

As Introduced

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H. B. No. 271

Representatives Schmidt, Williams

**Cosponsors: Representatives Newman, Johnson, Brewer, White, E., Troy,
Brennan, Rogers, Brownlee, Ray, Click, Richardson, Robb Blasdel, Hall, T.,
Odioso, White, A., Abrams**

To amend sections 1751.62, 3923.52, 3923.53,	1
5162.20, and 5164.08 of the Revised Code to	2
revise the law governing insurance and Medicaid	3
coverage of breast cancer screenings and	4
examinations and to name this act the Breast	5
Examination and Screening Transformation Act, or	6
BEST Act.	7

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

Section 1. That sections 1751.62, 3923.52, 3923.53,	8
5162.20, and 5164.08 of the Revised Code be amended to read as	9
follows:	10

Sec. 1751.62. (A) As used in this section:	11
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(1) "Screening mammography" means a radiologic examination	12
<u>that, in accordance with applicable American college of</u>	13
<u>radiology guidelines, is utilized to detect unsuspected breast</u>	14
cancer at an early stage in an asymptomatic woman and includes	15
the x-ray examination of the breast using equipment that is	16
dedicated specifically for mammography, including, but not	17
limited to, the x-ray tube, filter, compression device, screens,	18

film, and cassettes, and that has an average radiation exposure 19
delivery of less than one rad mid-breast. "Screening 20
mammography" includes digital breast tomosynthesis. "Screening 21
mammography" includes two views for each breast. The term also 22
includes the professional interpretation of the film. 23

"Screening mammography" does not include diagnostic 24
mammography. 25

(2) ~~"Medicare reimbursement rate" means the reimbursement 26
rate paid in Ohio under the medicare program for screening 27
mammography that does not include digitization or computer-aided 28
detection, regardless of whether the actual benefit includes 29
digitization or computer-aided detection. 30~~

~~(3) "Diagnostic breast examination" means any examination 31
that, in accordance with applicable American college of 32
radiology guidelines, is deemed medically necessary by a 33
treating health care provider to diagnose breast cancer, 34
including diagnostic mammography, magnetic resonance imaging, 35
ultrasound, or biopsy. 36~~

(3) "Supplemental breast cancer screening" means any 37
additional screening method deemed medically necessary by a 38
treating health care provider for proper breast cancer screening 39
in accordance with applicable American college of radiology 40
guidelines, including magnetic resonance imaging, ultrasound, 41
contrast enhanced mammography, or molecular breast imaging. 42

(4) "Cost-sharing" means the cost to an enrollee under an 43
individual or group health insuring corporation policy, 44
contract, or agreement according to any coverage limit, 45
copayment, coinsurance, deductible, or other out-of-pocket 46
expense requirements imposed by the policy, contract, or 47

agreement. 48

(B) Notwithstanding section 3901.71 of the Revised Code, 49
every individual or group health insuring corporation policy, 50
contract, or agreement providing basic health care services that 51
is delivered, issued for delivery, or renewed in this state 52
shall provide benefits for the expenses of all of the following: 53

(1) To detect the presence of breast cancer in adult 54
~~women~~individuals, a screening mammography; 55

(2) To detect the presence of breast cancer in adult ~~women~~ 56
individuals meeting either or both of the conditions described 57
in division (C) (2) of this section, supplemental breast cancer 58
screening; 59

(3) To diagnose breast cancer in adult individuals meeting 60
the condition described in division (C) (3) of this section, a 61
diagnostic breast examination; 62

(4) To detect the presence of cervical cancer, cytologic 63
screening. 64

(C) (1) The benefits provided under division (B) (1) of this 65
section shall cover expenses for one screening mammography every 66
year, including digital breast tomosynthesis. 67

(2) The benefits provided under division (B) (2) of this 68
section shall cover expenses for supplemental breast cancer 69
screening for an adult ~~woman~~individual who meets either or both 70
of the following conditions: 71

