36-151. Guidelines shall include but not be limited to:

1. Home health services that are prescribed by a physician OR A REGISTERED NURSE PRACTITIONER.

2. Home health services that are determined to cost less if provided in the home than the average length of in-hospital service for the same service.

3. Skilled professional care in the home that is comparable to skilled professional care provided in-hospital and that is reviewed and approved at thirty day intervals by a physician.

E. Pursuant to section 41-1750, subsection G, the director may receive criminal history record information in connection with the issuance, renewal, suspension or revocation of a license or certificate of authority or the consideration of a merger or acquisition. The director may require a person to submit a full set of fingerprints to the department. The department of insurance shall submit the fingerprints to the department of public safety for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

Sec. 16. Section 20-826, Arizona Revised Statutes, is amended to read:

20-826. <u>Subscription contracts; definitions</u>

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

1 services with which the corporation has contracted for hospital, medical,
2 dental or optometric services.
3 C. Each contract, except for dental services or optometric services,
4 shall be so written that the corporation shall pay benefits for each of the
5 following:
6 1. Performance of any surgical service that is covered by the terms of
7 such contract, regardless of the place of service.
8 2. Any home health services that are performed by a licensed home
9 health agency and that a physician has prescribed in lieu of hospital
10 services, as defined by the director, providing the hospital services would
11 have been covered.
12 3. Any diagnostic service that a physician has performed outside a
13 hospital in lieu of inpatient service, providing the inpatient service would
14 have been covered.
15 4. Any service performed in a hospital's outpatient department or in a
16 freestanding surgical facility, if such service would have been covered if
17 performed as an inpatient service.
18 D. Each contract for dental or optometric services shall be so written
19 that the corporation shall pay benefits for contracted dental or optometric
20 services provided by dentists or optometrists.
21 E. Any contract, except accidental death and dismemberment, applied
22 for that provides family coverage shall, as to such coverage of family
23 members, also provide that the benefits applicable for children shall be
24 payable with respect to a newly born child of the insured from the instant of
25 such child's birth, to a child adopted by the insured, regardless of the age
26 at which the child was adopted, and to a child who has been placed for
27 adoption with the insured and for whom the application and approval
28 procedures for adoption pursuant to section 8-105 or 8-108 have been
29 completed to the same extent that such coverage applies to other members of
30 the family. The coverage for newly born or adopted children or children
31 placed for adoption shall include coverage of injury or sickness including
32 necessary care and treatment of medically diagnosed congenital defects and
33 birth abnormalities. If payment of a specific premium is required to provide
34 coverage for a child, the contract may require that notification of birth,
35 adoption or adoption placement of the child and payment of the required
36 premium must be furnished to the insurer within thirty-one days after the
37 date of birth, adoption or adoption placement in order to have the coverage
38 continue beyond the thirty-one day period.
39 F. Each contract that is delivered or issued for delivery in this
40 state after December 25, 1977 and that provides that coverage of a dependent
41 child shall terminate upon attainment of the limiting age for dependent
42 children specified in the contract shall also provide in substance that
43 attainment of such limiting age shall not operate to terminate the coverage
44 of such child while the child is and continues to be both incapable of
45 self-sustaining employment by reason of mental retardation or physical

1 handicap and chiefly dependent upon the subscriber for support and
2 maintenance. Proof of such incapacity and dependency shall be furnished to
3 the corporation by the subscriber within thirty-one days of the child's
4 attainment of the limiting age and subsequently as may be required by the
5 corporation, but not more frequently than annually after the two-year period
6 following the child's attainment of the limiting age.
7 G. No corporation may cancel or refuse to renew any subscriber's
8 contract without giving notice of such cancellation or nonrenewal to the
9 subscriber under such contract. A notice by the corporation to the
10 subscriber of cancellation or nonrenewal of a subscription contract shall be
11 mailed to the named subscriber at least forty-five days before the effective
12 date of such cancellation or nonrenewal. The notice shall include or be
13 accompanied by a statement in writing of the reasons for such action by the
14 corporation. Failure of the corporation to comply with the provisions of
15 this subsection shall invalidate any cancellation or nonrenewal except a
16 cancellation or nonrenewal for nonpayment of premium.
17 H. A contract that provides coverage for surgical services for a
18 mastectomy shall also provide coverage incidental to the patient's covered
19 mastectomy for surgical services for reconstruction of the breast on which
20 the mastectomy was performed, surgery and reconstruction of the other breast
21 to produce a symmetrical appearance, prostheses, treatment of physical
22 complications for all stages of the mastectomy, including lymphedemas, and at
23 least two external postoperative prostheses subject to all of the terms and
24 conditions of the policy.
25 I. A contract that provides coverage for surgical services for a
26 mastectomy shall also provide coverage for mammography screening performed on
27 dedicated equipment for diagnostic purposes on referral by a patient's
28 physician, subject to all of the terms and conditions of the policy and
29 according to the following guidelines:
30 1. A baseline mammogram for a woman from age thirty-five to
31 thirty-nine.
32 2. A mammogram for a woman from age forty to forty-nine every two
33 years or more frequently based on the recommendation of the woman's
34 physician.
35 3. A mammogram every year for a woman fifty years of age and over.
36 J. Any contract that is issued to the insured and that provides
37 coverage for maternity benefits shall also provide that the maternity
38 benefits apply to the costs of the birth of any child legally adopted by the
39 insured if all of the following are true:
40 1. The child is adopted within one year of birth.
41 2. The insured is legally obligated to pay the costs of birth.
42 3. All preexisting conditions and other limitations have been met by
43 the insured.
44 4. The insured has notified the insurer of the insured's acceptability
45 to adopt children pursuant to section 8-105, within sixty days after such

1 approval or within sixty days after a change in insurance policies, plans or
2 companies.
3 K. The coverage prescribed by subsection J of this section is excess
4 to any other coverage the natural mother may have for maternity benefits
5 except coverage made available to persons pursuant to title 36, chapter 29
6 but not including coverage made available to persons defined as eligible
7 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If
8 such other coverage exists the agency, attorney or individual arranging the
9 adoption shall make arrangements for the insurance to pay those costs that
10 may be covered under that policy and shall advise the adopting parent in
11 writing of the existence and extent of the coverage without disclosing any
12 confidential information such as the identity of the natural parent. The
13 insured adopting parents shall notify their insurer of the existence and
14 extent of the other coverage.
15 L. The director may disapprove any contract if the benefits provided
16 in the form of such contract are unreasonable in relation to the premium
17 charged.
18 M. The director shall adopt emergency rules applicable to persons who
19 are leaving active service in the armed forces of the United States and
20 returning to civilian status including:
21 1. Conditions of eligibility.
22 2. Coverage of dependents.
23 3. Preexisting conditions.
24 4. Termination of insurance.
25 5. Probationary periods.
26 6. Limitations.
27 7. Exceptions.
28 8. Reductions.
29 9. Elimination periods.
30 10. Requirements for replacement.
31 11. Any other condition of subscription contracts.
32 N. Any contract that provides maternity benefits shall not restrict
33 benefits for any hospital length of stay in connection with childbirth for
34 the mother or the newborn child to less than forty-eight hours following a
35 normal vaginal delivery or ninety-six hours following a cesarean
36 section. The contract shall not require the provider to obtain authorization
37 from the corporation for prescribing the minimum length of stay required by
38 this subsection. The contract may provide that an attending provider in
39 consultation with the mother may discharge the mother or the newborn child
40 before the expiration of the minimum length of stay required by this
41 subsection. The corporation shall not:
42 1. Deny the mother or the newborn child eligibility or continued
43 eligibility to enroll or to renew coverage under the terms of the contract
44 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

1 coverage required in this paragraph is effective six months after the
2 coverage is required under medicare.
3 Q. Nothing in subsection P of this section prohibits a medical service
4 corporation, a hospital service corporation or a hospital, medical, dental
5 and optometric service corporation from imposing deductibles, coinsurance or
6 other cost sharing in relation to benefits for equipment or supplies for the
7 treatment of diabetes.
8 R. Any hospital or medical service contract that provides coverage for
9 prescription drugs shall not limit or exclude coverage for any prescription
10 drug prescribed for the treatment of cancer on the basis that the
11 prescription drug has not been approved by the United States food and drug
12 administration for the treatment of the specific type of cancer for which the
13 prescription drug has been prescribed, if the prescription drug has been
14 recognized as safe and effective for treatment of that specific type of
15 cancer in one or more of the standard medical reference compendia prescribed
16 in subsection S of this section or medical literature that meets the criteria
17 prescribed in subsection S of this section. The coverage required under this
18 subsection includes covered medically necessary services associated with the
19 administration of the prescription drug. This subsection does not:
20 1. Require coverage of any prescription drug used in the treatment of
21 a type of cancer if the United States food and drug administration has
22 determined that the prescription drug is contraindicated for that type of
23 cancer.
24 2. Require coverage for any experimental prescription drug that is not
25 approved for any indication by the United States food and drug
26 administration.
27 3. Alter any law with regard to provisions that limit the coverage of
28 prescription drugs that have not been approved by the United States food and
29 drug administration.
30 4. Notwithstanding section 20-841.05, require reimbursement or
31 coverage for any prescription drug that is not included in the drug formulary
32 or list of covered prescription drugs specified in the contract.
33 5. Notwithstanding section 20-841.05, prohibit a contract from
34 limiting or excluding coverage of a prescription drug, if the decision to
35 limit or exclude coverage of the prescription drug is not based primarily on
36 the coverage of prescription drugs required by this section.
37 6. Prohibit the use of deductibles, coinsurance, copayments or other
38 cost sharing in relation to drug benefits and related medical benefits
39 offered.
40 S. For the purposes of subsection R of this section:
41 1. The acceptable standard medical reference compendia are the
42 following:
43 (a) The American medical association drug evaluations, a publication
44 of the American medical association.

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

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. 17. Section 20-826.03, Arizona Revised Statutes, is amended to read:

20-826.03. <u>Eosinophilic gastrointestinal disorder; formula</u>

A. Any contract that is offered by a hospital service corporation or medical service corporation and that contains a prescription drug benefit shall cover amino acid-based formula that is ordered by a physician OR A REGISTERED NURSE PRACTITIONER if:

1. The subscriber has been diagnosed with an eosinophilic gastrointestinal disorder.

2. The subscriber is under the continuous 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.

3. There is risk of a mental or physical impairment without the use of the formula.

B. A hospital service corporation or medical service corporation shall cover at least seventy-five per cent of the cost of the formula. The hospital service corporation or medical service corporation may limit the maximum annual benefit for formula under this section to twenty thousand dollars.

C. This section does not apply to limited benefit coverage as defined in section 20-1137.

Sec. 18. Section 20-833, Arizona Revised Statutes, is amended to read:

20-833. Relationship of health care professional and patient; financial incentives; definition

A. Nothing in this article alters the relationship of physician and patient, REGISTERED NURSE PRACTITIONER AND PATIENT, dentist and patient or optometrist and patient.

B. The corporation shall not in any way influence the subscriber in the subscriber's free choice of hospital, physician, REGISTERED NURSE PRACTITIONER, dentist or optometrist other than to limit its benefits to participating hospitals, physicians, dentists and optometrists.

C. Nothing in this article abridges the right of any physician, hospital, dentist or optometrist to decline patients in accordance with the standards and practices of such physician, hospital, dentist or optometrist, and the corporation shall not be deemed to be engaged in the corporate practice of medicine, dentistry or optometry.

D. A contract between the corporation and a health care professional shall not contain a financial incentive plan that includes a specific payment made to or withheld from the health care professional as an inducement to deny, reduce, limit or delay medically necessary care that is covered by the contract with a subscriber or group of subscribers for a specific disease or condition. This section does not prohibit per diem or per case payments, diagnostic related grouping payments, or financial incentive plans, including capitation payments or shared risk arrangements, that are not connected to specific medical decisions relating to a subscriber or a group of subscribers for a specific disease or condition. Each corporation shall file with its annual report a written statement with the director that certifies that the corporation is in compliance with this subsection.

