Sen. Graciela Guzmán

Filed: 5/8/2026

AMENDMENT TO HOUSE BILL 5001

AMENDMENT NO. _____. Amend House Bill 5001 by replacing everything after the enacting clause with the following:

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

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

Sec. 356g. Mammograms; mastectomies.

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

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

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

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

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

(4.3) For an individual or group policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 103rd General Assembly, a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice medicine in all of its branches, advanced

practice registered nurse, or physician assistant.

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

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

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

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

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

For purposes of this Section:

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

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

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

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

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

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

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

(a-15) Notwithstanding any age requirement set forth in

this Section, coverage shall be consistent with evidence-based clinical guidelines, including, but not limited to, guidelines established by the National Comprehensive Cancer Network, and shall be provided in accordance with the determination of a health care provider. Nothing in this subsection shall be construed to limit coverage otherwise required under this Section based on age.

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

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

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

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

Care shall be determined in consultation with the attending physician and the patient. The offered coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to

other benefits. When a mastectomy is performed and there is no evidence of malignancy then the offered coverage may be limited to the provision of prosthetic devices and reconstructive surgery to within 2 years after the date of the mastectomy. As used in this Section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician.

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

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

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

Section 99. Effective date. This Act takes effect January

1, 2028.".