(a) The ~~woman's~~individual's screening mammography 72
demonstrates, based on the breast imaging reporting and data 73
system established by the American college of radiology, that 74
the ~~woman~~individual has dense breast tissue; 75

(b) The ~~woman~~individual is at an increased risk of breast 76
cancer due to family history, prior personal history of breast 77
cancer, ancestry, genetic predisposition, or other reasons as 78
determined by the ~~woman's~~individual's health care provider. 79

(3) The benefits provided under division (B) (3) of this 80
section shall cover expenses for diagnostic breast examination 81
for an adult individual who has an abnormality seen or suspected 82
from, or detected by, a screening mammography, supplemental 83
breast cancer screening, or another means of examination. 84

(D) (1) Subject to divisions (D) (2) and (3) of this 85
section, if a provider, hospital, or other health care facility 86
provides a service that is a component of ~~the screening~~ 87
~~mammography~~ a benefit in provided under division (B) (1), (2), or 88
(3) of this section or a component of the supplemental breast 89
cancer screening benefit in division (B) (2) of this section and 90
submits a separate claim for that component, a separate payment 91
shall be made to the provider, hospital, or other health care 92
facility ~~in an amount that corresponds to the ratio paid by~~ 93
~~medicare in this state for that component. 94~~

~~(2) Regardless of whether separate payments are made for 95~~
~~the~~ The total benefit provided under division (B) (1), ~~or~~ (2), or 96
(3) of this section, the total benefit for a screening 97
~~mammography or supplemental breast cancer screening shall not 98~~
~~exceed one hundred thirty per cent of the medicare reimbursement 99~~
~~rate in this state for screening mammography or supplemental 100~~
~~breast cancer screening. If there is more than one medicare 101~~
~~reimbursement rate in this state for screening mammography or a 102~~
~~component of a screening mammography or supplemental breast 103~~
~~cancer screening or a component of supplemental breast cancer 104~~
~~screening, the reimbursement limit shall be one hundred thirty 105~~

per cent of the lowest medicare and any separate payment for a 106
service that is a component of such a benefit under division (D) 107
(1) of this section, shall not be less than any reimbursement 108
rate previously paid by the same individual or group health 109
insuring corporation under a policy, contract, or agreement 110
providing basic health care services that is delivered, issued 111
for delivery, or renewed in this state after the effective date 112
of this amendment to the same provider, hospital, or other 113
health care facility for the same benefit or service that is a 114
component of such benefit. 115

(3) The benefit paid in accordance with ~~division~~ divisions 116
(D) (1) and (2) of this section shall constitute full payment. No 117
provider, hospital, or other health care facility shall seek or 118
receive remuneration in excess of the payment made in accordance 119
with ~~division~~ divisions (D) (1) and (2) of this section, ~~except~~ 120
~~for approved deductibles and copayments.~~ 121

~~(E) The~~ (E) (1) Except as provided in division (E) (2) of 122
this section, the benefits provided under division (B) (1) ~~or,~~ 123
(2), or (3) of this section shall be provided only for screening 124
mammographies ~~or,~~ supplemental breast cancer screenings, or 125
diagnostic breast examinations that are performed in a health 126
care facility or mobile mammography screening unit that is 127
accredited under the American college of radiology mammography 128
accreditation program or in a hospital as defined in section 129
3727.01 of the Revised Code. 130

(2) With respect to diagnostic breast examinations that 131
are biopsies, the policy shall not, as a condition of coverage, 132
require biopsies to be performed in a facility, mobile 133
mammography screening unit, or hospital as described in division 134
(E) (1) of this section. 135

(F) The benefits provided under division (B) of this 136
section shall be provided according to the terms of the 137
subscriber contract. 138

(G) The benefits provided under division ~~(B) (3)~~ (B) (4) of 139
this section shall be provided only for cytologic screenings 140
that are processed and interpreted in a laboratory certified by 141
the college of American pathologists or in a hospital as defined 142
in section 3727.01 of the Revised Code. 143

