



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB5001

Introduced 2/10/2026, by Rep. Nabeela Syed and Katie Stuart

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356g

from Ch. 73, par. 968g

Amends the Illinois Insurance Code. Requires every insurer to provide in each group or individual policy, contract, or certificate of insurance issued or renewed for persons who are residents of the State, coverage for screening by low-dose mammography for all patients 30 (instead of 35) years of age or older for the presence of occult breast cancer within the provisions of the policy, contract, or certificate. Requires coverage for a baseline mammogram for patients 30 to 34 (instead of 35 to 39) years of age and an annual mammogram for patients 35 (instead of 40) years of age or older. Effective January 1, 2027.

LRB104 15320 BAB 28474 b

1 AN ACT concerning regulation.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Illinois Insurance Code is amended by
5 changing Section 356g as follows:

6 (215 ILCS 5/356g) (from Ch. 73, par. 968g)

7 (Text of Section before amendment by P.A. 103-808)

8 Sec. 356g. Mammograms; mastectomies.

9 (a) Every insurer shall provide in each group or
10 individual policy, contract, or certificate of insurance
11 issued or renewed for persons who are residents of this State,
12 coverage for screening by low-dose mammography for all women
13 30 ~~35~~ years of age or older for the presence of occult breast
14 cancer within the provisions of the policy, contract, or
15 certificate. The coverage shall be as follows:

16 (1) A baseline mammogram for women 30 to 34 ~~35 to 39~~
17 years of age.

18 (2) An annual mammogram for women 35 ~~40~~ years of age or
19 older.

20 (3) A mammogram at the age and intervals considered
21 medically necessary by the woman's health care provider
22 for women under 35 ~~40~~ years of age and having a family
23 history of breast cancer, prior personal history of breast

1 cancer, positive genetic testing, or other risk factors.

2 (4) For an individual or group policy of accident and
3 health insurance or a managed care plan that is amended,
4 delivered, issued, or renewed on or after the effective
5 date of this amendatory Act of the 101st General Assembly,
6 a comprehensive ultrasound screening and MRI of an entire
7 breast or breasts if a mammogram demonstrates
8 heterogeneous or dense breast tissue or when medically
9 necessary as determined by a physician licensed to
10 practice medicine in all of its branches.

11 (5) A screening MRI when medically necessary, as
12 determined by a physician licensed to practice medicine in
13 all of its branches.

14 (6) For an individual or group policy of accident and
15 health insurance or a managed care plan that is amended,
16 delivered, issued, or renewed on or after the effective
17 date of this amendatory Act of the 101st General Assembly,
18 a diagnostic mammogram when medically necessary, as
19 determined by a physician licensed to practice medicine in
20 all its branches, advanced practice registered nurse, or
21 physician assistant.

22 A policy subject to this subsection shall not impose a
23 deductible, coinsurance, copayment, or any other cost-sharing
24 requirement on the coverage provided; except that this
25 sentence does not apply to coverage of diagnostic mammograms
26 to the extent such coverage would disqualify a high-deductible

1 health plan from eligibility for a health savings account
2 pursuant to Section 223 of the Internal Revenue Code (26
3 U.S.C. 223).

4 For purposes of this Section:

5 "Diagnostic mammogram" means a mammogram obtained using
6 diagnostic mammography.

7 "Diagnostic mammography" means a method of screening that
8 is designed to evaluate an abnormality in a breast, including
9 an abnormality seen or suspected on a screening mammogram or a
10 subjective or objective abnormality otherwise detected in the
11 breast.

12 "Low-dose mammography" means the x-ray examination of the
13 breast using equipment dedicated specifically for mammography,
14 including the x-ray tube, filter, compression device, and
15 image receptor, with radiation exposure delivery of less than
16 1 rad per breast for 2 views of an average size breast. The
17 term also includes digital mammography and includes breast
18 tomosynthesis. As used in this Section, the term "breast
19 tomosynthesis" means a radiologic procedure that involves the
20 acquisition of projection images over the stationary breast to
21 produce cross-sectional digital three-dimensional images of
22 the breast.

