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136th General Assembly
Regular Session
2025-2026

Sub. H. B. No. 271

To amend sections 1751.62, 3923.52, 3923.53,
5162.20, and 5164.08 of the Revised Code to
revise the law governing insurance and Medicaid
coverage of breast cancer screenings and
examinations and to name this act the Breast
Examination and Screening Transformation Act, or
BEST Act.

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BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1751.62, 3923.52, 3923.53,
5162.20, and 5164.08 of the Revised Code be amended to read as
follows:

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Sec. 1751.62. (A) As used in this section:

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(1) "Screening mammography" means a radiologic examination
that, in accordance with applicable American college of
radiology guidelines, is utilized to detect ~~unsuspected~~ breast
cancer ~~at an early stage in an asymptomatic woman~~ and includes
the x-ray examination of the breast using equipment that is
dedicated specifically for mammography, including, but not
limited to, the x-ray tube, filter, compression device, screens,
film, and cassettes, and that has an average radiation exposure

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delivery of less than one rad mid-breast. "Screening
mammography" includes digital breast tomosynthesis. "Screening
mammography" includes two views for each breast. The term also
includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic
mammography.

(2) "Medicare reimbursement rate" means the reimbursement
rate paid in Ohio under the medicare program for a screening
mammography, supplemental breast cancer screening, or diagnostic
breast examination that does not include digitization or
computer-aided detection, regardless of whether the actual
benefit includes digitization or computer-aided detection.

(3) "Diagnostic breast examination" means any examination
that, in accordance with applicable American college of
radiology guidelines, is deemed medically necessary by a
treating health care provider to diagnose breast cancer,
including diagnostic mammography, magnetic resonance imaging,
ultrasound, or biopsy.

(4) "Supplemental breast cancer screening" means any
additional screening method deemed medically necessary by a
treating health care provider for proper breast cancer screening
in accordance with applicable American college of radiology
guidelines, including magnetic resonance imaging, ultrasound,
contrast enhanced mammography, or molecular breast imaging.

(5) "Cost-sharing" means the cost to an enrollee under an
individual or group health insuring corporation policy,
contract, or agreement according to any coverage limit,
copayment, coinsurance, deductible, or other out-of-pocket
expense requirements imposed by the policy, contract, or

agreement. 49

(B) Notwithstanding section 3901.71 of the Revised Code, 50
every individual or group health insuring corporation policy, 51
contract, or agreement providing basic health care services that 52
is delivered, issued for delivery, or renewed in this state 53
shall provide benefits for the expenses of all of the following: 54

(1) To detect the presence of breast cancer in adult 55
~~women~~individuals, a screening mammography; 56

(2) To detect the presence of breast cancer in adult ~~women~~ 57
individuals meeting either or both of the conditions described 58
in division (C) (2) of this section, supplemental breast cancer 59
screening; 60

(3) To diagnose breast cancer in adult individuals meeting 61
the condition described in division (C) (3) of this section, a 62
diagnostic breast examination; 63

(4) To detect the presence of cervical cancer, cytologic 64
screening. 65

(C) (1) The benefits provided under division (B) (1) of this 66
section shall cover expenses for one screening mammography every 67
year, including digital breast tomosynthesis. 68

(2) The benefits provided under division (B) (2) of this 69
section shall cover expenses for supplemental breast cancer 70
screening for an adult ~~woman~~individual who meets either or both 71
of the following conditions: 72

(a) The ~~woman's~~individual's screening mammography 73
demonstrates, based on the breast imaging reporting and data 74
system established by the American college of radiology, that 75
the ~~woman~~individual has dense breast tissue; 76

(b) The ~~woman~~individual is at an increased risk of breast 77
cancer due to family history, prior personal history of breast 78
cancer, ancestry, genetic predisposition, or other reasons as 79
determined by the ~~woman's~~individual's health care provider. 80

(3) The benefits provided under division (B) (3) of this 81
section shall cover expenses for diagnostic breast examination 82
for an adult individual who has an abnormality seen or suspected 83
from, or detected by, a screening mammography, supplemental 84
breast cancer screening, or another means of examination. 85