(H) No individual or group health insuring corporation 144
policy, contract, or agreement providing basic health care 145
services that is delivered, issued for delivery, or renewed in 146
this state shall impose a cost-sharing requirement for the 147
benefits provided under division (B) of this section. 148

Sec. 3923.52. (A) As used in this section and section 149
3923.53 of the Revised Code: 150

(1) "Screening mammography" means a radiologic examination 151
that, in accordance with applicable American college of 152
radiology guidelines, is utilized to detect ~~unsuspected~~ breast 153
cancer ~~at an early stage in asymptomatic women~~ and includes the 154
x-ray examination of the breast using equipment that is 155
dedicated specifically for mammography, including, but not 156
limited to, the x-ray tube, filter, compression device, screens, 157
film, and cassettes, and that has an average radiation exposure 158
delivery of less than one rad mid-breast. "Screening 159
mammography" includes digital breast tomosynthesis. "Screening 160
mammography" includes two views for each breast. The term also 161
includes the professional interpretation of the film. 162

"Screening mammography" does not include diagnostic 163
mammography. 164

(2) "Diagnostic breast examination" means any examination 165
that, in accordance with applicable American college of 166
radiology guidelines, is deemed medically necessary by a 167
treating health care provider to diagnose breast cancer, 168
including diagnostic mammography, magnetic resonance imaging, 169
ultrasound, or biopsy. 170

(3) "Cost-sharing" means the cost to an individual insured 171
under an individual or group policy of sickness and accident 172
insurance or a public employee benefit plan according to any 173
coverage limit, copayment, coinsurance, deductible, or other 174
out-of-pocket expense requirements imposed by the policy or 175
plan. 176

(4) "Supplemental breast cancer screening" means any 177
additional screening method deemed medically necessary by a 178
treating health care provider for proper breast cancer screening 179
in accordance with applicable American college of radiology 180
guidelines, including magnetic resonance imaging, ultrasound, 181
contrast enhanced mammography, or molecular breast imaging. 182

(B) Notwithstanding section 3901.71 of the Revised Code, 183
every policy of individual or group sickness and accident 184
insurance that is delivered, issued for delivery, or renewed in 185
this state shall provide benefits for the expenses of all of the 186
following: 187

(1) To detect the presence of breast cancer in adult 188
~~women~~individuals, a screening mammography; 189

(2) To detect the presence of breast cancer in adult ~~women~~ 190
individuals meeting either or both of the conditions described 191
in division (C) (2) of this section, supplemental breast cancer 192
screening; 193

(3) To diagnose breast cancer in adult individuals meeting 194
the condition described in division (C) (3) of this section, a 195
diagnostic breast examination; 196

(4) To detect the presence of cervical cancer, cytologic 197
screening. 198

(C) (1) The benefits provided under division (B) (1) of this 199
section shall cover expenses for one screening mammography every 200
year, including digital breast tomosynthesis. 201

(2) The benefits provided under division (B) (2) of this 202
section shall cover expenses for supplemental breast cancer 203
screening for an adult ~~woman~~-individual who meets either or both 204
of the following conditions: 205

(a) The ~~woman's~~-individual's screening mammography 206
demonstrates, based on the breast imaging reporting and data 207
system established by the American college of radiology, that 208
the ~~woman~~-individual has dense breast tissue; 209

(b) The ~~woman~~-individual is at an increased risk of breast 210
cancer due to family history, prior personal history of breast 211
cancer, ancestry, genetic predisposition, or other reasons as 212
determined by the ~~woman's~~-individual's health care provider. 213

(3) The benefits provided under division (B) (3) of this 214
section shall cover expenses for diagnostic breast examination 215
for an adult individual who has an abnormality seen or suspected 216
from, or detected by, a screening mammography, supplemental 217
breast cancer screening, or another means of examination. 218