23 If, at any time, the Secretary of the United States
24 Department of Health and Human Services, or its successor
25 agency, promulgates rules or regulations to be published in
26 the Federal Register or publishes a comment in the Federal

1 Register or issues an opinion, guidance, or other action that
2 would require the State, pursuant to any provision of the
3 Patient Protection and Affordable Care Act (Public Law
4 111-148), including, but not limited to, 42 U.S.C.
5 18031(d)(3)(B) or any successor provision, to defray the cost
6 of any coverage for breast tomosynthesis outlined in this
7 subsection, then the requirement that an insurer cover breast
8 tomosynthesis is inoperative other than any such coverage
9 authorized under Section 1902 of the Social Security Act, 42
10 U.S.C. 1396a, and the State shall not assume any obligation
11 for the cost of coverage for breast tomosynthesis set forth in
12 this subsection.

13 (a-5) Coverage as described by subsection (a) shall be
14 provided at no cost to the insured and shall not be applied to
15 an annual or lifetime maximum benefit.

16 (a-10) When health care services are available through
17 contracted providers and a person does not comply with plan
18 provisions specific to the use of contracted providers, the
19 requirements of subsection (a-5) are not applicable. When a
20 person does not comply with plan provisions specific to the
21 use of contracted providers, plan provisions specific to the
22 use of non-contracted providers must be applied without
23 distinction for coverage required by this Section and shall be
24 at least as favorable as for other radiological examinations
25 covered by the policy or contract.

26 (b) No policy of accident or health insurance that

1 provides for the surgical procedure known as a mastectomy
2 shall be issued, amended, delivered, or renewed in this State
3 unless that coverage also provides for prosthetic devices or
4 reconstructive surgery incident to the mastectomy. Coverage
5 for breast reconstruction in connection with a mastectomy
6 shall include:

7 (1) reconstruction of the breast upon which the
8 mastectomy has been performed;

9 (2) surgery and reconstruction of the other breast to
10 produce a symmetrical appearance; and

11 (3) prostheses and treatment for physical
12 complications at all stages of mastectomy, including
13 lymphedemas.

14 Care shall be determined in consultation with the attending
15 physician and the patient. The offered coverage for prosthetic
16 devices and reconstructive surgery shall be subject to the
17 deductible and coinsurance conditions applied to the
18 mastectomy, and all other terms and conditions applicable to
19 other benefits. When a mastectomy is performed and there is no
20 evidence of malignancy then the offered coverage may be
21 limited to the provision of prosthetic devices and
22 reconstructive surgery to within 2 years after the date of the
23 mastectomy. As used in this Section, "mastectomy" means the
24 removal of all or part of the breast for medically necessary
25 reasons, as determined by a licensed physician.

26 Written notice of the availability of coverage under this

1 Section shall be delivered to the insured upon enrollment and
2 annually thereafter. An insurer may not deny to an insured
3 eligibility, or continued eligibility, to enroll or to renew
4 coverage under the terms of the plan solely for the purpose of
5 avoiding the requirements of this Section. An insurer may not
6 penalize or reduce or limit the reimbursement of an attending
7 provider or provide incentives (monetary or otherwise) to an
8 attending provider to induce the provider to provide care to
9 an insured in a manner inconsistent with this Section.

10 (c) Rulemaking authority to implement Public Act 95-1045,
11 if any, is conditioned on the rules being adopted in
12 accordance with all provisions of the Illinois Administrative
13 Procedure Act and all rules and procedures of the Joint
14 Committee on Administrative Rules; any purported rule not so
15 adopted, for whatever reason, is unauthorized.

16 (Source: P.A. 100-395, eff. 1-1-18; 101-580, eff. 1-1-20.)