(D) (1) Subject to divisions (D) (2) and (3) of this 86
section, if a provider, hospital, or other health care facility 87
provides a service that is a component of ~~the screening~~ 88
~~mammography~~ a benefit is provided under division (B) (1), (2), or 89
(3) of this section or a component of the supplemental breast 90
~~cancer screening benefit in division (B) (2) of this section and~~ 91
submits a separate claim for that component, a separate payment 92
shall be made to the provider, hospital, or other health care 93
facility in an amount that corresponds to the ratio paid by 94
medicare in this state for that component. 95

(2) Regardless of whether separate payments are made for 96
the benefit provided under division (B) (1), ~~or (2), or (3)~~ of 97
this section, the total benefit for a screening mammography ~~or,~~ 98
supplemental breast cancer screening, or diagnostic breast 99
examination shall not exceed ~~one hundred thirty three hundred~~ 100
per cent of the medicare reimbursement rate in this state for a 101
screening mammography ~~or,~~ supplemental breast cancer screening, 102
or diagnostic breast examination. If there is more than one 103
medicare reimbursement rate in this state for a screening 104
~~mammography or a component of a screening mammography or,~~ 105
supplemental breast cancer screening, diagnostic breast 106

examination, or a component of ~~supplemental breast cancer~~ 107
~~screening~~any of the foregoing, the reimbursement limit shall be 108
~~one hundred thirty-three~~ hundred per cent of the lowest medicare 109
reimbursement rate in this state. 110

(3) The benefit paid in accordance with ~~division~~divisions 111
(D) (1) and (2) of this section shall constitute full payment. No 112
provider, hospital, or other health care facility shall seek or 113
receive remuneration in excess of the payment made in accordance 114
with ~~division~~divisions (D) (1) and (2) of this section, ~~except~~ 115
~~for approved deductibles and copayments.~~ 116

~~(E) The~~ (E) (1) Except as provided in division (E) (2) of 117
this section, the benefits provided under division (B) (1) ~~or~~, 118
(2), or (3) of this section shall be provided only for screening 119
mammographies ~~or~~, supplemental breast cancer screenings, or 120
diagnostic breast examinations that are performed in a health 121
care facility or mobile mammography screening unit that is 122
accredited under the American college of radiology mammography 123
accreditation program or in a hospital as defined in section 124
3727.01 of the Revised Code. 125

(2) With respect to diagnostic breast examinations that 126
are biopsies, the policy shall not, as a condition of coverage, 127
require biopsies to be performed in a facility, mobile 128
mammography screening unit, or hospital as described in division 129
(E) (1) of this section. 130

(F) The benefits provided under division (B) of this 131
section shall be provided according to the terms of the 132
subscriber contract. 133

(G) The benefits provided under division ~~(B) (3)~~ (B) (4) of 134
this section shall be provided only for cytologic screenings 135

that are processed and interpreted in a laboratory certified by 136
the college of American pathologists or in a hospital as defined 137
in section 3727.01 of the Revised Code. 138

(H) No individual or group health insuring corporation 139
policy, contract, or agreement providing basic health care 140
services that is delivered, issued for delivery, or renewed in 141
this state shall impose a cost-sharing requirement for the 142
benefits provided under division (B) of this section. 143

Sec. 3923.52. (A) As used in this section and section 144
3923.53 of the Revised Code: 145

(1) "Screening mammography" means a radiologic examination 146
that, in accordance with applicable American college of 147
radiology guidelines, is utilized to detect ~~unsuspected~~ breast 148
cancer at an early stage in asymptomatic women and includes the 149
x-ray examination of the breast using equipment that is 150
dedicated specifically for mammography, including, but not 151
limited to, the x-ray tube, filter, compression device, screens, 152
film, and cassettes, and that has an average radiation exposure 153
delivery of less than one rad mid-breast. "Screening 154
mammography" includes digital breast tomosynthesis. "Screening 155
mammography" includes two views for each breast. The term also 156
includes the professional interpretation of the film. 157

