514C.4 Mandated coverage for mammography.

1. *a.* A policy or contract providing for third-party payment or prepayment of health or medical expenses shall provide minimum mammography examination coverage, including, but not limited to, the following classes of third-party payment provider contracts or policies delivered, issued for delivery, continued, or renewed in this state.

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) An individual or group Medicare supplemental policy, unless coverage pursuant to such policy is preempted by federal law.

b. A long-term care policy or contract is specifically excluded from regulation under this section.

2. As used in this section, "*minimum mammography examination coverage*" means benefits which are better than or equal to the following minimum requirements:

a. One baseline mammogram for any woman who is thirty-five through thirty-nine years of age, or more frequent mammograms if recommended by the woman's physician.

b. A mammogram every two years for any woman who is forty through forty-nine years of age, or more frequently if recommended by the woman's physician.

c. A mammogram every year for any woman who is fifty years of age or older, or more frequently if recommended by the woman's physician.

3. Mammogram benefits may be subject to any policy or contract provisions which apply generally to other services covered by the policy or contract.

4. The commissioner of insurance shall adopt rules under chapter 17A necessary to implement this section.

89 Acts, ch 289, §1; 92 Acts, ch 1162, §32, 33; 2003 Acts, ch 135, §1 – 3; 2012 Acts, ch 1023, §157