E. For the purposes of this section, "health care professional" has the same meaning prescribed in section 20-3151.

Sec. 19. Section 20-841.04, Arizona Revised Statutes, is amended to read:

20-841.04. Standing referrals to network health care professionals; definition

A. Any corporation that offers a health benefits plan shall establish a procedure by which a subscriber may apply for a standing referral to a

network health care professional. The corporation shall provide a subscriber with a standing referral if all of the following conditions are met:

1. The subscriber is a covered member of that corporation.

2. The subscriber has a disease or condition that is life threatening, degenerative, chronic or disabling.

3. The subscriber's primary care physician OR REGISTERED NURSE PRACTITIONER in conjunction with a network health care professional determines that the subscriber's health care requires a network health care professional's expertise.

4. The subscriber's primary care physician OR REGISTERED NURSE PRACTITIONER determines that the subscriber's disease or condition will require ongoing medical care for an extended period of time.

5. The standing referral is made by the subscriber's primary care physician OR REGISTERED NURSE PRACTITIONER to a network health care professional who is responsible for providing and coordinating the subscriber's specialty care.

6. The network health care professional is authorized by the corporation to provide the services under the standing referral.

B. The corporation may limit the number of visits and time period for which a subscriber may receive a standing referral.

C. If the subscriber receives a standing referral or any other referral from the subscriber's primary care physician, that referral remains in effect even if the primary care physician leaves the corporation's network.

D. If the treating health care professional leaves the network or the subscriber ceases to be a covered member, the standing referral expires.

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, "network health care professional" means a practitioner of a health profession as defined in section 32-3101 who is under written contract with the corporation to provide services in a specialty discipline that is recognized by an American medical specialty board.

Sec. 20. Section 20-1051, Arizona Revised Statutes, is amended to read:

20-1051. <u>Definitions</u>

In this article, unless the context otherwise requires:

1. "Director" means the director of the department of insurance.

2. "Enrollee" means an individual who has been enrolled in a health care plan.

3. "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee and setting out the coverage to which the enrollee is entitled.

1 4. "Genetic information" means information about genes, gene products
2 and inherited characteristics that may derive from the individual or a family
3 member, including information regarding carrier status and information
4 derived from laboratory tests that identify mutations in specific genes or
5 chromosomes, physical medical examinations, family histories and direct
6 analysis of genes or chromosomes.
7 5. "Health care plan" means any contractual arrangement whereby any
8 health care services organization undertakes to provide directly or to
9 arrange for all or a portion of contractually covered health care services
10 and to pay or make reimbursement for any remaining portion of the health care
11 services on a prepaid basis through insurance or otherwise. A health care
12 plan shall include those health care services required in this article or in
13 any rule adopted pursuant to this article.
14 6. "Health care services" means services for the purpose of
15 diagnosing, preventing, alleviating, curing or healing human illness or
16 injury.
17 7. "Health care services organization" means any person that
18 undertakes to conduct one or more health care plans. Unless the context
19 otherwise requires, health care services organization includes a provider
20 sponsored health care services organization.
21 8. "Health status-related factor" means any factor in relation to the
22 health of the individual or a dependent of the individual enrolled or to be
23 enrolled in a health care services organization including:
24 (a) Health status.
25 (b) Medical condition, including physical and mental illness.
26 (c) Claims experience.
27 (d) Receipt of health care.
28 (e) Medical history.
29 (f) Genetic information.
30 (g) Evidence of insurability, including conditions arising out of acts
31 of domestic violence as defined in section 20-448.
32 (h) The existence of a physical or mental disability.
33 9. "Network plan" means health care services that are provided by a
34 health care services organization under which the financing and delivery of
35 health care services are provided, in whole or in part, through a defined set
36 of providers under contract with the health care services organization.
37 10. "Person" means any natural or artificial person including, but not
38 limited to, individuals, partnerships, associations, providers of health
39 care, trusts, insurers, hospital or medical service corporations or other
40 corporations, prepaid group practice plans, foundations for medical care and
41 health maintenance organizations.
42 11. "Provider" means any physician, hospital or other person that is
43 licensed or otherwise authorized to furnish health care services in this
44 state.

12. "Provider sponsored health care services organization" means a provider sponsored organization that provides at least one health care plan only to medicare beneficiaries under the medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859).

13. "Provider sponsored organization" means an entity that:

(a) Is a legal aggregation of providers that operate collectively to provide health care services to medicare beneficiaries under the medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859).

(b) Acts through a licensed firm or corporation that has authority over the entity's activities and responsibility for satisfying the requirements of this article relating to the operation of a provider sponsored health care services organization.

(c) Provides a substantial proportion of the health care services required to be provided under the medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859) directly through providers or affiliated groups of providers.

14. "REGISTERED NURSE PRACTITIONER" HAS THE SAME MEANING PRESCRIBED IN SECTION 32-1601.

Sec. 21. Section 20-1057, Arizona Revised Statutes, is amended to read:

20-1057. <u>Evidence of coverage by health care services organizations; renewability; definitions</u>

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, ~~also provide~~ 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

1 stated in the contract for such action by the organization. Failure of the
2 organization to comply with this subsection shall invalidate any cancellation
3 or nonrenewal except a cancellation or nonrenewal for nonpayment of premium,
4 for fraud or misrepresentation in the application or other enrollment
5 documents or for loss of eligibility as defined in the evidence of coverage.
6 A health care services organization shall not cancel an enrollee's evidence
7 of coverage issued on a group basis because of the enrollee's or dependent's
8 age, except for loss of eligibility as defined in the evidence of coverage,
9 sex, health status-related factor, national origin or frequency of
10 utilization of health care services of the enrollee. An evidence of coverage
11 issued on a group basis shall clearly delineate all terms under which the
12 health care services organization may cancel or refuse to renew an evidence
13 of coverage for an enrollee or dependent. Nothing in this subsection
14 prohibits the cancellation or nonrenewal of a health benefits plan contract
15 issued on a group basis for any of the reasons allowed in section 20-2309. A
16 health care services organization may cancel or nonrenew an evidence of
17 coverage issued to an individual on a nongroup basis only for the reasons
18 allowed by subsection N of this section.
19 I. A health care plan that provides coverage for surgical services for
20 a mastectomy shall also provide coverage incidental to the patient's covered
21 mastectomy for surgical services for reconstruction of the breast on which
22 the mastectomy was performed, surgery and reconstruction of the other breast
23 to produce a symmetrical appearance, prostheses, treatment of physical
24 complications for all stages of the mastectomy, including lymphedemas, and at
25 least two external postoperative prostheses subject to all of the terms and
26 conditions of the policy.
27 J. A contract that provides coverage for surgical services for a
28 mastectomy shall also provide coverage for mammography screening performed on
29 dedicated equipment for diagnostic purposes on referral by a patient's
30 physician, subject to all of the terms and conditions of the policy and
31 according to the following guidelines:
32 1. A baseline mammogram for a woman from age thirty-five to
33 thirty-nine.
34 2. A mammogram for a woman from age forty to forty-nine every two
35 years or more frequently based on the recommendation of the woman's
36 physician.
37 3. A mammogram every year for a woman fifty years of age and over.
38 K. Any contract that is issued to the enrollee and that provides
39 coverage for maternity benefits shall also provide that the maternity
40 benefits apply to the costs of the birth of any child legally adopted by the
41 enrollee if all the following are true:
42 1. The child is adopted within one year of birth.
43 2. The enrollee is legally obligated to pay the costs of birth.
44 3. All preexisting conditions and other limitations have been met and
45 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 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 P of this section including:

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
6. Limitations.
7. Exceptions.
8. Reductions.
9. Elimination periods.
10. Requirements for replacement.
11. 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.

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

1 6. Drawing up devices and monitors for the visually impaired.
2 7. Injection aids.
3 8. Insulin cartridges for the legally blind.
4 9. Syringes and lancets including automatic lancing devices.
5 10. Prescribed oral agents for controlling blood sugar that are
6 included on the plan formulary.
7 11. To the extent coverage is required under medicare, podiatric
8 appliances for prevention of complications associated with diabetes.
9 12. Any other device, medication, equipment or supply for which
10 coverage is required under medicare from and after January 1, 1999. The
11 coverage required in this paragraph is effective six months after the
12 coverage is required under medicare.
13 U. Nothing in subsection T of this section:
14 1. Entitles a member or enrollee of a health care services
15 organization to equipment or supplies for the treatment of diabetes that are
16 not medically necessary as determined by the health care services
17 organization medical director or the medical director's designee.
18 2. Provides coverage for diabetic supplies obtained by a member or
19 enrollee of a health care services organization without a prescription unless
20 otherwise permitted pursuant to the terms of the health care plan.
21 3. Prohibits a health care services organization from imposing
22 deductibles, coinsurance or other cost sharing in relation to benefits for
23 equipment or supplies for the treatment of diabetes.
24 V. Any contract or evidence of coverage that provides coverage for
25 prescription drugs shall not limit or exclude coverage for any prescription
26 drug prescribed for the treatment of cancer on the basis that the
27 prescription drug has not been approved by the United States food and drug
28 administration for the treatment of the specific type of cancer for which the
29 prescription drug has been prescribed, if the prescription drug has been
30 recognized as safe and effective for treatment of that specific type of
31 cancer in one or more of the standard medical reference compendia prescribed
32 in subsection W of this section or medical literature that meets the criteria
33 prescribed in subsection W of this section. The coverage required under this
34 subsection includes covered medically necessary services associated with the
35 administration of the prescription drug. This subsection does not:
36 1. Require coverage of any prescription drug used in the treatment of
37 a type of cancer if the United States food and drug administration has
38 determined that the prescription drug is contraindicated for that type of
39 cancer.
40 2. Require coverage for any experimental prescription drug that is not
41 approved for any indication by the United States food and drug
42 administration.
43 3. Alter any law with regard to provisions that limit the coverage of
44 prescription drugs that have not been approved by the United States food and
45 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 medical association drug evaluations, a publication of the American medical association.

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

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

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.

1 BB. A health care services organization shall cover at least fifty per
2 cent of the cost of medical foods prescribed to treat inherited metabolic
3 disorders and covered pursuant to this section. An organization may limit
4 the maximum annual benefit for medical foods under this section to five
5 thousand dollars, which applies to the cost of all prescribed modified low
6 protein foods and metabolic formula.
7 CC. Unless preempted under federal law or unless federal law imposes
8 greater requirements than this section, this section applies to a provider
9 sponsored health care services organization.
10 DD. For the purposes of:
11 1. This section:
12 (a) "Inherited metabolic disorder" means a disease caused by an
13 inherited abnormality of body chemistry and includes a disease tested under
14 the newborn screening program prescribed in section 36-694.
15 (b) "Medical foods" means modified low protein foods and metabolic
16 formula.
17 (c) "Metabolic formula" means foods that are all of the following:
18 (i) Formulated to be consumed or administered enterally under the
19 supervision of a physician who is licensed pursuant to title 32, chapter 13
20 or 17 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE
21 32, CHAPTER 15.
22 (ii) Processed or formulated to be deficient in one or more of the
23 nutrients present in typical foodstuffs.
24 (iii) Administered for the medical and nutritional management of a
25 person who has limited capacity to metabolize foodstuffs or certain nutrients
26 contained in the foodstuffs or who has other specific nutrient requirements
27 as established by medical evaluation.
28 (iv) Essential to a person's optimal growth, health and metabolic
29 homeostasis.
30 (d) "Modified low protein foods" means foods that are all of the
31 following:
32 (i) Formulated to be consumed or administered enterally under the
33 supervision of a physician who is licensed pursuant to title 32, chapter 13
34 or 17 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE
35 32, CHAPTER 15.
36 (ii) Processed or formulated to contain less than one gram of protein
37 per unit of serving, but does not include a natural food that is naturally
38 low in protein.
39 (iii) Administered for the medical and nutritional management of a
40 person who has limited capacity to metabolize foodstuffs or certain nutrients
41 contained in the foodstuffs or who has other specific nutrient requirements
42 as established by medical evaluation.
43 (iv) Essential to a person's optimal growth, health and metabolic
44 homeostasis.

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 the age of eighteen years.

Sec. 22. Section 20-1057.01, Arizona Revised Statutes, is amended to read:

20-1057.01. Standing referrals to network health care professionals; definition

A. A health care services organization shall establish a procedure by which an enrollee may apply for a standing referral to a network health care professional. The health care services organization shall provide an ~~insured~~ ENROLLEE with a standing referral if all of the following conditions are met:

1. The enrollee is a covered member of that health care services organization.

2. The enrollee has a disease or condition that is life threatening, degenerative, chronic or disabling.

3. The enrollee's primary care physician OR REGISTERED NURSE PRACTITIONER in conjunction with a network health care professional determines that the enrollee's health care requires a network health care professional's expertise.

