§4237-A. Coverage for screening mammograms and diagnostic and supplemental breast examinations

1. Definition.
[PL 2023, c. 338, §10 (RP).]

1-A. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Cost-sharing requirements" means a deductible, coinsurance, copayment or out-of-pocket expense and any maximum limitation on the deductible, coinsurance, copayment or other out-of-pocket expense. [PL 2023, c. 338, §11 (NEW).]

B. "Diagnostic breast examination" means a medically necessary examination of the breast, including an examination using diagnostic mammography, magnetic resonance imaging or ultrasound, that is:

(1) Used to evaluate an abnormality seen on or suspected from a screening mammogram; or

(2) Used to evaluate an abnormality detected by another means of examination. [PL 2023, c. 338, §11 (NEW).]

C. "Screening mammogram" means a radiologic procedure that is provided to an asymptomatic individual for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive. [PL 2023, c. 338, §11 (NEW).]

D. "Supplemental breast examination" means a medical examination of the breast, including an examination using diagnostic mammography, magnetic resonance imaging or ultrasound, to screen for breast cancer when there is no abnormality seen or suspected, but, based on personal or family medical history or other additional factors, the individual has an increased risk of breast cancer. [PL 2023, c. 338, §11 (NEW).]
[PL 2023, c. 338, §11 (NEW).]

2. Required coverage. All individual and group coverage subject to this chapter must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Health and Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.
[PL 1997, c. 408, §7 (NEW); PL 1997, c. 408, §8 (AFF); PL 2003, c. 689, Pt. B, §6 (REV).]

2-A. No cost-sharing requirements. All individual and group coverage subject to this chapter may not impose any cost-sharing requirements on a screening mammogram, diagnostic breast examination or supplemental breast examination performed by a provider in accordance with this section. This subsection does not apply to individual or group coverage offered for use with a health savings account unless the federal Internal Revenue Service determines that the requirements in this subsection are permissible in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2).
[PL 2023, c. 338, §12 (NEW).]

3. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2003, c. 517, Pt. B, §25 (NEW).]

SECTION HISTORY

PL 1997, c. 408, §7 (NEW). PL 1997, c. 408, §8 (AFF). PL 2003, c. 517, §B25 (AMD). PL 2003, c. 689, §B6 (REV). PL 2007, c. 153, §3 (AMD). PL 2007, c. 153, §5 (AFF). PL 2023, c. 338, §§9-12 (AMD).