

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 Sec. 356g. Mammograms; mastectomies.

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

15 (1) A baseline mammogram for patients 35 to 39 years
16 of age.

17 (2) An annual mammogram for patients 40 years of age
18 or older.

19 (3) A mammogram at the age and intervals considered
20 medically necessary by the patient's health care provider
21 for patients under 40 years of age and having a family
22 history of breast cancer, prior personal history of breast
23 cancer, positive genetic testing, or other risk factors.

1 (4) For an individual or group policy of accident and
2 health insurance or a managed care plan that is amended,
3 delivered, issued, or renewed on or after January 1, 2020
4 (the effective date of Public Act 101-580) and before the
5 effective date of this amendatory Act of the 103rd General
6 Assembly, a comprehensive ultrasound screening and MRI of
7 an entire 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 (4.3) For an individual or group policy of accident
12 and health insurance or a managed care plan that is
13 amended, delivered, issued, or renewed on or after 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, advanced
20 practice registered nurse, or physician assistant.

21 (4.5) For a group policy of accident and health
22 insurance that is amended, delivered, issued, or renewed
23 on or after the effective date of this amendatory Act of
24 the 103rd General Assembly, molecular breast imaging (MBI)
25 of 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 (5) A screening MRI when medically necessary, as
5 determined by a physician licensed to practice medicine in
6 all of its branches.

7 (6) For an individual or group policy of accident and
8 health insurance or a managed care plan that is amended,
9 delivered, issued, or renewed on or after January 1, 2020
10 (the effective date of Public Act 101-580), a diagnostic
11 mammogram when medically necessary, as determined by a
12 physician licensed to practice medicine in all its
13 branches, advanced practice registered nurse, or physician
14 assistant.

15 A policy subject to this subsection shall not impose a
16 deductible, coinsurance, copayment, or any other cost-sharing
17 requirement on the coverage provided; except that this
18 sentence does not apply to coverage of diagnostic mammograms
19 to the extent such coverage would disqualify a high-deductible
20 health plan from eligibility for a health savings account
21 pursuant to Section 223 of the Internal Revenue Code (26
22 U.S.C. 223).

23 For purposes of this Section:

24 "Diagnostic mammogram" means a mammogram obtained using
25 diagnostic mammography.

26 "Diagnostic mammography" means a method of screening that

1 is designed to evaluate an abnormality in a breast, including
2 an abnormality seen or suspected on a screening mammogram or a
3 subjective or objective abnormality otherwise detected in the
4 breast.

5 "Low-dose mammography" means the x-ray examination of the
6 breast using equipment dedicated specifically for mammography,
7 including the x-ray tube, filter, compression device, and
8 image receptor, with radiation exposure delivery of less than
9 1 rad per breast for 2 views of an average size breast. The
10 term also includes digital mammography and includes breast
11 tomosynthesis. As used in this Section, the term "breast
12 tomosynthesis" means a radiologic procedure that involves the
13 acquisition of projection images over the stationary breast to
14 produce cross-sectional digital three-dimensional images of
15 the breast.

16 If, at any time, the Secretary of the United States
17 Department of Health and Human Services, or its successor
18 agency, promulgates rules or regulations to be published in
19 the Federal Register or publishes a comment in the Federal
20 Register or issues an opinion, guidance, or other action that
21 would require the State, pursuant to any provision of the
22 Patient Protection and Affordable Care Act (Public Law
23 111-148), including, but not limited to, 42 U.S.C.
24 18031(d)(3)(B) or any successor provision, to defray the cost
25 of any coverage for breast tomosynthesis outlined in this
26 subsection, then the requirement that an insurer cover breast

1 tomosynthesis is inoperative other than any such coverage
2 authorized under Section 1902 of the Social Security Act, 42
3 U.S.C. 1396a, and the State shall not assume any obligation
4 for the cost of coverage for breast tomosynthesis set forth in
5 this subsection.

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

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

19 (a-15) Notwithstanding any age requirement set forth in
20 this Section, coverage shall be consistent with evidence-based
21 clinical guidelines, including, but not limited to, guidelines
22 established by the National Comprehensive Cancer Network, and
23 shall be provided in accordance with the determination of a
24 health care provider, including coverage for individuals under
25 35 years of age when appropriate. Nothing in this subsection
26 shall be construed to limit coverage otherwise required under

1 this Section based on age.

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 99. Effective date. This Act takes effect January
20 1, 2028.