4. The enrollee's primary care physician OR REGISTERED NURSE PRACTITIONER determines that the enrollee's disease or condition will require ongoing medical care for an extended period of time.

5. The standing referral is made by the enrollee's primary care physician OR REGISTERED NURSE PRACTITIONER to a network health care professional who is responsible for providing and coordinating the enrollee's specialty care.

6. The network health care professional is authorized by the health care services organization to provide the services under the standing referral.

B. The health care services organization may limit the number of visits and time period for which an enrollee may receive a standing referral.

C. If the enrollee receives a standing referral or any other REFERRAL from the enrollee's primary care physician, that referral remains in effect even if the primary care physician leaves the health care services organization's network.

D. If the treating health care professional leaves the network or the enrollee ceases to be a covered member, the standing referral expires.

E. For the purposes of this section, "network health care professional" means a practitioner of a health profession as defined in section 32-3101 who is under written contract with the health care services organization to provide services in a specialty discipline that is recognized by an American medical specialty board.

1 Sec. 23. Section 20-1057.10, Arizona Revised Statutes, is amended to
2 read:
3 20-1057.10. Eosinophilic gastrointestinal disorder; formula
4 A. Any contract or evidence of coverage that is offered by a health
5 care services organization and that contains a prescription drug benefit
6 shall cover amino acid-based formula that is ordered by a physician OR A
7 REGISTERED NURSE PRACTITIONER if:
8 1. The enrollee has been diagnosed with an eosinophilic
9 gastrointestinal disorder.
10 2. The enrollee is under the continuous supervision of a physician who
11 is licensed pursuant to title 32, chapter 13 or 17 OR A REGISTERED NURSE
12 PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15.
13 3. There is risk of a mental or physical impairment without the use of
14 the formula.
15 B. A health care services organization shall cover at least
16 seventy-five per cent of the cost of the formula. The health care services
17 organization may limit the maximum annual benefit for formula under this
18 section to twenty thousand dollars.
19 C. This section does not apply to limited benefit coverage as defined
20 in section 20-1137.
21 Sec. 24. Section 20-1342, Arizona Revised Statutes, is amended to
22 read:
23 20-1342. Scope and format of policy; definitions
24 A. A policy of disability insurance shall not be delivered or issued
25 for delivery to any person in this state unless it otherwise complies with
26 this title and complies with the following:
27 1. The entire money and other considerations shall be expressed in the
28 policy.
29 2. The time when the insurance takes effect and terminates shall be
30 expressed in the policy.
31 3. It shall purport to insure only one person, except that a policy
32 may insure, originally or by subsequent amendment, on the application of the
33 policyholder or the policyholder's spouse, any two or more eligible members
34 of that family, including husband, wife, dependent children or any children
35 under a specified age that does not exceed nineteen years and any other
36 person dependent upon the policyholder. Any policy, except accidental death
37 and dismemberment, applied for that provides family coverage shall, as to
38 such coverage of family members, also provide that the benefits applicable
39 for children shall be payable with respect to a newly born child of the
40 insured from the instant of such child's birth, to a child adopted by the
41 insured, regardless of the age at which the child was adopted, and to a child
42 who has been placed for adoption with the insured and for whom the
43 application and approval procedures for adoption pursuant to section 8-105 or
44 8-108 have been completed to the same extent that such coverage applies to
45 other members of the family. The coverage for newly born or adopted children

1 or children placed for adoption shall include coverage of injury or sickness
2 including necessary care and treatment of medically diagnosed congenital
3 defects and birth abnormalities. If payment of a specific premium is
4 required to provide coverage for a child, the policy may require that
5 notification of birth, adoption or adoption placement of the child and
6 payment of the required premium must be furnished to the insurer within
7 thirty-one days after the date of birth, adoption or adoption placement in
8 order to have the coverage continue beyond the thirty-one day period.
9 4. The style, arrangement and overall appearance of the policy shall
10 give no undue prominence to any portion of the text, and every printed
11 portion of the text of the policy and of any endorsements or attached papers
12 shall be plainly printed in light-faced type of a style in general use, the
13 size of which shall be uniform and not less than ten point with a lower case
14 unspaced alphabet length of not less than one hundred and twenty point.
15 "Text" shall include all printed matter except the name and address of the
16 insurer, name or title of the policy, the brief description, if any, and
17 captions and subcaptions.
18 5. The exceptions and reductions of indemnity shall be set forth in
19 the policy and, other than those contained in sections 20-1345 through
20 20-1368, shall be printed and, at the insurer's option, either included with
21 the benefit provision to which they apply or under an appropriate caption
22 such as "exceptions", or "exceptions and reductions", except that if an
23 exception or reduction specifically applies only to a particular benefit of
24 the policy, a statement of such exception or reduction shall be included with
25 the benefit provision to which it applies.
26 6. Each such form, including riders and endorsements, shall be
27 identified by a form number in the lower left-hand corner of the first page.
28 7. The policy shall contain no provision purporting to make any
29 portion of the charter, rules, constitution or bylaws of the insurer a part
30 of the policy unless such portion is set forth in full in the policy, except
31 in the case of the incorporation of, or reference to, a statement of rates or
32 classification of risks, or short-rate table filed with the director.
33 8. Each contract shall be so written that the corporation shall pay
34 benefits:
35 (a) For performance of any surgical service that is covered by the
36 terms of such contract, regardless of the place of service.
37 (b) For any home health services that are performed by a licensed home
38 health agency and that a physician has prescribed in lieu of hospital
39 services, as defined by the director, providing the hospital services would
40 have been covered.
41 (c) For any diagnostic service that a physician has performed outside
42 a hospital in lieu of inpatient service, providing the inpatient service
43 would have been covered.

1 (d) For any service performed in a hospital's outpatient department or
2 in a freestanding surgical facility, providing such service would have been
3 covered if performed as an inpatient service.
4 9. A disability insurance policy that provides coverage for the
5 surgical expense of a mastectomy shall also provide coverage incidental to
6 the patient's covered mastectomy for the expense of reconstructive surgery of
7 the breast on which the mastectomy was performed, surgery and reconstruction
8 of the other breast to produce a symmetrical appearance, prostheses,
9 treatment of physical complications for all stages of the mastectomy,
10 including lymphedemas, and at least two external postoperative prostheses
11 subject to all of the terms and conditions of the policy.
12 10. A contract, except a supplemental contract covering a specified
13 disease or other limited benefits, that provides coverage for surgical
14 services for a mastectomy shall also provide coverage for mammography
15 screening performed on dedicated equipment for diagnostic purposes on
16 referral by a patient's physician, subject to all of the terms and conditions
17 of the policy and according to the following guidelines:
18 (a) A baseline mammogram for a woman from age thirty-five to
19 thirty-nine.
20 (b) A mammogram for a woman from age forty to forty-nine every two
21 years or more frequently based on the recommendation of the woman's
22 physician.
23 (c) A mammogram every year for a woman fifty years of age and over.
24 11. Any contract that is issued to the insured and that provides
25 coverage for maternity benefits shall also provide that the maternity
26 benefits apply to the costs of the birth of any child legally adopted by the
27 insured if all the following are true:
28 (a) The child is adopted within one year of birth.
29 (b) The insured is legally obligated to pay the costs of birth.
30 (c) All preexisting conditions and other limitations have been met by
31 the insured.
32 (d) The insured has notified the insurer of the insured's
33 acceptability to adopt children pursuant to section 8-105, within sixty days
34 after such approval or within sixty days after a change in insurance
35 policies, plans or companies.
36 12. The coverage prescribed by paragraph 11 of this subsection is
37 excess to any other coverage the natural mother may have for maternity
38 benefits except coverage made available to persons pursuant to title 36,
39 chapter 29, but not including coverage made available to persons defined as
40 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and
41 (e). If such other coverage exists the agency, attorney or individual
42 arranging the adoption shall make arrangements for the insurance to pay those
43 costs that may be covered under that policy and shall advise the adopting
44 parent in writing of the existence and extent of the coverage without
45 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.

1 4. Require reimbursement or coverage for any prescription drug that is
2 not included in the drug formulary or list of covered prescription drugs
3 specified in the contract.
4 5. Prohibit a contract from limiting or excluding coverage of a
5 prescription drug, if the decision to limit or exclude coverage of the
6 prescription drug is not based primarily on the coverage of prescription
7 drugs required by this section.
8 6. Prohibit the use of deductibles, coinsurance, copayments or other
9 cost sharing in relation to drug benefits and related medical benefits
10 offered.
11 G. For the purposes of subsection F of this section:
12 1. The acceptable standard medical reference compendia are the
13 following:
14 (a) The American medical association drug evaluations, a publication
15 of the American medical association.
16 (b) The American hospital formulary service drug information, a
17 publication of the American society of health system pharmacists.
18 (c) Drug information for the health care provider, a publication of
19 the United States pharmacopoeia convention.
20 2. Medical literature may be accepted if all of the following apply:
21 (a) At least two articles from major peer reviewed professional
22 medical journals have recognized, based on scientific or medical criteria,
23 the drug's safety and effectiveness for treatment of the indication for which
24 the drug has been prescribed.
25 (b) No article from a major peer reviewed professional medical journal
26 has concluded, based on scientific or medical criteria, that the drug is
27 unsafe or ineffective or that the drug's safety and effectiveness cannot be
28 determined for the treatment of the indication for which the drug has been
29 prescribed.
30 (c) The literature meets the uniform requirements for manuscripts
31 submitted to biomedical journals established by the international committee
32 of medical journal editors or is published in a journal specified by the
33 United States department of health and human services as acceptable peer
34 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
35 security act (42 United States Code section 1395x(t)(2)(B)).
36 H. Any contract that is offered by a disability insurer and that
37 contains a routine outpatient prescription drug benefit shall provide
38 coverage of medical foods to treat inherited metabolic disorders as provided
39 by this section.
40 I. The metabolic disorders triggering medical foods coverage under
41 this section shall:
42 1. Be part of the newborn screening program prescribed in section
43 36-694.
44 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

1 or 17 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE
2 32, CHAPTER 15.
3 (ii) Processed or formulated to contain less than one gram of protein
4 per unit of serving, but does not include a natural food that is naturally
5 low in protein.
6 (iii) Administered for the medical and nutritional management of a
7 person who has limited capacity to metabolize foodstuffs or certain nutrients
8 contained in the foodstuffs or who has other specific nutrient requirements
9 as established by medical evaluation.
10 (iv) Essential to a person's optimal growth, health and metabolic
11 homeostasis.
12 2. Subsection A of this section, the term "child", for purposes of
13 initial coverage of an adopted child or a child placed for adoption but not
14 for purposes of termination of coverage of such child, means a person under
15 the age of eighteen years.
16 Sec. 25. Section 20-1342.05, Arizona Revised Statutes, is amended to
17 read:
18 20-1342.05. Eosinophilic gastrointestinal disorder; formula
19 A. Any policy of disability insurance that is offered by a disability
20 insurer and that contains a prescription drug benefit shall cover amino
21 acid-based formula that is ordered by a physician OR BY A REGISTERED NURSE
22 PRACTITIONER if:
23 1. The insured has been diagnosed with an eosinophilic
24 gastrointestinal disorder.
25 2. The insured is under the continuous supervision of a physician who
26 is licensed pursuant to title 32, chapter 13 or 17 OR A REGISTERED NURSE
27 PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15.
28 3. There is risk of a mental or physical impairment without the use of
29 the formula.
30 B. A disability insurer shall cover at least seventy-five per cent of
31 the cost of the formula. The disability insurer may limit the maximum annual
32 benefit for formula under this section to twenty thousand dollars.
33 C. This section does not apply to limited benefit coverage as defined
34 in section 20-1137.
35 Sec. 26. Section 20-1376, Arizona Revised Statutes, is amended to
36 read:
37 20-1376. Prohibiting denial of certain contract benefits
38 A. Notwithstanding any provision of any disability insurance contract,
39 benefits shall not be denied under the contract for any medical or surgical
40 service performed by a holder of a license issued pursuant to title 32,
41 chapter 7 or 11, OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT
42 TO TITLE 32, CHAPTER 15, if the service performed is within the lawful scope
43 of such person's license, and if the service is surgical, such person is a
44 member of the staff of an accredited hospital, and if such contract would

have provided benefits if such service had been performed by a holder of a license issued pursuant to title 32, chapter 13.