"Screening mammography" does not include diagnostic 158
mammography. 159

(2) "Diagnostic breast examination" means any examination 160
that, in accordance with applicable American college of 161
radiology guidelines, is deemed medically necessary by a 162
treating health care provider to diagnose breast cancer, 163
including diagnostic mammography, magnetic resonance imaging, 164

ultrasound, or biopsy. 165

(3) "Cost-sharing" means the cost to an individual insured 166
under an individual or group policy of sickness and accident 167
insurance or a public employee benefit plan according to any 168
coverage limit, copayment, coinsurance, deductible, or other 169
out-of-pocket expense requirements imposed by the policy or 170
plan. 171

(4) "Supplemental breast cancer screening" means any 172
additional screening method deemed medically necessary by a 173
treating health care provider for proper breast cancer screening 174
in accordance with applicable American college of radiology 175
guidelines, including magnetic resonance imaging, ultrasound, 176
contrast enhanced mammography, or molecular breast imaging. 177

(B) Notwithstanding section 3901.71 of the Revised Code, 178
every policy of individual or group sickness and accident 179
insurance that is delivered, issued for delivery, or renewed in 180
this state shall provide benefits for the expenses of all of the 181
following: 182

(1) To detect the presence of breast cancer in adult 183
~~women~~ individuals, a screening mammography; 184

(2) To detect the presence of breast cancer in adult ~~women~~ 185
individuals meeting either or both of the conditions described 186
in division (C) (2) of this section, supplemental breast cancer 187
screening; 188

(3) To diagnose breast cancer in adult individuals meeting 189
the condition described in division (C) (3) of this section, a 190
diagnostic breast examination; 191

(4) To detect the presence of cervical cancer, cytologic 192
screening. 193

(C) (1) The benefits provided under division (B) (1) of this 194
section shall cover expenses for one screening mammography every 195
year, including digital breast tomosynthesis. 196

(2) The benefits provided under division (B) (2) of this 197
section shall cover expenses for supplemental breast cancer 198
screening for an adult ~~woman~~ individual who meets either or both 199
of the following conditions: 200

(a) The ~~woman's~~ individual's screening mammography 201
demonstrates, based on the breast imaging reporting and data 202
system established by the American college of radiology, that 203
the ~~woman~~ individual has dense breast tissue; 204

(b) The ~~woman~~ individual is at an increased risk of breast 205
cancer due to family history, prior personal history of breast 206
cancer, ancestry, genetic predisposition, or other reasons as 207
determined by the ~~woman's~~ individual's health care provider. 208

(3) The benefits provided under division (B) (3) of this 209
section shall cover expenses for diagnostic breast examination 210
for an adult individual who has an abnormality seen or suspected 211
from, or detected by, a screening mammography, supplemental 212
breast cancer screening, or another means of examination. 213

(D) As used in this division, "medicare reimbursement 214
rate" means the reimbursement rate paid in this state under the 215
medicare program for screening mammography, supplemental breast 216
cancer screening, or diagnostic breast examination that does not 217
include digitization or computer-aided detection, regardless of 218
whether the actual benefit includes digitization or computer- 219
aided detection. 220

(1) Subject to divisions (D) (2) and (3) of this section, 221
if a provider, hospital, or other health care facility provides 222

a service that is a component of ~~the screening mammography a~~ 223
benefit ~~in~~ provided under division (B) (1), (2), or (3) of this 224
section ~~or a component of the supplemental breast cancer~~ 225
~~screening benefit in division (B) (2) of this section~~ and submits 226
a separate claim for that component, a separate payment shall be 227
made to the provider, hospital, or other health care facility ~~in~~ 228
~~an amount that corresponds to the ratio paid by medicare in this~~ 229
~~state for that component.~~ 230

(2) ~~Regardless of whether separate payments are made for~~ 231
~~the~~ The total benefit provided under division (B) (1), ~~or~~ (2), or 232
(3) of this section, the total benefit for a screening 233
mammography or supplemental breast cancer screening shall not 234
exceed ~~one hundred thirty three~~ three hundred per cent of the medicare 235
reimbursement rate in this state for screening mammography or 236
supplemental breast cancer screening. If there is more than one 237
medicare reimbursement rate in this state for screening 238
mammography or a component of a screening mammography or 239
supplemental breast cancer screening or a component of 240
supplemental breast cancer screening, the reimbursement limit 241
shall be ~~one hundred thirty three~~ three hundred per cent of the lowest 242
medicare reimbursement rate in this state. 243