17 (Text of Section after amendment by P.A. 103-808)

18 Sec. 356g. Mammograms; mastectomies.

19 (a) Every insurer shall provide in each group or
20 individual policy, contract, or certificate of insurance
21 issued or renewed for persons who are residents of this State,
22 coverage for screening by low-dose mammography for all
23 patients 30 ~~35~~ years of age or older for the presence of occult
24 breast cancer within the provisions of the policy, contract,
25 or certificate. The coverage shall be as follows:

1 (1) A baseline mammogram for patients 30 to 34 ~~35 to 39~~
2 years of age.

3 (2) An annual mammogram for patients 35 ~~40~~ years of
4 age or older.

5 (3) A mammogram at the age and intervals considered
6 medically necessary by the patient's health care provider
7 for patients under 35 ~~40~~ years of age and having a family
8 history of breast cancer, prior personal history of breast
9 cancer, positive genetic testing, or other risk factors.

10 (4) For an individual or group policy of accident and
11 health insurance or a managed care plan that is amended,
12 delivered, issued, or renewed on or after January 1, 2020
13 (the effective date of Public Act 101-580) and before the
14 effective date of this amendatory Act of the 103rd General
15 Assembly, a comprehensive ultrasound screening and MRI of
16 an entire breast or breasts if a mammogram demonstrates
17 heterogeneous or dense breast tissue or when medically
18 necessary as determined by a physician licensed to
19 practice medicine in all of its branches.

20 (4.3) For an individual or group policy of accident
21 and health insurance or a managed care plan that is
22 amended, delivered, issued, or renewed on or after the
23 effective date of this amendatory Act of the 103rd General
24 Assembly, a comprehensive ultrasound screening and MRI of
25 an entire breast or breasts if a mammogram demonstrates
26 heterogeneous or dense breast tissue or when medically

1 necessary as determined by a physician licensed to
2 practice medicine in all of its branches, advanced
3 practice registered nurse, or physician assistant.

4 (4.5) For a group policy of accident and health
5 insurance that is amended, delivered, issued, or renewed
6 on or after the effective date of this amendatory Act of
7 the 103rd General Assembly, molecular breast imaging (MBI)
8 of an entire breast or breasts if a mammogram demonstrates
9 heterogeneous or dense breast tissue or when medically
10 necessary as determined by a physician licensed to
11 practice medicine in all of its branches, advanced
12 practice registered nurse, or physician assistant.

13 (5) A screening MRI when medically necessary, as
14 determined by a physician licensed to practice medicine in
15 all of its branches.

16 (6) For an individual or group policy of accident and
17 health insurance or a managed care plan that is amended,
18 delivered, issued, or renewed on or after January 1, 2020
19 (the effective date of Public Act 101-580), a diagnostic
20 mammogram when medically necessary, as determined by a
21 physician licensed to practice medicine in all its
22 branches, advanced practice registered nurse, or physician
23 assistant.

24 A policy subject to this subsection shall not impose a
25 deductible, coinsurance, copayment, or any other cost-sharing
26 requirement on the coverage provided; except that this

1 sentence does not apply to coverage of diagnostic mammograms
2 to the extent such coverage would disqualify a high-deductible
3 health plan from eligibility for a health savings account
4 pursuant to Section 223 of the Internal Revenue Code (26
5 U.S.C. 223).

6 For purposes of this Section:

7 "Diagnostic mammogram" means a mammogram obtained using
8 diagnostic mammography.

9 "Diagnostic mammography" means a method of screening that
10 is designed to evaluate an abnormality in a breast, including
11 an abnormality seen or suspected on a screening mammogram or a
12 subjective or objective abnormality otherwise detected in the
13 breast.

14 "Low-dose mammography" means the x-ray examination of the
15 breast using equipment dedicated specifically for mammography,
16 including the x-ray tube, filter, compression device, and
17 image receptor, with radiation exposure delivery of less than
18 1 rad per breast for 2 views of an average size breast. The
19 term also includes digital mammography and includes breast
20 tomosynthesis. As used in this Section, the term "breast
21 tomosynthesis" means a radiologic procedure that involves the
22 acquisition of projection images over the stationary breast to
23 produce cross-sectional digital three-dimensional images of
24 the breast.