B. If any disability insurance contract provides for or offers eye care services, the subscriber shall have freedom of choice to select either an optometrist or a physician and surgeon skilled in diseases of the eye to provide the examination, care, or treatment for which the subscriber is eligible and ~~which~~ THAT falls within the scope of practice of the optometrist or physician and surgeon. Unless such disability insurance contract otherwise provides, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses~~,~~ or appurtenances ~~thereto~~ TO THESE MATERIALS OR ITEMS.

C. If any individual disability insurance contract is written to provide coverage for psychiatric, drug abuse or alcoholism services, reimbursement for such services shall be made 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. Reimbursement for the cost of the service may be made directly to the person licensed or certified pursuant to title 32, chapter 13 or 19.1 or to the subscriber if the cost of the service has not been reimbursed to another provider or health care institution.

Sec. 27. 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 shall, as to such coverage of family members, 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

1 approval procedures for adoption pursuant to section 8-105 or 8-108 have been
2 completed to the same extent that such coverage applies to other members of
3 the family. The coverage for newly born or adopted children or children
4 placed for adoption shall include coverage of injury or sickness including
5 the necessary care and treatment of medically diagnosed congenital defects
6 and birth abnormalities. If payment of a specific premium is required to
7 provide coverage for a child, the policy may require that notification of
8 birth, adoption or adoption placement of the child and payment of the
9 required premium must be furnished to the insurer within thirty-one days
10 after the date of birth, adoption or adoption placement in order to have the
11 coverage continue beyond such thirty-one day period.
12 3. A provision that to the group originally insured may be added from
13 time to time eligible new employees or members or dependents, as the case may
14 be, in accordance with the terms of the policy.
15 4. Each contract shall be so written that the corporation shall pay
16 benefits:
17 (a) For performance of any surgical service that is covered by the
18 terms of such contract, regardless of the place of service.
19 (b) For any home health services that are performed by a licensed home
20 health agency and that a physician has prescribed in lieu of hospital
21 services, as defined by the director, providing the hospital services would
22 have been covered.
23 (c) For any diagnostic service that a physician has performed outside
24 a hospital in lieu of inpatient service, providing the inpatient service
25 would have been covered.
26 (d) For any service performed in a hospital's outpatient department or
27 in a freestanding surgical facility, providing such service would have been
28 covered if performed as an inpatient service.
29 5. A group disability insurance policy that provides coverage for the
30 surgical expense of a mastectomy shall also provide coverage incidental to
31 the patient's covered mastectomy for the expense of reconstructive surgery of
32 the breast on which the mastectomy was performed, surgery and reconstruction
33 of the other breast to produce a symmetrical appearance, prostheses,
34 treatment of physical complications for all stages of the mastectomy,
35 including lymphedemas, and at least two external postoperative prostheses
36 subject to all of the terms and conditions of the policy.
37 6. A contract, except a supplemental contract covering a specified
38 disease or other limited benefits, that provides coverage for surgical
39 services for a mastectomy shall also provide coverage for mammography
40 screening performed on dedicated equipment for diagnostic purposes on
41 referral by a patient's physician, subject to all of the terms and conditions
42 of the policy and according to the following guidelines:
43 (a) A baseline mammogram for a woman from age thirty-five to
44 thirty-nine.

1 (b) A mammogram for a woman from age forty to forty-nine every two
2 years or more frequently based on the recommendation of the woman's
3 physician.
4 (c) A mammogram every year for a woman fifty years of age and over.
5 7. Any contract that is issued to the insured and that provides
6 coverage for maternity benefits shall also provide that the maternity
7 benefits apply to the costs of the birth of any child legally adopted by the
8 insured if all the following are true:
9 (a) The child is adopted within one year of birth.
10 (b) The insured is legally obligated to pay the costs of birth.
11 (c) All preexisting conditions and other limitations have been met by
12 the insured.
13 (d) The insured has notified the insurer of the insured's
14 acceptability to adopt children pursuant to section 8-105, within sixty days
15 after such approval or within sixty days after a change in insurance
16 policies, plans or companies.
17 8. The coverage prescribed by paragraph 7 of this subsection is excess
18 to any other coverage the natural mother may have for maternity benefits
19 except coverage made available to persons pursuant to title 36, chapter 29,
20 but not including coverage made available to persons defined as eligible
21 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If
22 such other coverage exists the agency, attorney or individual arranging the
23 adoption shall make arrangements for the insurance to pay those costs that
24 may be covered under that policy and shall advise the adopting parent in
25 writing of the existence and extent of the coverage without disclosing any
26 confidential information such as the identity of the natural parent. The
27 insured adopting parents shall notify their insurer of the existence and
28 extent of the other coverage.
29 B. Any policy that provides maternity benefits shall not restrict
30 benefits for any hospital length of stay in connection with childbirth for
31 the mother or the newborn child to less than forty-eight hours following a
32 normal vaginal delivery or ninety-six hours following a cesarean section.
33 The policy shall not require the provider to obtain authorization from the
34 insurer for prescribing the minimum length of stay required by this
35 subsection. The policy may provide that an attending provider in
36 consultation with the mother may discharge the mother or the newborn child
37 before the expiration of the minimum length of stay required by this
38 subsection. The insurer shall not:
39 1. Deny the mother or the newborn child eligibility or continued
40 eligibility to enroll or to renew coverage under the terms of the policy
41 solely for the purpose of avoiding the requirements of this subsection.
42 2. Provide monetary payments or rebates to mothers to encourage those
43 mothers to accept less than the minimum protections available pursuant to
44 this subsection.

1 3. Penalize or otherwise reduce or limit the reimbursement of an
2 attending provider because that provider provided care to any insured under
3 the policy in accordance with this subsection.
4 4. Provide monetary or other incentives to an attending provider to
5 induce that provider to provide care to an insured under the policy in a
6 manner that is inconsistent with this subsection.
7 5. Except as described in subsection C of this section, restrict
8 benefits for any portion of a period within the minimum length of stay in a
9 manner that is less favorable than the benefits provided for any preceding
10 portion of that stay.
11 C. Nothing in subsection B of this section:
12 1. Requires a mother to give birth in a hospital or to stay in the
13 hospital for a fixed period of time following the birth of the child.
14 2. Prevents an insurer from imposing deductibles, coinsurance or other
15 cost sharing in relation to benefits for hospital lengths of stay in
16 connection with childbirth for a mother or a newborn child under the policy,
17 except that any coinsurance or other cost sharing for any portion of a period
18 within a hospital length of stay required pursuant to subsection B of this
19 section shall not be greater than the coinsurance or cost sharing for any
20 preceding portion of that stay.
21 3. Prevents an insurer from negotiating the level and type of
22 reimbursement with a provider for care provided in accordance with
23 subsection B of this section.
24 D. Any contract that provides coverage for diabetes shall also provide
25 coverage for equipment and supplies that are medically necessary and that are
26 prescribed by a health care provider including:
27 1. Blood glucose monitors.
28 2. Blood glucose monitors for the legally blind.
29 3. Test strips for glucose monitors and visual reading and urine
30 testing strips.
31 4. Insulin preparations and glucagon.
32 5. Insulin cartridges.
33 6. Drawing up devices and monitors for the visually impaired.
34 7. Injection aids.
35 8. Insulin cartridges for the legally blind.
36 9. Syringes and lancets including automatic lancing devices.
37 10. Prescribed oral agents for controlling blood sugar that are
38 included on the plan formulary.
39 11. To the extent coverage is required under medicare, podiatric
40 appliances for prevention of complications associated with diabetes.
41 12. Any other device, medication, equipment or supply for which
42 coverage is required under medicare from and after January 1, 1999. The
43 coverage required in this paragraph is effective six months after the
44 coverage is required under medicare.

1 E. Nothing in subsection D of this section prohibits a group
2 disability insurer from imposing deductibles, coinsurance or other cost
3 sharing in relation to benefits for equipment or supplies for the treatment
4 of diabetes.
5 F. Any contract that provides coverage for prescription drugs shall
6 not limit or exclude coverage for any prescription drug prescribed for the
7 treatment of cancer on the basis that the prescription drug has not been
8 approved by the United States food and drug administration for the treatment
9 of the specific type of cancer for which the prescription drug has been
10 prescribed, if the prescription drug has been recognized as safe and
11 effective for treatment of that specific type of cancer in one or more of the
12 standard medical reference compendia prescribed in subsection G of this
13 section or medical literature that meets the criteria prescribed in
14 subsection G of this section. The coverage required under this subsection
15 includes covered medically necessary services associated with the
16 administration of the prescription drug. This subsection does not:
17 1. Require coverage of any prescription drug used in the treatment of
18 a type of cancer if the United States food and drug administration has
19 determined that the prescription drug is contraindicated for that type of
20 cancer.
21 2. Require coverage for any experimental prescription drug that is not
22 approved for any indication by the United States food and drug
23 administration.
24 3. Alter any law with regard to provisions that limit the coverage of
25 prescription drugs that have not been approved by the United States food and
26 drug administration.
27 4. Require reimbursement or coverage for any prescription drug that is
28 not included in the drug formulary or list of covered prescription drugs
29 specified in the contract.
30 5. Prohibit a contract from limiting or excluding coverage of a
31 prescription drug, if the decision to limit or exclude coverage of the
32 prescription drug is not based primarily on the coverage of prescription
33 drugs required by this section.
34 6. Prohibit the use of deductibles, coinsurance, copayments or other
35 cost sharing in relation to drug benefits and related medical benefits
36 offered.
37 G. For the purposes of subsection F of this section:
38 1. The acceptable standard medical reference compendia are the
39 following:
40 (a) The American medical association drug evaluations, a publication
41 of the American medical association.
42 (b) The American hospital formulary service drug information, a
43 publication of the American society of health system pharmacists.
44 (c) Drug information for the health care provider, a publication of
45 the United States pharmacopoeia convention.

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 ~~federal~~ 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 ~~federal~~ 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.

1 (b) "Medical foods" means modified low protein foods and metabolic
2 formula.
3 (c) "Metabolic formula" means foods that are all of the following:
4 (i) Formulated to be consumed or administered enterally under the
5 supervision of a physician who is licensed pursuant to title 32, chapter 13
6 or 17 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE
7 32, CHAPTER 15.
8 (ii) Processed or formulated to be deficient in one or more of the
9 nutrients present in typical foodstuffs.
10 (iii) Administered for the medical and nutritional management of a
11 person who has limited capacity to metabolize foodstuffs or certain nutrients
12 contained in the foodstuffs or who has other specific nutrient requirements
13 as established by medical evaluation.
14 (iv) Essential to a person's optimal growth, health and metabolic
15 homeostasis.
16 (d) "Modified low protein foods" means foods that are all of the
17 following:
18 (i) Formulated to be consumed or administered enterally under the
19 supervision of a physician who is licensed pursuant to title 32, chapter 13
20 or 17 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE
21 32, CHAPTER 15.
22 (ii) Processed or formulated to contain less than one gram of protein
23 per unit of serving, but does not include a natural food that is naturally
24 low in protein.
25 (iii) Administered for the medical and nutritional management of a
26 person who has limited capacity to metabolize foodstuffs or certain nutrients
27 contained in the foodstuffs or who has other specific nutrient requirements
28 as established by medical evaluation.
29 (iv) Essential to a person's optimal growth, health and metabolic
30 homeostasis.
31 2. Subsection A of this section, the term "child", for purposes of
32 initial coverage of an adopted child or a child placed for adoption but not
33 for purposes of termination of coverage of such child, means a person under
34 the age of eighteen years.
35 3. Subsection M of this section, "religious employer" means an entity
36 for which all of the following apply:
37 (a) The entity primarily employs persons who share the religious
38 tenets of the entity.
39 (b) The entity serves primarily persons who share the religious tenets
40 of the entity.
41 (c) The entity is a nonprofit organization as described in section
42 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

1 Sec. 28. Section 20-1402.02, Arizona Revised Statutes, is amended to
2 read:
3 20-1402.02. Eosinophilic gastrointestinal disorder; formula
4 A. Any group disability policy that is offered by a group disability
5 insurer and that contains a prescription drug benefit shall cover amino
6 acid-based formula that is ordered by a physician OR A REGISTERED NURSE
7 PRACTITIONER if:
8 1. The insured has been diagnosed with an eosinophilic
9 gastrointestinal disorder.
10 2. The insured is under the continuous supervision of a physician who
11 is licensed pursuant to title 32, chapter 13 or 17 OR A REGISTERED NURSE
12 PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15.
13 3. There is risk of a mental or physical impairment without the use of
14 the formula.
15 B. A group disability insurer shall cover at least seventy-five per
16 cent of the cost of the formula. The group disability insurer may limit the
17 maximum annual benefit for formula under this section to twenty thousand
18 dollars.
19 C. This section does not apply to limited benefit coverage as defined
20 in section 20-1137.
21 Sec. 29. Section 20-1404, Arizona Revised Statutes, is amended to
22 read:
23 20-1404. Blanket disability insurance; definitions
24 A. Blanket disability insurance is that form of disability insurance
25 covering special groups of persons as enumerated in one of the following
26 paragraphs:
27 1. Under a policy or contract issued to any common carrier, which
28 shall be deemed the policyholder, covering a group defined as all persons who
29 may become passengers on such common carrier.
30 2. Under a policy or contract issued to an employer, who shall be
31 deemed the policyholder, covering all employees or any group of employees
32 defined by reference to exceptional hazards incident to such employment.
33 Dependents of the employees and guests of the employer may also be included
34 where exposed to the same hazards.
35 3. Under a policy or contract issued to a college, school or other
36 institution of learning or to the head or principal thereof, who or which
37 shall be deemed the policyholder, covering students or teachers.
38 4. Under a policy or contract issued in the name of any volunteer fire
39 department or first aid or other such volunteer group, or agency having
40 jurisdiction thereof, which shall be deemed the policyholder, covering all of
41 the members of such fire department or group.
42 5. Under a policy or contract issued to a creditor, who shall be
43 deemed the policyholder, to insure debtors of the creditor.