(3) The benefit paid in accordance with ~~division~~ divisions 244
(D) (1) and (2) of this section shall constitute full payment. No 245
provider, hospital, or other health care facility shall seek or 246
receive compensation in excess of the payment made in accordance 247
with ~~division~~ divisions (D) (1) and (2) of this section, ~~except~~ 248
~~for approved deductibles and copayments.~~ 249

~~(E) The~~ (E) (1) Except as provided in division (E) (2) of 250
this section, the benefits provided under division (B) (1) ~~or~~, 251
(2), or (3) of this section shall be provided only for screening 252

mammographies~~or~~, supplemental breast cancer screenings, or 253
diagnostic breast examinations that are performed in a facility 254
or mobile mammography screening unit that is accredited under 255
the American college of radiology mammography accreditation 256
program or in a hospital as defined in section 3727.01 of the 257
Revised Code. 258

(2) With respect to diagnostic breast examinations that 259
are biopsies, the policy shall not, as a condition of coverage, 260
require biopsies to be performed in a facility, mobile 261
mammography screening unit, or hospital as described in division 262
(E) (1) of this section. 263

(F) The benefits provided under division ~~(B) (3)~~ (B) (4) of 264
this section shall be provided only for cytologic screenings 265
that are processed and interpreted in a laboratory certified by 266
the college of American pathologists or in a hospital as defined 267
in section 3727.01 of the Revised Code. 268

(G) No policy of individual or group sickness and accident 269
insurance that is delivered, issued for delivery, or renewed in 270
this state shall impose a cost-sharing requirement for the 271
benefits provided under division (B) of this section. 272

(H) This section does not apply to any policy that 273
provides coverage for specific diseases or accidents only, or to 274
any hospital indemnity, medicare supplement, or other policy 275
that offers only supplemental benefits. 276

Sec. 3923.53. (A) Notwithstanding section 3901.71 of the 277
Revised Code, every public employee benefit plan that is 278
established or modified in this state shall provide benefits for 279
the expenses of all of the following: 280

(1) To detect the presence of breast cancer in adult 281

~~women~~individuals, a screening mammography; 282

(2) To detect the presence of breast cancer in adult ~~women~~ 283
individuals meeting ~~any~~ either or both of the conditions 284
described in division (B) (2) of this section, supplemental 285
breast cancer screening; 286

(3) To diagnose breast cancer in adult individuals meeting 287
the condition described in division (B) (3) of this section, a 288
diagnostic breast examination; 289

(4) To detect the presence of cervical cancer, cytologic 290
screening. 291

(B) (1) The benefits provided under division (A) (1) of this 292
section shall cover expenses for one screening mammography every 293
year, including digital breast tomosynthesis. 294

(2) The benefits provided under division (A) (2) of this 295
section shall cover expenses for supplemental breast cancer 296
screening for an adult ~~woman~~individual who meets ~~any~~ either or 297
both of the following conditions: 298

(a) The ~~woman's~~individual's screening mammography 299
demonstrates, based on the breast imaging reporting and data 300
system established by the American college of radiology, that 301
the ~~woman~~individual has dense breast tissue; 302

(b) The ~~woman~~individual is at an increased risk of breast 303
cancer due to family history, prior personal history of breast 304
cancer, ancestry, genetic predisposition, or other reasons as 305
determined by the ~~woman's~~individual's health care provider. 306

(3) The benefits provided under division (B) (3) of this 307
section shall cover expenses for diagnostic breast examination 308
for an adult individual who has an abnormality seen or suspected 309

from, or detected by, a screening mammography, supplemental 310
breast cancer screening, or another means of examination. 311

