

**I\_136\_0107-2**

**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:

(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. 20  
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"Screening mammography" does not include diagnostic mammography. 24  
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(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. 26  
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(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. 32  
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(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. 38  
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(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 44  
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<u>agreement.</u>	49
(B) Notwithstanding section 3901.71 of the Revised Code, every individual or group health insuring corporation policy, contract, or agreement providing basic health care services that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of all of the following:	50 51 52 53 54
(1) To detect the presence of breast cancer in adult <u>women</u> <u>individuals</u> , <u>a</u> screening mammography;	55 56
(2) To detect the presence of breast cancer in adult <u>women</u> <u>individuals</u> meeting either <u>or both</u> of the conditions described in division (C)(2) of this section, supplemental breast cancer screening;	57 58 59 60
(3) <u>To diagnose breast cancer in adult individuals meeting</u> <u>the condition described in division (C)(3) of this section, a</u> <u>diagnostic breast examination;</u>	61 62 63
(4) To detect the presence of cervical cancer, cytologic screening.	64 65
(C) (1) The benefits provided under division (B)(1) of this section shall cover expenses for one screening mammography every year, including digital breast tomosynthesis.	66 67 68
(2) The benefits provided under division (B)(2) of this section shall cover expenses for supplemental breast cancer screening for an adult <u>woman</u> <u>individual</u> who meets either <u>or both</u> of the following conditions:	69 70 71 72
(a) The <u>woman's</u> <u>individual's</u> screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the <u>woman</u> <u>individual</u> has dense breast tissue;	73 74 75 76

(b) The <del>woman-individual</del> 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 <del>woman's-individual's</del> 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 <del>the screening</del>	88
<del>mammography</del> a benefit <del>in provided under</del> division (B) (1), (2), or	89
<del>(3)</del> 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), <del>or</del> (2), or (3) of	97
this section, the total benefit for a screening mammography <del>or</del> ,	98
supplemental breast cancer screening, <del>or</del> diagnostic breast	99
examination shall not exceed <del>one hundred thirty three</del> hundred	100
per cent of the medicare reimbursement rate in this state for a	101
screening mammography <del>or</del> , supplemental breast cancer screening,	102
<del>or</del> diagnostic breast examination. If there is more than one	103
medicare reimbursement rate in this state for a screening	104
mammography <del>or</del> a component of a screening mammography <del>or</del> ,	105
supplemental breast cancer screening, <del>diagnostic</del> breast	106

examination, or a component of supplemental breast cancer 107  
screeningany 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

<u>ultrasound, or biopsy.</u>	165
(3) <u>"Cost-sharing"</u> means the cost to an individual insured under an individual or group policy of sickness and accident insurance or a public employee benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy or plan.	166 167 168 169 170 171
(4) <u>"Supplemental breast cancer screening"</u> 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, <u>contrast enhanced mammography</u> , or molecular breast imaging.	172 173 174 175 176 177
(B) Notwithstanding section 3901.71 of the Revised Code, every policy of individual or group sickness and accident insurance that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of all of the following:	178 179 180 181 182
(1) To detect the presence of breast cancer in adult <u>women</u> <u>individuals</u> , <u>a</u> screening mammography;	183 184
(2) To detect the presence of breast cancer in adult <u>women</u> <u>individuals</u> meeting either <u>or</u> both of the conditions described in division (C)(2) of this section, supplemental breast cancer screening;	185 186 187 188
(3) <u>To diagnose breast cancer in adult individuals meeting the condition described in division (C)(3) of this section, a diagnostic breast examination;</u>	189 190 191
(4) <u>To detect the presence of cervical cancer, cytologic screening.</u>	192 193

(C) (1) The benefits provided under division (B) (1) of this  
section shall cover expenses for one screening mammography every  
year, including digital breast tomosynthesis. 194  
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(2) The benefits provided under division (B) (2) of this  
section shall cover expenses for supplemental breast cancer  
screening for an adult ~~woman~~individual who meets either or both  
of the following conditions: 197  
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(a) The ~~woman's~~individual's screening mammography  
demonstrates, based on the breast imaging reporting and data  
system established by the American college of radiology, that  
the ~~woman~~individual has dense breast tissue; 201  
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(b) The ~~woman~~individual is at an increased risk of breast  
cancer due to family history, prior personal history of breast  
cancer, ancestry, genetic predisposition, or other reasons as  
determined by the ~~woman's~~individual's health care provider. 205  
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(3) The benefits provided under division (B) (3) of this  
section shall cover expenses for diagnostic breast examination  
for an adult individual who has an abnormality seen or suspected  
from, or detected by, a screening mammography, supplemental  
breast cancer screening, or another means of examination. 209  
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(D) As used in this division, "medicare reimbursement  
rate" means the reimbursement rate paid in this state under the  
medicare program for 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. 214  
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(1) Subject to divisions (D) (2) and (3) of this section,  
if a provider, hospital, or other health care facility provides 221  
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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 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 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  
diagnostic breast examinations that are performed in a facility  
or mobile mammography screening unit that is accredited under  
the American college of radiology mammography accreditation  
program or in a hospital as defined in section 3727.01 of the  
Revised Code. 253  
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(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