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 may, at the insurer's option, 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 shall, as to such coverage of family members, 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

1 such other coverage exists the agency, attorney or individual arranging the
2 adoption shall make arrangements for the insurance to pay those costs that
3 may be covered under that policy and shall advise the adopting parent in
4 writing of the existence and extent of the coverage without disclosing any
5 confidential information such as the identity of the natural parent. The
6 insured adopting parents shall notify their insurer of the existence and
7 extent of the other coverage.
8 K. Any contract that provides maternity benefits shall not restrict
9 benefits for any hospital length of stay in connection with childbirth for
10 the mother or the newborn child to less than forty-eight hours following a
11 normal vaginal delivery or ninety-six hours following a cesarean section.
12 The contract shall not require the provider to obtain authorization from the
13 insurer for prescribing the minimum length of stay required by this
14 subsection. The contract may provide that an attending provider in
15 consultation with the mother may discharge the mother or the newborn child
16 before the expiration of the minimum length of stay required by this
17 subsection. The insurer shall not:
18 1. Deny the mother or the newborn child eligibility or continued
19 eligibility to enroll or to renew coverage under the terms of the contract
20 solely for the purpose of avoiding the requirements of this subsection.
21 2. Provide monetary payments or rebates to mothers to encourage those
22 mothers to accept less than the minimum protections available pursuant to
23 this subsection.
24 3. Penalize or otherwise reduce or limit the reimbursement of an
25 attending provider because that provider provided care to any insured under
26 the contract in accordance with this subsection.
27 4. Provide monetary or other incentives to an attending provider to
28 induce that provider to provide care to an insured under the contract in a
29 manner that is inconsistent with this subsection.
30 5. Except as described in subsection L of this section, restrict
31 benefits for any portion of a period within the minimum length of stay in a
32 manner that is less favorable than the benefits provided for any preceding
33 portion of that stay.
34 L. Nothing in subsection K of this section:
35 1. Requires a mother to give birth in a hospital or to stay in the
36 hospital for a fixed period of time following the birth of the child.
37 2. Prevents an insurer from imposing deductibles, coinsurance or other
38 cost sharing in relation to benefits for hospital lengths of stay in
39 connection with childbirth for a mother or a newborn child under the
40 contract, except that any coinsurance or other cost sharing for any portion
41 of a period within a hospital length of stay required pursuant to subsection
42 K of this section shall not be greater than the coinsurance or cost sharing
43 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 medical association drug evaluations, a publication of the American medical association.

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

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

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 ~~federal~~ 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 ~~federal~~ 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 ~~paragraph~~ 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

1 or 17 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE
2 32, CHAPTER 15.
3 (ii) Processed or formulated to contain less than one gram of protein
4 per unit of serving, but does not include a natural food that is naturally
5 low in protein.
6 (iii) Administered for the medical and nutritional management of a
7 person who has limited capacity to metabolize foodstuffs or certain nutrients
8 contained in the foodstuffs or who has other specific nutrient requirements
9 as established by medical evaluation.
10 (iv) Essential to a person's optimal growth, health and metabolic
11 homeostasis.
12 2. Subsection E of this section, the term "child", for purposes of
13 initial coverage of an adopted child or a child placed for adoption but not
14 for purposes of termination of coverage of such child, means a person under
15 the age of eighteen years.
16 3. Subsection V of this section, "religious employer" means an entity
17 for which all of the following apply:
18 (a) The entity primarily employs persons who share the religious
19 tenets of the entity.
20 (b) The entity serves primarily persons who share the religious tenets
21 of the entity.
22 (c) The entity is a nonprofit organization as described in section
23 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.
24 Sec. 30. Section 20-1404.02, Arizona Revised Statutes, is amended to
25 read:
26 20-1404.02. Eosinophilic gastrointestinal disorder; formula
27 A. Any policy or contract that is offered by a blanket disability
28 insurer and that contains a prescription drug benefit shall cover amino
29 acid-based formula that is ordered by a physician OR A REGISTERED NURSE
30 PRACTITIONER if:
31 1. The insured has been diagnosed with an eosinophilic
32 gastrointestinal disorder.
33 2. The insured is under the continuous supervision of a physician who
34 is licensed pursuant to title 32, chapter 13 or 17 OR A REGISTERED NURSE
35 PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15.
36 3. There is risk of a mental or physical impairment without the use of
37 the formula.
38 B. A blanket disability insurer shall cover at least seventy-five per
39 cent of the cost of the formula. The blanket disability insurer may limit
40 the maximum annual benefit for formula under this section to twenty thousand
41 dollars.
42 C. This section does not apply to limited benefit coverage as defined
43 in section 20-1137.

Sec. 31. Section 20-1406, Arizona Revised Statutes, is amended to read:

20-1406. Prohibiting denial of certain contract benefits

A. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract, benefits shall not be denied under the contract for any medical or surgical service performed by a holder of a license issued pursuant to title 32, chapter 7 or 11 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15, if the service performed is within the lawful scope of such person's license, and if the service is surgical, such person is a member of the staff of an accredited hospital, and if such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to title 32, chapter 13.

B. If any group disability insurance contract or blanket disability insurance contract provides for or offers eye care services, the subscriber shall have freedom of choice to select either an optometrist or a physician and surgeon skilled in diseases of the eye to provide the examination, care, or treatment for which the subscriber is eligible and which falls within the scope of practice of the optometrist or physician and surgeon. Unless such group disability insurance contract or blanket disability insurance contract otherwise provides, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances thereto.

C. If any group disability insurance contract is written to provide coverage for psychiatric, drug abuse or alcoholism services, reimbursement for such services shall be made 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. Reimbursement for the cost of the service may be made directly to the person licensed or certified pursuant to title 32, chapter 13 or 19.1 or to the subscriber if the cost of the service has not been reimbursed to another provider or health care institution.

Sec. 32. Section 20-1631, Arizona Revised Statutes, is amended to read:

20-1631. Definition of motor vehicle; cancellation of or failure to renew coverage; limitations; limitation of liability; exceptions; insurance producers

A. In this article, unless the context otherwise requires, "motor vehicle" means a licensed land, motor-driven vehicle but does not mean:

1. A private passenger or station wagon type vehicle used as a public or livery conveyance or rented to others.

2. Any other four-wheel motor vehicle of a load capacity of fifteen hundred pounds or less ~~which~~ THAT is used in the business of transporting passengers for hire, used in business primarily to transport property or equipment, used as a public or livery conveyance or rented to others.

3. Any motor vehicle with a load capacity of more than fifteen hundred pounds.

B. A motor vehicle used as a public or livery conveyance or rented to others does not include a motor vehicle used in the course of volunteer work for a tax-exempt organization as described in section 43-1201, paragraph 4.

C. An insurer shall not cancel or refuse to renew a motor vehicle insurance policy solely because of the location of residence, age, race, color, religion, sex, national origin or ancestry of anyone who is an insured.

D. An insurer shall not issue a motor vehicle insurance policy in this state unless the cancellation and renewal conditions of the policy or the endorsement on the policy includes the limitations required by this section. After a policy issued in this state has been in effect for sixty days, or if the policy is a renewal, effective immediately, the company shall not exercise its right to cancel or fail to renew the insurance afforded under the policy unless:

1. The named insured fails to discharge when due any of the obligations of the named insured in connection with the payment of premium for this policy or any installment of the premium.

2. The insurance was obtained through fraudulent misrepresentation.

3. The named insured, any person who resides in the same household as the named insured and customarily operates a motor vehicle insured under the policy or any other person who regularly and frequently operates a motor vehicle insured under the policy:

(a) Has had the person's driver license suspended or revoked during the policy period.

(b) Becomes permanently disabled, either physically or mentally, and such individual does not produce a certificate from a physician OR A REGISTERED NURSE PRACTITIONER testifying to such person's ability to operate a motor vehicle.

(c) Is or has been convicted during the thirty-six months immediately preceding the effective date of the policy or during the policy period of:

(i) Criminal negligence resulting in death, homicide or assault and arising out of the operation of a motor vehicle.

(ii) Operating a motor vehicle while in an intoxicated condition or while under the influence of drugs.

(iii) Leaving the scene of an accident.

(iv) Making false statements in an application for a driver license.

(v) Reckless driving.

4. The insurer is placed in rehabilitation or receivership by the insurance supervisory official in its state of domicile or by a court of competent jurisdiction or the director has suspended the insurer's certificate of authority based on its financially hazardous condition.

5. The named insured, any person who resides in the same household as the named insured and customarily operates a motor vehicle insured under the policy or any other person who regularly and frequently operates a motor vehicle insured under the policy uses a motor vehicle rated or insured under

the policy as a private passenger motor vehicle regularly and frequently for commercial purposes.

6. The director determines that the continuation of the policy would place the insurer in violation of the laws of this state or would jeopardize the solvency of the insurer.

7. If the insured and the insured's family members are eligible for insurance based solely on the insured's employment with the insurer, employment of the insured with that insurer is terminated and the insurer exercises its right to nonrenew the policy within twelve months following the insured's termination of employment.

E. In addition to the authorization to fail to renew insurance provided by subsection D of this section, an insurer may exercise its right to fail to renew a motor vehicle insurance policy pursuant to this subsection. An insurer shall provide notice of the nonrenewal to the named insured as prescribed by section 20-1632 at least forty-five days before the nonrenewal. A named insured who disputes the nonrenewal of the named insured's policy may file an objection with the director pursuant to section 20-1633. An insurer shall not fail to renew more than one-half of one per cent of its policies annually pursuant to this subsection. An insurer may fail to renew a motor vehicle insurance policy if the named insured, any person who resides in the same household as the named insured and who customarily operates a motor vehicle insured under the policy or any other person who regularly and frequently operates a motor vehicle insured under the policy has had at any time during the thirty-six months immediately before the notice of nonrenewal three or more at-fault accidents under any motor vehicle insurance policy issued by this insurer in which the property damage paid by the insurer for each accident ~~which~~ THAT occurred prior to January 1, 2000 is more than one thousand eight hundred dollars. For accidents occurring on or after January 1, 2000, the department of insurance shall annually adjust and publish, to the nearest ten dollars, the threshold amount of property damages in this subsection by the percentage change in the all items component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics. The insurer shall not exercise its right to fail to renew the insurance under this subsection unless the same individual has had all the accidents that make the policy subject to nonrenewal under this subsection. The insurer shall not exercise its right to fail to renew a motor vehicle insurance policy pursuant to this subsection due to the accident record of the named insured if the named insured has been insured for standard automobile bodily injury coverage for at least ten consecutive years with the same insurer prior to the most recent accident that makes the policy subject to nonrenewal under this subsection. For the purposes of this subsection, "at-fault" means the insured is at least fifty per cent responsible for the accident.