(C) As used in this division, "medicare reimbursement 312
rate" means the reimbursement rate paid in this state under the 313
medicare program for a screening mammography that does not 314
include digitization or computer-aided detection, regardless of 315
whether the actual benefit includes digitization or computer- 316
aided detection. 317

~~(1) (D) (1)~~ Subject to divisions ~~(C) (2) (D) (2)~~ and (3) of 318
this section, if a provider, hospital, or other health care 319
facility provides a service that is a component of ~~the screening~~ 320
~~mammography a benefit in provided under division (A) (1), (2), or~~ 321
~~(3) of this section or a component of the supplemental breast~~ 322
~~cancer screening benefit in division (A) (2) of this section and~~ 323
submits a separate claim for that component, a separate payment 324
shall be made to the provider, hospital, or other health care 325
facility ~~in an amount that corresponds to the ratio paid by~~ 326
~~medicare in this state for that component.~~ 327

~~(2) Regardless of whether separate payments are made for~~ 328
~~the~~ The total benefit provided under division (A) (1), ~~or (2), or~~ 329
~~(3)~~ of this section, the total benefit for a screening 330
mammography or supplemental breast cancer screening shall not 331
exceed ~~one hundred thirty three hundred~~ per cent of the medicare 332
reimbursement rate in this state for a screening mammography or 333
supplemental breast cancer screening. If there is more than one 334
medicare reimbursement rate in this state for screening 335
mammography or a component of a screening mammography or 336
supplemental breast cancer screening or a component of 337
supplemental breast cancer screening, the reimbursement limit 338
shall be ~~one hundred thirty three hundred~~ per cent of the lowest 339

medicare reimbursement rate in this state. 340

(3) The benefit paid in accordance with ~~division~~ divisions 341
~~(C) (1)~~ (D) (1) and (2) of this section shall constitute full 342
payment. No provider, hospital, or other health care facility 343
shall seek or receive compensation in excess of the payment made 344
in accordance with ~~division (C) (1)~~ divisions (D) (1) and (2) of 345
this section, ~~except for approved deductibles and copayments.~~ 346

~~(D)~~ (E) (1) Except as provided in division (E) (1) of 347
this section, the benefits provided under division (A) (1) ~~or,~~ 348
(2), or (3) of this section shall be provided only for screening 349
mammographies ~~or,~~ supplemental breast cancer screenings, or 350
diagnostic breast examinations that are performed in a facility 351
or mobile mammography screening unit that is accredited under 352
the American college of radiology mammography accreditation 353
program or in a hospital as defined in section 3727.01 of the 354
Revised Code. 355

(2) With respect to diagnostic breast examinations that 356
are biopsies, the public employee benefit plan shall not, as a 357
condition of coverage, require biopsies to be performed in a 358
facility, mobile mammography screening unit, or hospital as 359
described in division (E) (1) of this section. 360

~~(E)~~ (F) The benefits provided under division ~~(A) (3)~~ (A) (4) 361
of this section shall be provided only for cytologic screenings 362
that are processed and interpreted in a laboratory certified by 363
the college of American pathologists or in a hospital as defined 364
in section 3727.01 of the Revised Code. 365

(G) No public employee benefit plan that is established or 366
modified in this state shall impose a cost-sharing requirement 367
for the benefits provided under division (A) of this section. 368

Sec. 5162.20. (A) The department of medicaid shall 369
institute cost-sharing requirements for the medicaid program. 370
The department shall not institute cost-sharing requirements in 371
a manner that does either of the following: 372

(1) Disproportionately impacts the ability of medicaid 373
recipients with chronic illnesses to obtain medically necessary 374
medicaid services; 375

(2) Violates section 5164.08, 5164.09, or 5164.10 of the 376
Revised Code. 377

(B) (1) No provider shall refuse to provide a service to a 378
medicaid recipient who is unable to pay a required copayment for 379
the service. 380

(2) Division (B) (1) of this section shall not be 381
considered to do either of the following with regard to a 382
medicaid recipient who is unable to pay a required copayment: 383

(a) Relieve the medicaid recipient from the obligation to 384
pay a copayment; 385

(b) Prohibit the provider from attempting to collect an 386
unpaid copayment. 387