<u>women</u> <u>individuals</u> , <u>a</u> screening mammography;	282
(2) To detect the presence of breast cancer in adult <u>women</u> <u>individuals</u> meeting <u>any</u> <u>either</u> <u>or</u> <u>both</u> <u>of</u> the conditions described in division (B) (2) of this section, supplemental breast cancer screening;	283 284 285 286
(3) <u>To diagnose breast cancer in adult individuals meeting</u> <u>the condition described in division (B) (3) of this section, a</u> <u>diagnostic breast examination;</u>	287 288 289
(4) <u>To detect the presence of cervical cancer, cytologic</u> screening.	290 291
(B) (1) The benefits provided under division (A) (1) of this section shall cover expenses for one screening mammography every year, including digital breast tomosynthesis.	292 293 294
(2) The benefits provided under division (A) (2) of this section shall cover expenses for supplemental breast cancer screening for an adult <u>woman</u> <u>individual</u> who meets <u>any</u> <u>either</u> <u>or</u> <u>both</u> <u>of</u> the following conditions:	295 296 297 298
(a) The <u>woman's</u> <u>individual's</u> screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the <u>woman</u> <u>individual</u> has dense breast tissue;	299 300 301 302
(b) The <u>woman</u> <u>individual</u> is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the <u>woman's</u> <u>individual's</u> health care provider.	303 304 305 306
(3) <u>The benefits provided under division (B) (3) of this</u> <u>section shall cover expenses for diagnostic breast examination</u> <u>for an adult individual who has an abnormality seen or suspected</u>	307 308 309

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.

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

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

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

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

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

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<b>Sec. 5162.20.</b> (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 <u>5164.08</u> , <u>5164.09</u> , or <u>5164.10</u> 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  
that, in accordance with applicable American college of  
radiology guidelines, is utilized to detect ~~un~~suspected breast  
cancer at an early stage in ~~asym~~ptomatic women and includes the  
x-ray examination of the breast using equipment that is  
dedicated specifically for mammography, including the x-ray  
tube, filter, compression device, screens, film, and cassettes,  
and that has an average radiation exposure 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. 426  
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"Screening mammography" does not include diagnostic  
mammography. 438  
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~~(2)~~—(3) "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. 440  
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(B) The medicaid program shall cover all of the following: 446

(1) To detect the presence of breast cancer in adult  
~~women~~individuals, screening mammography; 447  
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(2) To detect the presence of breast cancer in adult ~~women~~  
~~individuals~~ meeting ~~any~~either or both of the conditions  
described in division (C) (2) of this section, supplemental  
breast cancer screening; 449  
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(3) To diagnose breast cancer in adult individuals meeting  
the condition described in division (C) (3) of this section, 453  
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<u>diagnostic breast examination;</u>	455
(4) To detect the presence of cervical cancer, cytologic screening.	456
(C) (1) The medicaid program's coverage pursuant to division (B) (1) of this section shall cover expenses for one screening mammography every year, including digital breast tomosynthesis.	458
(2) The medicaid program's coverage pursuant to division (B) (2) of this section shall cover expenses for supplemental breast cancer screening for an adult <del>woman-individual</del> who meets <del>any</del> <u>either or both</u> of the following conditions:	462
(a) The <del>woman's-individual's</del> screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the <del>woman-individual</del> has dense breast tissue;	466
(b) The <del>woman-individual</del> is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the <del>woman's-individual's</del> health care provider.	470
(3) The medicaid program's coverage pursuant to division (B) (3) of this section shall cover expenses for <u>diagnostic breast examination</u> for an adult individual who has an <u>abnormality seen or suspected from, or detected by, any of the following: screening mammography, supplemental breast cancer screening, or another means of examination.</u>	474
(D) The medicaid program shall not impose cost-sharing requirements on the coverage described in division (B) of this section.	480
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<u>(E) (1) Except as provided in division (E) (2) of this</u>	483
<u>section, the medicaid program's coverage of screening</u>	484
<u>mammographies pursuant to division (B) (1)—or, (2), or (3) of</u>	485
<u>this section shall be provided only for screening mammographies</u>	486
<u>or, supplemental breast cancer screenings, or diagnostic breast</u>	487
<u>examinations that are performed in a facility or mobile</u>	488
<u>mammography screening unit that is accredited under the American</u>	489
<u>college of radiology mammography accreditation program or in a</u>	490
<u>hospital as defined in section 3727.01 of the Revised Code.</u>	491
<u>(2) With respect to diagnostic breast examinations that</u>	492
<u>are biopsies, the medicaid program shall not, as a condition of</u>	493
<u>coverage, require biopsies to be performed in a facility, mobile</u>	494
<u>mammography screening unit, or hospital as described in division</u>	495
<u>(E) (1) of this section.</u>	496
<u>(E)—(F) The medicaid program's coverage of cytologic</u>	497
<u>screenings pursuant to division (B)(3)—(B)(4) of this section</u>	498
<u>shall be provided only for cytologic screenings that are</u>	499
<u>processed and interpreted in a laboratory certified by the</u>	500
<u>college of American pathologists or in a hospital as defined in</u>	501
<u>section 3727.01 of the Revised Code.</u>	502
<b>Section 2.</b> That existing sections 1751.62, 3923.52,	503
3923.53, 5162.20, and 5164.08 of the Revised Code are hereby	504
repealed.	505
<b>Section 3.</b> 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