F. The company shall not cancel or fail to renew the insurance when a person other than the named insured has violated subsection D, paragraph 3 of

this section, or fail to renew the insurance pursuant to subsection E of this section due to the driving record of an individual other than the named insured, if the named insured in writing agrees to exclude as insured the person by name when operating a motor vehicle and further agrees to exclude coverage to the named insured for any negligence ~~which~~ THAT may be imputed by law to the named insured arising out of the maintenance, operation or use of a motor vehicle by the excluded person. The written agreement that excludes coverage under a policy for a named individual is effective for each renewal of the policy by the insurer and remains in effect until the insurer agrees in writing to provide coverage for the named individual who was previously excluded from coverage.

G. This article does not apply to any policy ~~which~~ THAT has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer unless the policy is a renewal policy, or to policies:

1. Insuring any motor vehicle other than a private passenger motor vehicle as defined in section 20-117.

2. Insuring the motor vehicle hazard of garages, motor vehicle sales agencies, repair shops, service stations or public parking places.

3. Providing insurance only on an excess basis.

H. If a consumer purchases motor vehicle insurance coverage from an insurance producer licensed in this state, the insurance producer that owns the policy expiration shall remain the insurance producer of record for that insured. In the event the insurer terminates the insurance producer's contract, the insurance producer shall continue to provide customary services to the insured. The insurer shall provide the insurance producer with a minimum degree of authority necessary to provide customary services to the insured and shall provide the same level of compensation for these services ~~which~~ THAT were in effect prior to the termination of the insurance producer contract.

I. Subsection H of this section shall not apply if one or more of the following conditions exist:

1. The insurance producer of record has had its license suspended or revoked by the department.

2. The insurance producer of record is indebted to the insurer.

3. The insured has supplied the insurer with a written request that its insurance producer of record be changed to another insurance producer of the insurer.

4. The insurance producer of record has authorized transfer of this account to another licensed insurance producer of the insurer.

5. The director has determined after a public hearing that continuation of this relationship is not in the best interest of the public.

6. The insurance producer of record is under an exclusive contract or contract requiring the insurance producer to submit all eligible business to an insurer or group of insurers under a common management.

J. Subsection H of this section shall not apply to any transaction in which the expiration of the policies is owned by the insurer.

K. Notwithstanding any law to the contrary, the issuance at renewal of revised policy provisions to modify an existing policy by adding coverages or policy provisions, modifying coverages or policy provisions, or eliminating coverages or policy provisions is not a nonrenewal or cancellation of the policy if the modification of a basic coverage does not eliminate the essential benefit of that basic coverage. If the modification of the basic coverage eliminates the essential benefit of the basic coverage, the director shall order the insurer to remove the modification from the policy. This subsection does not allow the insurer, without the written consent of the insured, to eliminate the basic coverages of the policy or to reduce the monetary limits of any of the basic coverages of the policy that were selected and agreed on. This subsection does not limit a policyholder from continuing to renew uninsured or underinsured motorist coverage pursuant to section 20-259.01. For the purposes of this subsection, "basic coverage" means any of the following:

1. Bodily injury coverage.
2. Property damage coverage.
3. Uninsured motorist coverage.
4. Underinsured motorist coverage.
5. Medical payments coverage.
6. Comprehensive coverage.
7. Collision coverage.

L. For the purposes of this section, "fail to renew" or "nonrenewal" does not include the issuance and delivery of a new policy within the same insurer or an insurer under the same ownership or management as the original insurer as provided in this subsection. An insurer may transfer up to one per cent of its policies to an affiliated insurer within one calendar year if under a policy to be transferred one or more of the insureds that are insured under the policy have individually within the past thirty-six months had two or more at-fault accidents under any motor vehicle insurance policy issued by this insurer in which the property damage paid by the insurer for each accident exceeded one thousand five hundred dollars or individually have had three or more moving violations. Moving violations for which an insured completes an approved traffic school program shall not be considered as a moving violation under this section. A company shall not transfer a policy if a named insured agrees in writing to exclude as an insured a person or persons who each individually meet the criteria for transfer pursuant to this subsection and further agrees to exclude coverage for any negligence ~~which~~ THAT may be imputed by law to the named insured arising out of the maintenance, operation or use of a motor vehicle by such excluded person or persons. An insurer shall transfer only those individuals responsible for the at-fault accidents or moving violations, and the excluded or transferred insured's driving record shall not be used in determining rates, surcharges

1 or premiums for the nonexcluded or nontransferred insured. The one per cent
2 limit set forth in this subsection shall not apply to transfers of policies
3 from the original insurer to another insurer under the same ownership or
4 management as the original insurer if the rates charged by the other insurer
5 are the same as or lower than the rates charged by the original insurer. No
6 insurer shall transfer policyholders because of their location of residence,
7 age, race, color, religion, sex, national origin or ancestry. Transfers by
8 an insurer pursuant to this subsection shall not be construed to permit a new
9 unrestricted sixty day period for cancellation or nonrenewal.
10 M. Except as provided in this subsection, an insurer shall not refuse
11 to renew a policy until after August 31, 1998, based on an insured's failure
12 to maintain membership in a bona fide association, until both the insurer and
13 bona fide association have complied with this subsection and shall not refuse
14 to renew any coverage continuously in effect before September 1, 1998,
15 subject to all the following:
16 1. In addition to any other reason provided in this section, an
17 insurer may refuse to renew an insurance policy issued pursuant to this
18 article if all of the following conditions apply:
19 (a) The insurer clearly discloses to the applicant and the insured in
20 the application for insurance and insurance policy that both the payment of
21 dues and current membership in the bona fide association are prerequisites to
22 obtaining or renewing the insurance.
23 (b) Any money paid to the bona fide association as a membership fee:
24 (i) Is not used by the insurer directly or indirectly to defray any
25 costs or expenses in connection with the sale or purchase of the insurance.
26 (ii) Is set independently of any factor used by the insurer to make
27 any judgment or determination about the eligibility of any individual,
28 including the member, an employee of a member or a dependent of a member, to
29 purchase or renew the insurance.
30 (c) The bona fide association has filed a certification with the
31 director verifying the eligibility of the insurer to refuse to renew an
32 insurance policy based on membership in the bona fide association.
33 2. To qualify as a bona fide association pursuant to this subsection,
34 the association shall meet all of the requirements of this paragraph. The
35 association shall file a statement with the director at least thirty days
36 before the commencement of the offer or sale of insurance as provided by this
37 subsection verifying that the association meets the requirements of this
38 paragraph. The association shall update the filing required by this
39 paragraph at least thirty days before the effective date of any material
40 change in the information contained in the statement, and shall file a
41 separate notice with the director if the insurance described in the statement
42 is no longer available through the association. The statement shall include
43 the following information:
44 (a) That the association has been in active existence for at least
45 five consecutive years immediately before the filing of the statement.

(b) That the association has been formed and maintained in good faith for purposes other than obtaining or providing insurance and does not condition membership in the association on the purchase of insurance.

(c) That the association has articles of incorporation and bylaws or other similar governing documents.

(d) That the association does not condition membership in the association or set membership fees on the eligibility of any individual, including the member, an employee of the member or a dependent of the member, to purchase or renew the insurance, or on any factor that the insurer could not lawfully consider when setting rates.

(e) That the association has a relationship with a specific insurer or insurers and identifies the insurer or insurers.

3. Membership fees collected by the bona fide association are not premiums of the insurer that issued the coverage unless the bona fide association:

(a) Uses any portion of the membership fees directly or indirectly to defray any costs or expenses in connection with the sale or purchase of the insurance.

(b) Sets or adjusts membership fees for any member of the bona fide association based on any factor used by the insurer that issues the insurance to make any judgment or determination about the eligibility of any individual, including the member, an employee of the member or a dependent of the member, to purchase or renew the insurance.

4. If the membership fees constitute premiums pursuant to paragraph 3 of this subsection, an insurer shall not refuse to renew a policy as otherwise permitted by this subsection.

Sec. 33. Section 20-2323, Arizona Revised Statutes, is amended to read:

20-2323. Disclosure of information

A. Each accountable health plan that offers a health benefits plan to the public shall provide disclosure forms as required by this section. The disclosure form shall be in a form that is prescribed by the director and that includes all of the following:

1. A separate roster of the plan's primary care physicians who are licensed pursuant to title 32, chapter 13, 17 or 29, AND REGISTERED NURSE PRACTITIONERS WHO ARE LICENSED PURSUANT TO TITLE 32, CHAPTER 15, including the physician's or REGISTERED NURSE PRACTITIONER'S degree and practice specialty, the year initially licensed to practice ~~medicine~~ and, if different, the year initially licensed to practice ~~medicine~~ in this state.

2. In concise and specific terms:

(a) The full premium cost of the plan.

(b) Any copayment, coinsurance or deductible requirements that an enrollee or the enrollee's family may incur in obtaining coverage under the plan and any reservation by the plan to change premiums.

(c) The health care benefits to which an enrollee would be entitled.

(d) Where and in what manner an enrollee may obtain services, including the procedures for selecting or changing primary care physicians AND REGISTERED NURSE PRACTITIONERS and the locations of hospitals and outpatient treatment centers that are under contract with the accountable health plan.

3. Any limitations of the services, kinds of services, benefits and exclusions that apply to the plan including:

(a) Procedures for emergency room, nighttime or weekend visits and referrals to specialist physicians AND REGISTERED NURSE PRACTITIONERS.

(b) Whether services received outside of the plan are covered and in what manner they are covered.

(c) The circumstances under which prior authorization is required for emergency ~~medical~~ HEALTH care and a statement as to whether and where the plan provides twenty-four hour emergency services.

(d) The circumstances under which the plan may retroactively deny coverage for emergency ~~medical~~ HEALTH RELATED treatment and nonemergency ~~medical~~ HEALTH RELATED treatment that had prior authorization under the plan's written policies.

(e) A statement regarding whether the plan's providers must comply with any specified numbers, targeted averages or maximum durations of patient visits and the specific requirements of each.

(f) The procedures that the enrollee must follow to consult with a physician OR A REGISTERED NURSE PRACTITIONER other than the enrollee's primary care physician OR REGISTERED NURSE PRACTITIONER and whether the enrollee's primary care physician OR REGISTERED NURSE PRACTITIONER, the plan's medical director or a committee must first authorize the referral.

(g) Whether it is necessary to repeat prior authorization if the specialist care is continuing.

(h) Whether a point of service option is available and how it is structured.

4. Grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care and access to care issues.

5. Subject to section 20-2326, a statement as to whether a plan physician OR REGISTERED NURSE PRACTITIONER is restricted to prescribing drugs from a plan list or plan formulary and the extent to which an enrollee will be reimbursed for costs of a drug that is not on a plan list or plan formulary.

6. A statement as to whether plan provider compensation programs include any incentives or penalties that are intended to encourage plan providers to withhold services or minimize or avoid referrals to specialist physicians, and if these types of incentives or penalties are included, a concise description of and, at the option of the accountable health plan, justification for each of them.

7. A statement that the disclosure form is a summary only and that the enrollee should consult the plan's evidence of coverage to determine any governing contractual provision.

B. An accountable health plan shall not disseminate a completed disclosure form until the form is submitted to the director. This section does not require an accountable health plan to submit to the director its separate roster of plan physicians AND REGISTERED NURSE PRACTITIONERS or any roster updates.

C. On request, an accountable health plan shall provide the information required under subsection A of this section to all employers who are considering participating in a health benefits plan that is offered by the accountable health plan or to an employer that is considering renewal of a health benefits plan that is provided by an accountable health plan.

D. An employer shall provide to its eligible employees the disclosures required under subsection A of this section no later than the initiation of any open enrollment period or at least ten days before any employee enrollment deadline that is not associated with an open enrollment period.

E. An employer shall not execute a contract with an accountable health plan until the employer receives the information required under subsection A of this section.

F. Nothing in this section provides any private right or cause of action to or on behalf of any enrollee, prospective enrollee, employer or other person, whether a resident or nonresident of this state. This section provides solely an administrative remedy to the director of the department of insurance for any violation of this section or any related rule.

Sec. 34. Section 20-2327, Arizona Revised Statutes, is amended to read:

20-2327. Metabolic disorders; medical foods; definitions

A. Any health benefits plan THAT IS offered by an accountable health plan AND that contains a prescription drug benefit shall provide coverage of medical foods to treat inherited metabolic disorders as provided by this section.