(C) Except as provided in division (F) of this section, no 388
provider shall waive a medicaid recipient's obligation to pay 389
the provider a copayment. 390

(D) No provider or drug manufacturer, including the 391
manufacturer's representative, employee, independent contractor, 392
or agent, shall pay any copayment on behalf of a medicaid 393
recipient. 394

(E) If it is the routine business practice of a provider 395
to refuse service to any individual who owes an outstanding debt 396

to the provider, the provider may consider an unpaid copayment 397
imposed by the cost-sharing requirements as an outstanding debt 398
and may refuse service to a medicaid recipient who owes the 399
provider an outstanding debt. If the provider intends to refuse 400
service to a medicaid recipient who owes the provider an 401
outstanding debt, the provider shall notify the recipient of the 402
provider's intent to refuse service. 403

(F) In the case of a provider that is a hospital, the 404
cost-sharing program shall permit the hospital to take action to 405
collect a copayment by providing, at the time services are 406
rendered to a medicaid recipient, notice that a copayment may be 407
owed. If the hospital provides the notice and chooses not to 408
take any further action to pursue collection of the copayment, 409
the prohibition against waiving copayments specified in division 410
(C) of this section does not apply. 411

(G) The department of medicaid may collaborate with a 412
state agency that is administering, pursuant to a contract 413
entered into under section 5162.35 of the Revised Code, one or 414
more components, or one or more aspects of a component, of the 415
medicaid program as necessary for the state agency to apply the 416
cost-sharing requirements to the components or aspects of a 417
component that the state agency administers. 418

Sec. 5164.08. (A) As used in this section: 419

(1) "Diagnostic breast examination" means any examination 420
that, in accordance with applicable American college of 421
radiology guidelines, is deemed medically necessary by a 422
treating health care provider to diagnose breast cancer, 423
including diagnostic mammography, magnetic resonance imaging, 424
ultrasound, or biopsy. 425

(2) "Screening mammography" means a radiologic examination 426
that, in accordance with applicable American college of 427
radiology guidelines, is utilized to detect ~~unsuspected~~ breast 428
~~cancer at an early stage in asymptomatic women~~ and includes the 429
x-ray examination of the breast using equipment that is 430
dedicated specifically for mammography, including the x-ray 431
tube, filter, compression device, screens, film, and cassettes, 432
and that has an average radiation exposure delivery of less than 433
one rad mid-breast. "Screening mammography" includes digital 434
breast tomosynthesis. "Screening mammography" includes two views 435
for each breast. The term also includes the professional 436
interpretation of the film. 437

"Screening mammography" does not include diagnostic 438
mammography. 439

~~(2)~~ (3) "Supplemental breast cancer screening" means any 440
additional screening method deemed medically necessary by a 441
treating health care provider for proper breast cancer screening 442
in accordance with applicable American college of radiology 443
guidelines, including magnetic resonance imaging, ultrasound, 444
contrast enhanced mammography, or molecular breast imaging. 445

(B) The medicaid program shall cover all of the following: 446

(1) To detect the presence of breast cancer in adult 447
~~women~~ individuals, screening mammography; 448

(2) To detect the presence of breast cancer in adult ~~women~~ 449
individuals meeting any either or both of the conditions 450
described in division (C) (2) of this section, supplemental 451
breast cancer screening; 452

(3) To diagnose breast cancer in adult individuals meeting 453
the condition described in division (C) (3) of this section, 454

diagnostic breast examination; 455

(4) To detect the presence of cervical cancer, cytologic 456
screening. 457

(C) (1) The medicaid program's coverage pursuant to 458
division (B) (1) of this section shall cover expenses for one 459
screening mammography every year, including digital breast 460
tomosynthesis. 461

(2) The medicaid program's coverage pursuant to division 462
(B) (2) of this section shall cover expenses for supplemental 463
breast cancer screening for an adult ~~woman~~-individual who meets 464
~~any~~ either or both of the following conditions: 465

(a) The ~~woman's~~-individual's screening mammography 466
demonstrates, based on the breast imaging reporting and data 467
system established by the American college of radiology, that 468
the ~~woman~~-individual has dense breast tissue; 469