25 If, at any time, the Secretary of the United States
26 Department of Health and Human Services, or its successor

1 agency, promulgates rules or regulations to be published in
2 the Federal Register or publishes a comment in the Federal
3 Register or issues an opinion, guidance, or other action that
4 would require the State, pursuant to any provision of the
5 Patient Protection and Affordable Care Act (Public Law
6 111-148), including, but not limited to, 42 U.S.C.
7 18031(d)(3)(B) or any successor provision, to defray the cost
8 of any coverage for breast tomosynthesis outlined in this
9 subsection, then the requirement that an insurer cover breast
10 tomosynthesis is inoperative other than any such coverage
11 authorized under Section 1902 of the Social Security Act, 42
12 U.S.C. 1396a, and the State shall not assume any obligation
13 for the cost of coverage for breast tomosynthesis set forth in
14 this subsection.

15 (a-5) Coverage as described by subsection (a) shall be
16 provided at no cost to the insured and shall not be applied to
17 an annual or lifetime maximum benefit.

18 (a-10) When health care services are available through
19 contracted providers and a person does not comply with plan
20 provisions specific to the use of contracted providers, the
21 requirements of subsection (a-5) are not applicable. When a
22 person does not comply with plan provisions specific to the
23 use of contracted providers, plan provisions specific to the
24 use of non-contracted providers must be applied without
25 distinction for coverage required by this Section and shall be
26 at least as favorable as for other radiological examinations

1 covered by the policy or contract.

2 (b) No policy of accident or health insurance that
3 provides for the surgical procedure known as a mastectomy
4 shall be issued, amended, delivered, or renewed in this State
5 unless that coverage also provides for prosthetic devices or
6 reconstructive surgery incident to the mastectomy. Coverage
7 for breast reconstruction in connection with a mastectomy
8 shall include:

9 (1) reconstruction of the breast upon which the
10 mastectomy has been performed;

11 (2) surgery and reconstruction of the other breast to
12 produce a symmetrical appearance; and

13 (3) prostheses and treatment for physical
14 complications at all stages of mastectomy, including
15 lymphedemas.

16 Care shall be determined in consultation with the attending
17 physician and the patient. The offered coverage for prosthetic
18 devices and reconstructive surgery shall be subject to the
19 deductible and coinsurance conditions applied to the
20 mastectomy, and all other terms and conditions applicable to
21 other benefits. When a mastectomy is performed and there is no
22 evidence of malignancy then the offered coverage may be
23 limited to the provision of prosthetic devices and
24 reconstructive surgery to within 2 years after the date of the
25 mastectomy. As used in this Section, "mastectomy" means the
26 removal of all or part of the breast for medically necessary

1 reasons, as determined by a licensed physician.

2 Written notice of the availability of coverage under this
3 Section shall be delivered to the insured upon enrollment and
4 annually thereafter. An insurer may not deny to an insured
5 eligibility, or continued eligibility, to enroll or to renew
6 coverage under the terms of the plan solely for the purpose of
7 avoiding the requirements of this Section. An insurer may not
8 penalize or reduce or limit the reimbursement of an attending
9 provider or provide incentives (monetary or otherwise) to an
10 attending provider to induce the provider to provide care to
11 an insured in a manner inconsistent with this Section.

12 (c) Rulemaking authority to implement Public Act 95-1045,
13 if any, is conditioned on the rules being adopted in
14 accordance with all provisions of the Illinois Administrative
15 Procedure Act and all rules and procedures of the Joint
16 Committee on Administrative Rules; any purported rule not so
17 adopted, for whatever reason, is unauthorized.

18 (Source: P.A. 103-808, eff. 1-1-26.)

19 Section 95. No acceleration or delay. Where this Act makes
20 changes in a statute that is represented in this Act by text
21 that is not yet or no longer in effect (for example, a Section
22 represented by multiple versions), the use of that text does
23 not accelerate or delay the taking effect of (i) the changes
24 made by this Act or (ii) provisions derived from any other
25 Public Act.

1 Section 99. Effective date. This Act takes effect January
2 1, 2027.