~~(D) As used in this division, "medicare reimbursement~~ 219
~~rate" means the reimbursement rate paid in this state under the~~ 220
~~medicare program for screening mammography that does not include~~ 221
~~digitization or computer-aided detection, regardless of whether~~ 222

~~the actual benefit includes digitization or computer-aided- 223
detection. 224~~

~~(1) (D) (1) Subject to divisions (D) (2) and (3) of this 225
section, if a provider, hospital, or other health care facility 226
provides a service that is a component of ~~the screening- 227
mammography a benefit in provided under division (B) (1), (2), or 228
(3) of this section or a component of the supplemental breast- 229
cancer screening benefit in division (B) (2) of this section and 230
submits a separate claim for that component, a separate payment 231
shall be made to the provider, hospital, or other health care 232
facility in an amount that corresponds to the ratio paid by 233
medicare in this state for that component. 234~~~~

~~(2) Regardless of whether separate payments are made for- 235
the The total benefit provided under division (B) (1), ~~or~~ (2), or 236
(3) of this section, the total benefit for a screening- 237
mammography or supplemental breast cancer screening shall not- 238
exceed one hundred thirty per cent of the medicare reimbursement 239
rate in this state for screening mammography or supplemental- 240
breast cancer screening. If there is more than one medicare- 241
reimbursement rate in this state for screening mammography or a- 242
component of a screening mammography or supplemental breast- 243
cancer screening or a component of supplemental breast cancer- 244
screening, the reimbursement limit shall be one hundred thirty- 245
per cent of the lowest medicare and any separate payment for a 246
service that is a component of such a benefit under division (D) 247
(1) of this section, shall not be less than any reimbursement 248
rate previously paid by the same insurer under a policy of 249
individual or group sickness and accident insurance that is 250
delivered, issued for delivery, or renewed in this state after 251
the effective date of this amendment to the same provider, 252
hospital, or other health care facility for the same benefit or 253~~

service that is a component of such benefit. 254

(3) The benefit paid in accordance with ~~division~~ divisions 255
(D) (1) and (2) of this section shall constitute full payment. No 256
provider, hospital, or other health care facility shall seek or 257
receive compensation in excess of the payment made in accordance 258
with ~~division~~ divisions (D) (1) and (2) of this section, ~~except~~ 259
~~for approved deductibles and copayments.~~ 260

~~(E) The~~ (E) (1) Except as provided in division (E) (2) of 261
this section, the benefits provided under division (B) (1) ~~or,~~ 262
(2), or (3) of this section shall be provided only for screening 263
mammographies ~~or,~~ supplemental breast cancer screenings, or 264
diagnostic breast examinations that are performed in a facility 265
or mobile mammography screening unit that is accredited under 266
the American college of radiology mammography accreditation 267
program or in a hospital as defined in section 3727.01 of the 268
Revised Code. 269

(2) With respect to diagnostic breast examinations that 270
are biopsies, the policy shall not, as a condition of coverage, 271
require biopsies to be performed in a facility, mobile 272
mammography screening unit, or hospital as described in division 273
(E) (1) of this section. 274

(F) The benefits provided under division ~~(B) (3)~~ (B) (4) of 275
this section shall be provided only for cytologic screenings 276
that are processed and interpreted in a laboratory certified by 277
the college of American pathologists or in a hospital as defined 278
in section 3727.01 of the Revised Code. 279

(G) No policy of individual or group sickness and accident 280
insurance that is delivered, issued for delivery, or renewed in 281
this state shall impose a cost-sharing requirement for the 282

benefits provided under division (B) of this section. 283

(H) This section does not apply to any policy that 284
provides coverage for specific diseases or accidents only, or to 285
any hospital indemnity, medicare supplement, or other policy 286
that offers only supplemental benefits. 287

Sec. 3923.53. (A) Notwithstanding section 3901.71 of the 288
Revised Code, every public employee benefit plan that is 289
established or modified in this state shall provide benefits for 290
the expenses of all of the following: 291