(b) The ~~woman~~-individual is at an increased risk of breast 470
cancer due to family history, prior personal history of breast 471
cancer, ancestry, genetic predisposition, or other reasons as 472
determined by the ~~woman's~~-individual's health care provider. 473

(3) The medicaid program's coverage pursuant to division 474
(B) (3) of this section shall cover expenses for diagnostic 475
breast examination for an adult individual who has an 476
abnormality seen or suspected from, or detected by, any of the 477
following: screening mammography, supplemental breast cancer 478
screening, or another means of examination. 479

(D) The medicaid program shall not impose cost-sharing 480
requirements on the coverage described in division (B) of this 481
section. 482

(E) (1) Except as provided in division (E) (2) of this 483
section, the medicaid program's coverage ~~of screening~~ 484
~~mammographies~~ pursuant to division (B) (1) ~~or, (2), or (3)~~ of 485
this section shall be provided only for screening mammographies 486
~~or, supplemental breast cancer screenings, or diagnostic breast~~ 487
examinations that are performed in a facility or mobile 488
mammography screening unit that is accredited under the American 489
college of radiology mammography accreditation program or in a 490
hospital as defined in section 3727.01 of the Revised Code. 491

(2) With respect to diagnostic breast examinations that 492
are biopsies, the medicaid program shall not, as a condition of 493
coverage, require biopsies to be performed in a facility, mobile 494
mammography screening unit, or hospital as described in division 495
(E) (1) of this section. 496

~~(E)~~ (F) The medicaid program's coverage of cytologic 497
screenings pursuant to division ~~(B) (3)~~ (B) (4) of this section 498
shall be provided only for cytologic screenings that are 499
processed and interpreted in a laboratory certified by the 500
college of American pathologists or in a hospital as defined in 501
section 3727.01 of the Revised Code. 502

Section 2. That existing sections 1751.62, 3923.52, 503
3923.53, 5162.20, and 5164.08 of the Revised Code are hereby 504
repealed. 505

Section 3. Section 1751.62 of the Revised Code, as amended 506
by this act, applies only to arrangements, policies, contracts, 507
and agreements that are created, delivered, issued for delivery, 508
or renewed in this state on or after the effective date of the 509
amendment. Section 3923.52 of the Revised Code, as amended by 510
this act, applies only to policies of sickness and accident 511
insurance delivered, issued for delivery, or renewed in this 512

state on or after the effective date of the amendment. Section 513
3923.53 of the Revised Code, as amended by this act, applies 514
only to public employee benefit plans that are established or 515
modified in this state on or after the effective date of the 516
amendment. 517

Section 4. (A) As used in this section: 518

(1) "Health plan issuer" has the same meaning as in 519
section 3922.01 of the Revised Code. 520

(2) "Hospital" has the same meaning as in section 3722.01 521
of the Revised Code. 522

(3) "Physician" means an individual authorized under 523
Chapter 4731. of the Revised Code to practice medicine and 524
surgery or osteopathic medicine and surgery. 525

(B) Not later than three months after the effective date 526
of this section, all of the following apply: 527

(1) The Director of Health shall notify each hospital and 528
physician of this act's enactment. 529

(2) The Superintendent of Insurance shall notify each 530
health plan issuer of this act's enactment. 531

(3) The notice shall be completed by certified mail. 532

(C) When notifying a health plan issuer, hospital, or 533
physician under this section, the Director or Superintendent 534
shall summarize the provisions of sections 1751.62, 3923.52, 535
3923.53, 5162.20, and 5164.08 of the Revised Code, each as 536
amended by this act, and shall describe the act's impact on 537
those provisions. 538

(D) The Director of Health may consult with the State 539

Medical Board of Ohio to assist the Director in identifying 540
physicians and determining their business addresses for purposes 541
of satisfying the notice requirements of this section. 542

Section 5. Sections 1 to 4 of this act take effect three 543
months after the effective date of this section. 544

Section 6. This act shall be known as the Breast 545
Examination and Screening Transformation Act, or BEST Act. 546