B. 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.

C. 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.

D. An accountable health plan 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 ~~corporation~~ PLAN may limit the maximum annual benefit for medical foods under this section to five thousand dollars ~~which~~ THAT applies to the cost of all prescribed modified low protein foods and metabolic formula.

E. For the purposes of this section:

1. "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.

2. "Medical foods" means modified low protein foods and metabolic formula.

3. "Metabolic formula" means foods that are all of the following:

(a) 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.

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

(c) 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.

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

4. "Modified low protein foods" means foods that are all of the following:

(a) 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.

(b) 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.

(c) 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.

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

Sec. 35. Section 20-2332, Arizona Revised Statutes, is amended to read:

20-2332. Eosinophilic gastrointestinal disorder; formula

A. Any health benefit plan that is offered by an accountable health plan and that contains a prescription drug benefit shall cover amino acid-based formula that is ordered by a physician OR BY A REGISTERED NURSE PRACTITIONER if:

1. The insured has been diagnosed with an eosinophilic gastrointestinal disorder.

2. The insured is under the continuous 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.

3. There is risk of a mental or physical impairment without the use of the formula.

B. An accountable health plan shall cover at least seventy-five per cent of the cost of the formula. The accountable health plan may limit the maximum annual benefit for formula under this section to twenty thousand dollars.

C. This section does not apply to limited benefit coverage as defined in section 20-1137.

Sec. 36. Section 21-202, Arizona Revised Statutes, is amended to read:

21-202. Persons entitled to be excused from jury service

A. It is the policy of this state that all qualified citizens have an obligation to serve on juries when summoned by the courts of this state, unless excused.

B. On timely application to the court, the following persons shall be excused temporarily from service as a juror if the judge or jury commissioner finds that any of the following ~~apply~~ APPLIES:

1. The prospective juror has a mental or physical condition that causes the juror to be incapable of performing jury service. The juror or the juror's personal representative shall provide to the court or jury commissioner a medical statement from a physician who is licensed pursuant to title 32 OR A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15 that explains an existing mental or physical condition that renders the person unfit for jury service. If a prospective juror does not have a physician OR A REGISTERED NURSE PRACTITIONER, the prospective juror or the juror's personal representative shall provide a sworn statement from a professional caregiver for the prospective juror that is deemed acceptable by the court or jury commissioner and that explains the mental or physical condition that renders the prospective juror incapable of performing jury service. For the purposes of this paragraph:

(a) The statement shall be in writing and shall contain a description and duration of any mobility restrictions, the specific symptoms that make

the prospective juror mentally or physically unfit for jury service and their duration, the employment status of the prospective juror and the printed name, signature, professional license number if applicable, area of specialty and contact information of the authorizing physician, REGISTERED NURSE PRACTITIONER or professional caregiver.

(b) A form that complies with this paragraph shall be made available at courthouses, the Arizona medical board ~~web site~~ WEBSITE, THE BOARD OF NURSING WEBSITE and other appropriate locations that are identified by the court or jury commissioner.

(c) These documents are not public records and shall not be disclosed to the general public.

2. Jury service by the prospective juror would substantially and materially affect the public interest or welfare in an adverse manner.

3. The prospective juror is not currently capable of understanding the English language.

4. Jury service would cause undue or extreme physical or financial hardship to the prospective juror or a person under the prospective juror's care or supervision. For the purposes of this paragraph:

(a) A judge or jury commissioner of the court for which the person was called to jury service shall determine whether jury service would cause the prospective juror undue or extreme physical or financial hardship.

(b) A person who requests to be excused under this paragraph shall take all actions necessary to obtain a ruling on the request before the date on which the person is scheduled to appear for jury duty.

(c) Undue or extreme physical or financial hardship is limited to the following circumstances in which a person:

(i) Would be required to abandon a person under the potential juror's care or supervision due to the impossibility of obtaining an appropriate substitute caregiver during the period of participation in the jury pool or on the jury.

(ii) Would incur costs that would have a substantial adverse impact on the payment of the person's necessary daily living expenses or on those for whom the potential juror provides regular employment or the principal means of support.

(iii) Would suffer physical hardship that would result in illness or disease.

(d) Undue or extreme physical or financial hardship does not exist solely based on the fact that a prospective juror will be required to be absent from the prospective juror's place of employment.

(e) A person who requests to be excused under this paragraph shall provide the judge or jury commissioner with documentation that supports the request to be excused, such as federal and state income tax returns, payroll records, medical statements from physicians licensed pursuant to title 32 OR REGISTERED NURSE PRACTITIONERS LICENSED PURSUANT TO TITLE 32, CHAPTER 15, proof of dependency or guardianship or other similar documents. The judge or

jury commissioner may excuse a person if the documentation clearly supports the request to be excused. These documents are not public records and shall not be disclosed to the general public.

5. The prospective juror is a peace officer who is certified by the Arizona peace officer standards and training board and who is employed as a peace officer by this state or any political subdivision of this state. The employer of a peace officer shall not in any way influence the peace officer to make or not to make an application to the court, pursuant to this section, to be excused from jury service.

6. A judge or jury commissioner of the court for which the person was called to jury service excuses the prospective juror for good cause based on a showing of undue or extreme hardship under the circumstances, including being temporarily absent from the jurisdiction or a lack of transportation.

C. Notwithstanding subsection B, a prospective juror who is at least seventy-five years of age may submit a written statement to the court requesting that the person be excused from service. The prospective juror may request to be excused temporarily or permanently. On receipt of the request, the judge or jury commissioner shall excuse the prospective juror from service.

D. A person who is excused temporarily pursuant to this section becomes eligible for qualification as a juror when the temporary excuse expires unless the person is permanently excused from jury service.

E. A person may be permanently excused only if the deciding judge or jury commissioner determines that the underlying grounds for being excused are permanent in nature or the person is permanently excused under subsection C.

Sec. 37. Section 28-447, Arizona Revised Statutes, is amended to read:

28-447. Public records

A. An application for a license, permit, title or registration made to the department and a document required by law or by the department to accompany the application is a public record, except a medical report and a report voluntarily submitted by a physician OR A REGISTERED NURSE PRACTITIONER as defined in section 28-3005, except as provided by section 28-455 and except as otherwise provided by law.

B. If the department is required or authorized to revoke, suspend or cancel a driver license or to suspend vehicle registrations pursuant to chapter 9 of this title, it shall notify the holder by a written notice that includes a citation to the statute or rule under which the action is authorized or required. The department shall retain a copy of the notice. The copy of the notice shall contain a certification that the original notice was mailed and the date the notice was mailed. The copy of the notice is a public record. If the copy is addressed to a licensee at the address last shown on the department's records, as evidenced by the person's driver license application or subsequent notification pursuant to section 28-448 by the person of a different address, it is presumed, unless otherwise shown by

clear and convincing evidence, that the person to whom the notice was addressed received the original notice.

C. The department may place notes, date stamps, identifying numbers or other information on an application, a record of conviction or any other record as is necessary to ensure the accuracy of the record and to expedite its handling. The information does not affect the validity of a record, except that the markings are not considered a part of the record for evidentiary purposes unless proven accurate by other records of the department or other competent evidence.

Sec. 38. Section 28-909, Arizona Revised Statutes, is amended to read:

28-909. Vehicle restraints required; exceptions; civil penalty

A. Each front seat occupant of a motor vehicle that is designed for carrying ten or fewer passengers, that is manufactured for the model year 1972 and thereafter and that is required to be equipped with an integrated lap and shoulder belt or a lap belt pursuant to the federal motor vehicle safety standards prescribed in 49 Code of Federal Regulations section 571.208 shall either:

1. Have the lap and shoulder belt properly adjusted and fastened while the vehicle is in motion.

2. If only a lap belt is installed where the occupant is sitting, have the lap belt properly adjusted and fastened while the vehicle is in motion.

B. The operator of a motor vehicle that is designed for carrying ten or fewer passengers, that is manufactured for the model year 1972 and thereafter and that is required to be equipped with an integrated lap and shoulder belt or a lap belt pursuant to the federal motor vehicle safety standards prescribed in 49 Code of Federal Regulations section 571.208 shall require each passenger under sixteen years of age to either:

1. Have the lap and shoulder belt properly adjusted and fastened while the vehicle is in motion.

2. If only a lap belt is installed where the passenger is sitting, have the lap belt properly adjusted and fastened while the vehicle is in motion.

C. A peace officer shall not stop or issue a citation to a person operating a motor vehicle on a highway in this state for a violation of this section unless the peace officer has reasonable cause to believe there is another alleged violation of a motor vehicle law of this state.

D. If a person is found responsible for a civil traffic violation under this section, a department or agency of this state shall not consider the violation for the purpose of determining whether the person's driver license should be suspended or revoked. A court shall not transmit abstracts of records of violations of this section to the department.

E. An insurer shall not consider a civil traffic violation under this section as a traffic violation against the person for the purposes of establishing rates for motor vehicle liability insurance or determining the

1 insurability of the person. An insurer shall not cancel or refuse to renew
2 any policy of insurance because of the violation.
3 F. This section does not apply to:
4 1. A child subject to the requirements of section 28-907.
5 2. A person possessing a written statement from a physician OR A
6 REGISTERED NURSE PRACTITIONER that the person is unable for medical or
7 psychological reasons to wear a lap and shoulder belt or a lap belt.
8 3. A letter carrier of the United States postal service while the
9 letter carrier is performing the letter carrier's duties.
10 G. If a person is found responsible for a civil traffic violation
11 under this section, the person is subject to a maximum civil penalty of ten
12 dollars for each violation.
13 Sec. 39. Section 28-2409, Arizona Revised Statutes, is amended to
14 read:
15 28-2409. International symbol of access special plates;
16 placard; definitions
17 A. The department shall issue special plates bearing the international
18 symbol of access to either:
19 1. A person who is permanently physically disabled and who is an owner
20 or lessee of a motor vehicle.
21 2. An organization that owns or leases a motor vehicle that primarily
22 transports physically disabled persons.
23 B. A permanently disabled special plate issued under this section is
24 valid for as long as the person to whom the plate is issued qualifies for
25 issuance under this section.
26 C. A person who is permanently physically disabled may obtain, if
27 qualified, a permanently disabled removable windshield placard. A person who
28 is temporarily physically disabled may obtain, if qualified, a temporarily
29 disabled removable windshield placard. An organization that primarily
30 transports physically disabled persons may obtain, if qualified, a placard
31 for each of the qualified vehicles. The department shall issue only one
32 valid placard to a temporarily or permanently physically disabled applicant,
33 except to replace a lost, stolen or mutilated placard or if the department
34 determines, on receiving the applicant's written request, that the needs of
35 the applicant are such that two valid placards are required. The department
36 shall issue a placard pursuant to this section at no additional charge.
37 D. A permanently disabled removable windshield placard issued or
38 renewed under this section is valid for five years. A temporarily disabled
39 removable windshield placard issued or renewed under this section is valid
40 for a period of time as determined by the department. A person who desires to
41 obtain a temporarily disabled removable windshield placard for an additional
42 period of time shall submit a new application.
43 E. A person or organization that desires to obtain a permanently
44 disabled or temporarily disabled removable windshield placard or
45 international symbol of access special plates shall submit an application to

the department on a form furnished by the department that contains one of the following:

1. If a permanently or temporarily disabled person, a certificate completed by a hospital administrator, ~~or by~~ an authorized physician OR A REGISTERED NURSE PRACTITIONER that certifies that the applicant is physically disabled.

2. If an organization, a signed statement by an authorized officer of the organization affirming that the registered vehicle that is owned or leased by the organization and that will display the placard or the international symbol of access special plates primarily transports physically disabled persons.

F. On receipt of the application containing the medical certificate or signed statement, if the department finds that the applicant qualifies for the parking privileges pursuant to chapter 3, article 14 of this title, the department shall issue the placard or international symbol of access special plates.

G. A person or an organization desiring to renew a permanently disabled removable windshield placard shall submit an application to the department containing one of the following:

1. If a permanently disabled person, a signed statement by the person that is witnessed by a department agent or notary public, that requests the renewal of the placard and that affirms that the person is physically disabled.

2. If an organization, a signed statement by an authorized officer of the organization affirming that the registered vehicle that is owned or leased by the organization and that will display the placard primarily transports physically disabled persons.

H. The placard or international symbol of access special plates shall be displayed on or in the motor vehicle in the manner prescribed by the department.