(1) To detect the presence of breast cancer in adult 292
~~women~~individuals, a screening mammography; 293

(2) To detect the presence of breast cancer in adult ~~women~~ 294
individuals meeting any either or both of the conditions 295
described in division (B) (2) of this section, supplemental 296
breast cancer screening; 297

(3) To diagnose breast cancer in adult individuals meeting 298
the condition described in division (B) (3) of this section, a 299
diagnostic breast examination; 300

(4) To detect the presence of cervical cancer, cytologic 301
screening. 302

(B) (1) The benefits provided under division (A) (1) of this 303
section shall cover expenses for one screening mammography every 304
year, including digital breast tomosynthesis. 305

(2) The benefits provided under division (A) (2) of this 306
section shall cover expenses for supplemental breast cancer 307
screening for an adult ~~woman~~individual who meets ~~any either or~~ 308
both of the following conditions: 309

(a) The ~~woman's~~individual's screening mammography 310

demonstrates, based on the breast imaging reporting and data 311
system established by the American college of radiology, that 312
the ~~woman~~-individual has dense breast tissue; 313

(b) The ~~woman~~-individual is at an increased risk of breast 314
cancer due to family history, prior personal history of breast 315
cancer, ancestry, genetic predisposition, or other reasons as 316
determined by the ~~woman's~~-individual's health care provider. 317

(3) The benefits provided under division (B) (3) of this 318
section shall cover expenses for diagnostic breast examination 319
for an adult individual who has an abnormality seen or suspected 320
from, or detected by, a screening mammography, supplemental 321
breast cancer screening, or another means of examination. 322

~~(C) As used in this division, "medicare reimbursement~~ 323
~~rate" means the reimbursement rate paid in this state under the~~ 324
~~medicare program for screening mammography that does not include~~ 325
~~digitization or computer-aided detection, regardless of whether~~ 326
~~the actual benefit includes digitization or computer-aided~~ 327
~~detection.~~ 328

~~(1)~~ (C) (1) Subject to divisions (C) (2) and (3) of this 329
section, if a provider, hospital, or other health care facility 330
provides a service that is a component of ~~the screening~~ 331
~~mammography~~ a benefit in provided under division (A) (1), (2), or 332
(3) of this section ~~or a component of the supplemental breast~~ 333
~~cancer screening benefit in division (A) (2) of this section and~~ 334
submits a separate claim for that component, a separate payment 335
shall be made to the provider, hospital, or other health care 336
facility ~~in an amount that corresponds to the ratio paid by~~ 337
~~medicare in this state for that component.~~ 338

~~(2) Regardless of whether separate payments are made for~~ 339

~~the~~ The total benefit provided under division (A) (1), ~~or~~ (2), or 340
(3) of this section, the total benefit for a screening 341
~~mammography or supplemental breast cancer screening shall not~~ 342
~~exceed one hundred thirty per cent of the medicare reimbursement~~ 343
~~rate in this state for screening mammography or supplemental~~ 344
~~breast cancer screening. If there is more than one medicare~~ 345
~~reimbursement rate in this state for screening mammography or a~~ 346
~~component of a screening mammography or supplemental breast~~ 347
~~cancer screening or a component of supplemental breast cancer~~ 348
~~screening, the reimbursement limit shall be one hundred thirty~~ 349
~~per cent of the lowest medicare and any separate payment for a~~ 350
service that is a component of such a benefit under division (D) 351
(1) of this section, shall not be less than any reimbursement 352
rate previously paid by the same insurer under a public employee 353
benefit plan that is delivered, issued for delivery, or renewed 354
in this state after the effective date of this amendment to the 355
same provider, hospital, or other health care facility for the 356
same benefit or service that is a component of such benefit. 357

(3) The benefit paid in accordance with ~~division~~ divisions 358
(C) (1) and (2) of this section shall constitute full payment. No 359
provider, hospital, or other health care facility shall seek or 360
receive compensation in excess of the payment made in accordance 361
with ~~division~~ divisions (C) (1) and (2) of this section, ~~except~~ 362
~~for approved deductibles and copayments.~~ 363

