

APPLICABILITY OF RIGHTS

The existing and expanded rights discussed in this brochure are not applicable to self-funded plans. If you are not sure whether you are covered by a self-funded plan, you should ask your employer (or former employer, if you are retired).

PUBLIC SECTOR EMPLOYERS MUST PROVIDE LEAVE FOR SCREENING

All public sector employers throughout New York State are required to provide their employees with four hours of leave each year for breast cancer screening.

GET SCREENED NO EXCUSES.

GET SCREENED ON YOUR SCHEDULE AT A CONVENIENT LOCATION

To make it easier for working New Yorkers, extended screening hours are now required by law.

Text “**Get Screened**” to **81336**, type in your zip code, and get information about screening locations near you with extended hours.

EARLY DETECTION SAVES LIVES

Each year, about 15,000 women in New York are diagnosed with breast cancer can increase the detection of the disease at an early stage.

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Early detection means more cancers will be found at earlier, more treatable stages, and more lives will be saved.

This brochure describes existing breast cancer screening rights for consumers covered by non- grandfathered policies issued in New York (a non- grandfathered policy is a policy that was issued after March 23, 2010, or a policy issued before that date which underwent significant changes to members’ benefits or cost share), and new rights under recently passed New York State breast legislation.

These new rights will be included in health insurance policies that are issued, renewed, modified or amended on or after January 1, 2017.

IF YOU HAVE QUESTIONS OR WANT TO FILE A COMPLAINT

The Department of Financial Services ensures that health insurers meet their legal obligations to cover breast cancer screening and treatment and works to eliminate any obstacles that New Yorkers and their families may face in the fight against breast cancer.

To file a complaint, or if you have questions about this new legislation and whether it applies to you, contact the **DFS Consumer Hotline at (800) 342- 3736** or visit our website at www.dfs.ny.gov



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What You Need to Know About...

BREAST CANCER SCREENING

Including new rights for health insurance policies issued, renewed, modified or amended on or after January 1, 2017



This guide is provided for informational purposes only and does not constitute legal advice.

INCREASED ACCESS TO SCREENINGS AND COVERAGE FOR POLICIES ISSUED, RENEWED OR MODIFIED ON OR AFTER JANUARY 1, 2017

Under New York State breast cancer legislation, for health insurance policies and contracts issued, renewed, modified or amended on or after January 1, 2017, coverage for breast cancer screening and diagnostic imaging, including diagnostic mammograms, breast ultrasounds, or magnetic resonance imaging (MRI), must be provided without cost-sharing by the individual.

Coverage that must be provided without cost-sharing includes breast cancer risk assessments, genetic testing, and medications to reduce the risk of breast cancer.

SCREENING AND DIAGNOSTIC IMAGING EXISTING RIGHTS

Under existing law, consumers of any age, who have a history of breast cancer or a first degree relative with a history of breast cancer, are covered for an annual mammogram without any cost-sharing when a physician recommends it.

COVERAGE FOR WOMEN AT INCREASED RISK FOR BREAST CANCER, GENETIC SCREENING & MEDICATIONS – EXISTING RIGHTS

New York-issued health insurance policies that are non-grandfathered must provide coverage (with no cost-sharing requirements):

- For primary care providers to screen individuals with a family history of breast, ovarian, tubal, or peritoneal cancer to identify potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2).

- For genetic counseling to individuals whose tests reveals positive screening results. If the genetic counseling determines specific BRCA testing is appropriate, coverage must be provided.
- For medications to reduce breast cancer risk for individuals at increased risk of breast cancer and at low risk for adverse medication effects. Such medication must be prescribed by an appropriate medical professional.

BREAST CANCER TREATMENT AND BREAST RECONSTRUCTION EXISTING RIGHTS

New York –issued health insurance policies must provide coverage for:

- **Medically necessary surgeries, including mastectomies and prophylactic mastectomies.** A prophylactic mastectomy is surgery to remove one or both breasts to reduce the risk of developing breast cancer.
- **Inpatient hospital care following a lymph node dissection or a lumpectomy for as long as is medically appropriate as determined by the attending physician, in consultation with the patient.** The insurance company may not deny a hospital stay as “not medically necessary.” The law states that the patient and their physician determine how long the patient needs to remain in the hospital.
- **Breast reconstruction following mastectomy** or partial mastectomy, including prophylactic mastectomy. Coverage includes all stages of reconstruction of the breast which was removed as well as surgery and reconstruction of the other breast to produce a symmetrical appearance. The patient’s physician, in

- consultation with the patient, will determine which type of reconstruction is appropriate. The insurance company may not deny the surgery as “not medically necessary.”
- **Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.** The patient’s physician, in consultation with the patient, will determine what treatment is appropriate for the patient’s condition. The insurance company may review for medical necessity using appropriate written clinical criteria based on the most recent medical literature.

EXPANDED COVERAGE FOR PREVENTATIVE CARE & TREATMENT OF BREAST CANCER

The newly issued guidelines require health insurers to eliminate:

- Annual deductibles.
- Co-payments and co-insurance payments for all mammograms including those provided to individuals more frequently than current federal screening guidelines (such as annual mammograms for women in their forties).
- Cost-sharing for diagnostic imaging for breast cancer, including diagnostic mammograms, breast ultrasounds, and breast MRIs for individuals at high risk for breast cancer.

As a result, policyholders in need of diagnostic test other than standard annual mammograms will not have to pay any additional out-of-pocket expenses. Services must be obtained from participating providers, unless your insurance company does not have a provider in their network with the appropriate training and experience to meet the particular health care needs of the policyholder.