I. A request for special plates issued under this section may be combined with a request for an honored military license plate issued under article 13 of this chapter or any other special plate. The department shall prescribe the form for the request. The request is subject to payment of only the fee required for the honored military license plate or other special plate and is not subject to any other special plate fee under section 28-2402. An international symbol of access special plate that is combined with an honored military license plate or any other special plate is not a personalized special plate under section 28-2406.

J. For the purposes of this section:

1. "Authorized physician" means a doctor of medicine, osteopathy, podiatry or chiropractic licensed to practice medicine in this state or another state or authorized by the United States government to practice medicine.

2. "Permanently disabled removable windshield placard" means a two-sided, hooked placard that includes on each side all of the following:

(a) The international symbol of access that is at least three inches in height, that is centered on the placard and that is white on a blue shield.

(b) An identification number.

(c) An expiration date.

(d) The seal or other identification of the issuing authority.

3. "Physically disabled person" means a person who, as determined by a hospital administrator or authorized physician, meets any of the following conditions:

(a) Cannot walk two hundred feet without stopping to rest.

(b) Cannot walk without the use of or assistance from any brace, cane, crutch, other person, prosthetic device, wheelchair or other assistive device.

(c) Is restricted by lung disease to such an extent that the person's forced respiratory, expiratory volume for one second, if measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/Hg on room air at rest.

(d) Uses portable oxygen.

(e) Has a cardiac condition to the extent that the person's functional limitations are classified in severity as class III or class IV according to standards set by the American heart association.

(f) Is severely limited in the person's ability to walk due to an arthritic, neurological or orthopedic condition.

4. "Temporarily disabled removable windshield placard" means a two-sided, hooked placard that includes on each side all of the following:

(a) The international symbol of access that is at least three inches in height, that is centered on the placard and that is white on a red shield.

(b) An identification number.

(c) A date of expiration.

(d) The seal or other identification of the issuing authority.

Sec. 40. Section 28-3005, Arizona Revised Statutes, is amended to read:

28-3005. Medical or psychological reports; immunity; definitions

A. ~~A physician, psychologist or~~ FOR MEDICAL CONDITIONS, A PHYSICIAN OR REGISTERED NURSE PRACTITIONER, FOR PSYCHOLOGICAL CONDITIONS, A PSYCHOLOGIST, PHYSICIAN, PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER OR substance abuse counselor who provides information to the director in good faith and at the written request of a driver license applicant or licensee concerning a person's medical or psychological condition with respect to operation of a motor vehicle is immune from personal liability with respect to the information provided.

B. Notwithstanding the physician-patient, NURSE-PATIENT or psychologist-client confidentiality relationship, a physician, REGISTERED NURSE PRACTITIONER or psychologist may voluntarily report a patient to the department who has a medical or psychological condition that in the opinion of the physician, REGISTERED NURSE PRACTITIONER or psychologist could significantly impair the person's ability to safely operate a motor vehicle. If a report is made, the physician, REGISTERED NURSE PRACTITIONER or psychologist shall make the report in writing, including the name, address and date of birth of the patient. On receipt of the report, the department may require an examination of the person reported in the manner provided by section 28-3314. A person shall not bring an action against a physician, REGISTERED NURSE PRACTITIONER or psychologist for not making a report pursuant to this subsection. The physician, REGISTERED NURSE PRACTITIONER or psychologist submitting the report in good faith is immune from civil or criminal liability for making the report pursuant to this subsection. The physician's, REGISTERED NURSE PRACTITIONER'S or psychologist's report is subject to subpoena or order to produce in an action except an action against the physician, REGISTERED NURSE PRACTITIONER or psychologist submitting the report.

C. In this section:

1. "Medical or psychological condition" means a condition that could affect a person's functional ability to safely operate a motor vehicle.

2. "Physician" means a medical doctor, optometrist, chiropractor, naturopathic physician, doctor of osteopathy or doctor of homeopathy who is licensed to practice in this state or another state or who is employed by the federal government and practicing in this state or their agents.

3. "PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER" MEANS A PERSON CERTIFIED AS A REGISTERED NURSE PRACTITIONER IN A PSYCHIATRIC MENTAL HEALTH SPECIALTY AREA UNDER THE PROVISIONS OF TITLE 32, CHAPTER 15.

~~3.~~ 4. "Psychologist" means a person who is licensed pursuant to title 32, chapter 19.1, who is licensed to practice psychology in another state or who is employed by the federal government and practicing in this state.

5. "REGISTERED NURSE PRACTITIONER" HAS THE SAME MEANING PRESCRIBED IN SECTION 32-1601.

~~4.~~ 6. "Substance abuse counselor" means a person who is licensed by the board of behavioral health examiners in this state, who is licensed or certified in another state, who is certified by a board for certification of addiction counselors, who is a nationally certified addiction counselor or who is employed by the federal government and practicing in this state.

Sec. 41. Section 28-3167, Arizona Revised Statutes, is amended to read:

28-3167. <u>Medical code information on license; rules; immunity</u>

A. The department shall provide on each driver license and on each nonoperating identification license a space where a licensee may indicate that the licensee suffers from some type of adverse medical condition using a

medical code prescribed by the department if the licensee presents a signed statement from 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 stating that the person suffers from the condition.

B. The department shall prescribe by rule a medical code to identify the medical conditions using a system of numerals or letters commonly accepted by the medical profession. Except for the purposes of entering the medical code on the driver license or nonoperating identification license, and unless the person affirmatively requests in writing that the person wants the medical code as part of the computer record, the department shall not maintain the medical code in the department computer after the department issues the driver license or nonoperating identification license.

C. The department and this state are exempt from liability for damages from the use of medical code information provided on a license pursuant to this section.

Sec. 42. Section 36-2907.01, Arizona Revised Statutes, is amended to read:

36-2907.01. Eosinophilic gastrointestinal disorder; formula

A. Any coverage that is offered by a contractor providing services to persons eligible pursuant to section 36-2901 and that contains a prescription drug benefit shall cover amino acid-based formula that is ordered by a physician OR A REGISTERED NURSE PRACTITIONER if:

1. The person has been diagnosed with an eosinophilic gastrointestinal disorder.

2. The person is under the continuous 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.

3. There is risk of a mental or physical impairment without the use of the formula.

B. This section does not apply to limited benefit coverage as defined in section 20-1137.

Sec. 43. Section 36-2912.03, Arizona Revised Statutes, is amended to read:

36-2912.03. Eosinophilic gastrointestinal disorder; formula

A. Any health benefit plan that is offered by a contractor to persons defined as eligible pursuant to section 36-2912 and that contains a prescription drug benefit shall cover amino acid-based formula that is ordered by a physician OR A REGISTERED NURSE PRACTITIONER if:

1. The person has been diagnosed with an eosinophilic gastrointestinal disorder.

2. The person is under the continuous 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.

3. There is risk of a mental or physical impairment without the use of the formula.

B. This section does not apply to limited benefit coverage as defined in section 20-1137.

Sec. 44. Section 44-133.01, Arizona Revised Statutes, is amended to read:

44-133.01. Capacity of minor to consent to treatment for use of a dangerous drug or narcotic

Notwithstanding any other ~~provision of~~ law, any minor WHO IS AT LEAST twelve years of age ~~or older~~ who is found, upon diagnosis of a licensed physician OR A REGISTERED NURSE PRACTITIONER, to be under the influence of a dangerous drug or narcotic, which includes withdrawal symptoms, may be considered an emergency case and ~~such~~ THE minor is ~~to be regarded~~ CONSIDERED as having consented to hospital or medical care needed for treatment for ~~such~~ THAT CONDITION. Such consent ~~shall~~ IS not ~~be~~ subject to disaffirmance because of minority. The consent of the parent, parents or legal guardian of ~~such~~ THAT minor is not necessary to authorize hospital or medical care, except that ~~such~~ THE consent ~~shall be~~ IS equally valid if obtained.

Sec. 45. Section 46-454, Arizona Revised Statutes, is amended to read:

46-454. Duty to report abuse, neglect and exploitation of incapacitated or vulnerable adults; duty to make medical records available; violation; classification

A. A physician, REGISTERED NURSE PRACTITIONER, hospital intern or resident, surgeon, dentist, psychologist, social worker, peace officer or other person who has responsibility for the care of an incapacitated or vulnerable adult and who has a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred shall immediately report or cause reports to be made of such reasonable basis to a peace officer or to a protective services worker. The guardian or conservator of an incapacitated or vulnerable adult shall immediately report or cause reports to be made of such reasonable basis to the superior court. All of the above reports shall be made immediately in person or by telephone and shall be followed by a written report mailed or delivered within forty-eight hours or on the next working day if the forty-eight hours expire on a weekend or holiday.

B. An attorney, accountant, trustee, guardian, conservator or other person who has responsibility for preparing the tax records of an incapacitated or vulnerable adult or a person who has responsibility for any other action concerning the use or preservation of the incapacitated or vulnerable adult's property and who, in the course of fulfilling that responsibility, discovers a reasonable basis to believe that exploitation of the adult's property has occurred or that abuse or neglect of the adult has occurred shall immediately report or cause reports to be made of such reasonable basis to a peace officer, to a protective services worker or to the public fiduciary of the county in which the incapacitated or vulnerable adult resides. If the public fiduciary is unable to investigate the contents of a report, the public fiduciary shall immediately forward the report to a

protective services worker. If a public fiduciary investigates a report and determines that the matter is outside the scope of action of a public fiduciary, then the report shall be immediately forwarded to a protective services worker. All of the above reports shall be made immediately in person or by telephone and shall be followed by a written report mailed or delivered within forty-eight hours or on the next working day if the forty-eight hours expire on a weekend or holiday.

C. Reports pursuant to subsections A and B shall contain:

1. The names and addresses of the adult and any persons having control or custody of the adult, if known.

2. The adult's age and the nature and extent of ~~his~~ incapacity or vulnerability.

3. The nature and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property.

4. Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

D. Any person other than one required to report or cause reports to be made in subsection A who has a reasonable basis to believe that abuse or neglect of an incapacitated or vulnerable adult has occurred may report the information to a peace officer or to a protective services worker.

E. A person having custody or control of medical or financial records of an incapacitated or vulnerable adult for whom a report is required or authorized under this section shall make such records, or a copy of such records, available to a peace officer or adult protective services worker investigating the incapacitated or vulnerable adult's neglect, exploitation or abuse on written request for the records signed by the peace officer or adult protective services worker. Records disclosed pursuant to this subsection are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from a report required or authorized under this section.

F. If reports pursuant to this section are received by a peace officer, ~~he~~ THE PEACE OFFICER shall notify the adult protective services of the department of economic security as soon as possible and make such information available to them.

G. A person required to receive reports pursuant to subsection A, B or D may take or cause to be taken photographs of the abused adult and the vicinity involved. Medical examinations including radiological examinations of the involved adult may be performed. Accounts, inventories or audits of the exploited adult's property may be performed. The person, department, agency, or court that initiates such photographs, examinations, accounts, inventories or audits shall pay the associated costs in accordance with existing statutes and rules. If any person is found to be responsible for the abuse, neglect or exploitation of an incapacitated or vulnerable adult in

1 a criminal or civil action, the court may order the person to make
2 restitution as the court deems appropriate.
3 H. If psychiatric records are requested pursuant to subsection E, the
4 custodian of the records shall notify the attending psychiatrist, who may
5 excise from the records, before they are made available:
6 1. Personal information about individuals other than the patient.
7 2. Information regarding specific diagnosis or treatment of a
8 psychiatric condition, if the attending psychiatrist certifies in writing
9 that release of the information would be detrimental to the patient's health
10 or treatment.
11 I. If any portion of a psychiatric record is excised pursuant to
12 subsection H, a court, upon application of a peace officer or adult
13 protective services worker, may order that the entire record or any portion
14 of such record containing information relevant to the reported abuse or
15 neglect be made available to the peace officer or adult protective services
16 worker investigating the abuse or neglect.
17 ~~K.~~ J. A licensing agency shall not find that a reported incidence of
18 abuse at a care facility by itself is sufficient grounds to permit the agency
19 to close the facility or to find that all residents are in imminent danger.
20 ~~J.~~ K. A person who violates any provision of this section is guilty
21 of a class 1 misdemeanor.

APPROVED BY THE GOVERNOR APRIL 18, 2007.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 18, 2007.