~~(D)~~ The (D) (1) Except as provided in division (D) (2) of 364
this section, the benefits provided under division (A) (1) ~~or~~, 365
(2), or (3) of this section shall be provided only for screening 366
~~mammographies ~~or~~,~~ supplemental breast cancer screenings, or 367
diagnostic breast examinations that are performed in a facility 368
or mobile mammography screening unit that is accredited under 369
the American college of radiology mammography accreditation 370

program or in a hospital as defined in section 3727.01 of the
Revised Code.

(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 (D) (1) of this section.

(E) 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.

(F) 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.

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

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

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

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

(2) Division (B) (1) of this section shall not be

considered to do either of the following with regard to a 399
medicaid recipient who is unable to pay a required copayment: 400

(a) Relieve the medicaid recipient from the obligation to 401
pay a copayment; 402

(b) Prohibit the provider from attempting to collect an 403
unpaid copayment. 404

(C) Except as provided in division (F) of this section, no 405
provider shall waive a medicaid recipient's obligation to pay 406
the provider a copayment. 407

(D) No provider or drug manufacturer, including the 408
manufacturer's representative, employee, independent contractor, 409
or agent, shall pay any copayment on behalf of a medicaid 410
recipient. 411

(E) If it is the routine business practice of a provider 412
to refuse service to any individual who owes an outstanding debt 413
to the provider, the provider may consider an unpaid copayment 414
imposed by the cost-sharing requirements as an outstanding debt 415
and may refuse service to a medicaid recipient who owes the 416
provider an outstanding debt. If the provider intends to refuse 417
service to a medicaid recipient who owes the provider an 418
outstanding debt, the provider shall notify the recipient of the 419
provider's intent to refuse service. 420

(F) In the case of a provider that is a hospital, the 421
cost-sharing program shall permit the hospital to take action to 422
collect a copayment by providing, at the time services are 423
rendered to a medicaid recipient, notice that a copayment may be 424
owed. If the hospital provides the notice and chooses not to 425
take any further action to pursue collection of the copayment, 426
the prohibition against waiving copayments specified in division 427

(C) of this section does not apply.

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

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

(1) "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.

(2) "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 asymptomatic 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.

"Screening mammography" does not include diagnostic mammography.

~~(2)~~ (3) "Supplemental breast cancer screening" means any 457
additional screening method deemed medically necessary by a 458
treating health care provider for proper breast cancer screening 459
in accordance with applicable American college of radiology 460
guidelines, including magnetic resonance imaging, ultrasound, 461
contrast enhanced mammography, or molecular breast imaging. 462

(B) The medicaid program shall cover all of the following: 463

(1) To detect the presence of breast cancer in adult 464
~~women~~ individuals, screening mammography; 465

(2) To detect the presence of breast cancer in adult ~~women~~ 466
individuals meeting any either or both of the conditions 467
described in division (C) (2) of this section, supplemental 468
breast cancer screening; 469

(3) To diagnose breast cancer in adult individuals meeting 470
the condition described in division (C) (3) of this section, 471
diagnostic breast examination; 472

(4) To detect the presence of cervical cancer, cytologic 473
screening. 474

(C) (1) The medicaid program's coverage pursuant to 475
division (B) (1) of this section shall cover expenses for one 476
screening mammography every year, including digital breast 477
tomosynthesis. 478

(2) The medicaid program's coverage pursuant to division 479
(B) (2) of this section shall cover expenses for supplemental 480
breast cancer screening for an adult ~~woman~~ individual who meets 481
~~any either or both~~ of the following conditions: 482

(a) The ~~woman's~~ individual's screening mammography 483
demonstrates, based on the breast imaging reporting and data 484

system established by the American college of radiology, that 485
the ~~woman~~-individual has dense breast tissue; 486

(b) The ~~woman~~-individual is at an increased risk of breast 487
cancer due to family history, prior personal history of breast 488
cancer, ancestry, genetic predisposition, or other reasons as 489
determined by the ~~woman's~~-individual's health care provider. 490

(3) The medicaid program's coverage pursuant to division 491
(B) (3) of this section shall cover expenses for diagnostic 492
breast examination for an adult individual who has an 493
abnormality seen or suspected from, or detected by, any of the 494
following: screening mammography, supplemental breast cancer 495
screening, or another means of examination. 496

(D) The medicaid program shall not impose cost-sharing 497
requirements on the coverage described in division (B) of this 498
section. 499

(E) (1) Except as provided in division (E) (2) of this 500
section, the medicaid program's coverage ~~of screening~~ 501
~~mammographies~~ pursuant to division (B) (1) ~~or, (2), or (3)~~ of 502
this section shall be provided only for screening mammographies 503
~~or, supplemental breast cancer screenings, or diagnostic breast~~ 504
~~examinations~~ that are performed in a facility or mobile 505
mammography screening unit that is accredited under the American 506
college of radiology mammography accreditation program or in a 507
hospital as defined in section 3727.01 of the Revised Code. 508

(2) With respect to diagnostic breast examinations that 509
are biopsies, the medicaid program shall not, as a condition of 510
coverage, require biopsies to be performed in a facility, mobile 511
mammography screening unit, or hospital as described in division 512
(E) (1) of this section. 513

~~(E)~~—(F) The medicaid program's coverage of cytologic 514
screenings pursuant to division ~~(B) (3)~~—(B) (4) of this section 515
shall be provided only for cytologic screenings that are 516
processed and interpreted in a laboratory certified by the 517
college of American pathologists or in a hospital as defined in 518
section 3727.01 of the Revised Code. 519

Section 2. That existing sections 1751.62, 3923.52, 520
3923.53, 5162.20, and 5164.08 of the Revised Code are hereby 521
repealed. 522

Section 3. Section 1751.62 of the Revised Code, as amended 523
by this act, applies only to arrangements, policies, contracts, 524
and agreements that are created, delivered, issued for delivery, 525
or renewed in this state on or after the effective date of the 526
amendment. Section 3923.52 of the Revised Code, as amended by 527
this act, applies only to policies of sickness and accident 528
insurance delivered, issued for delivery, or renewed in this 529
state on or after the effective date of the amendment. Section 530
3923.53 of the Revised Code, as amended by this act, applies 531
only to public employee benefit plans that are established or 532
modified in this state on or after the effective date of the 533
amendment. 534

Section 4. (A) As used in this section: 535

(1) "Health plan issuer" has the same meaning as in 536
section 3922.01 of the Revised Code. 537

(2) "Hospital" has the same meaning as in section 3722.01 538
of the Revised Code. 539

(3) "Physician" means an individual authorized under 540
Chapter 4731. of the Revised Code to practice medicine and 541
surgery or osteopathic medicine and surgery. 542

(B) Not later than three months after the effective date 543
of this section, all of the following apply: 544

(1) The Director of Health shall notify each hospital and 545
physician of this act's enactment. 546

(2) The Superintendent of Insurance shall notify each 547
health plan issuer of this act's enactment. 548

(3) The notice shall be completed by certified mail. 549

(C) When notifying a health plan issuer, hospital, or 550
physician under this section, the Director or Superintendent 551
shall summarize the provisions of sections 1751.62, 3923.52, 552
3923.53, 5162.20, and 5164.08 of the Revised Code, each as 553
amended by this act, and shall describe the act's impact on 554
those provisions. 555

(D) The Director of Health may consult with the State 556
Medical Board of Ohio to assist the Director in identifying 557
physicians and determining their business addresses for purposes 558
of satisfying the notice requirements of this section. 559

Section 5. This act shall be known as the Breast 560
Examination and Screening Transformation Act, or BEST Act. 561