



# Illinois Insurance Facts

## Illinois Department of Insurance

### Coverage for the Diagnosis and Treatment of Breast Conditions

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Note: This information was developed to provide consumers with general information and guidance about insurance coverage and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

This fact sheet provides a summary of insurance laws related to diagnosis and treatment of breast conditions, including breast cancer.

## ***Breast Exams***

### **Illinois Law**

**Clinical Breast Exams** – All individual and group health insurance and HMO policies must provide coverage for a complete and thorough **clinical examination of the breast** according to the following schedule:

- Women age 20 to 39 – at least once every three years; and
- Women age 40 and older – annually.

215 ILCS 5/356g.5(b) – Insurers

215 ILCS 125/4-6.5 – HMOs

215 ILCS 165/10 – Voluntary Health Services Plans Act

### **Federal law**

Section 2713 of the Affordable Care Act (ACA), signed on March 23, 2010, requires plans to cover preventive services without any cost-sharing for the enrollee when delivered by in-network providers. This federal law applies to plans issued on or after September 23, 2010, known as non-grandfathered plans. These services include coverage for a well-woman visit, which includes a breast exam, annually for women under age 65. This does not apply to plans that were in place before the law was passed (called *grandfathered* plans). You can find out the date your insurance plan started by contacting your health insurance plan administrator.

## ***Mammograms***

### **Illinois Law**

**Mammograms** – All individual and group health insurance and HMO policies must cover **routine mammograms** for all women age 35 and older. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. The insurance company or HMO must provide for routine mammograms according to the following schedule:

- Women age 35 to 39 – one baseline mammogram; and
- Women age 40 or older – one mammogram annually.

For women under age 40 who have a family history of breast cancer or other risk factors, coverage must include a mammogram at the age and intervals considered medically necessary by the woman's health care provider.

If a routine mammogram reveals heterogeneous or dense breast tissue, coverage must provide for a **comprehensive ultrasound screening** of an entire breast or breasts, when determined to be medically necessary by a physician. [215 ILCS 5/356g(a)(4) and 215 ILCS 125/4-6.1(a)(4)]

The required coverage for mammograms and ultrasound screenings as described above must be provided **at no cost to the insured** (*i.e.*, co-pays or deductibles may not be applied) if a preferred provider is utilized. The cost of the mammogram or screening must not count against any annual or lifetime benefit limits contained in the insurance policy or HMO contract. If the mammogram or screening is provided by an out-of-network provider, the cost-sharing prohibition does not apply. However, the insurance company or HMO must provide coverage that is at least as favorable as out-of-network coverage for other radiological examinations.

215 ILCS 5/356g(a) – Insurers

215 ILCS 125/4-6.1(a) – HMOs

215 ILCS 165/10 – Voluntary Health Services Plans Act

This law does not apply to short-term travel, disability income, long term care, accident only or specified disease policies.

### **Federal law**

Section 2713 of the Affordable Care Act (ACA), signed on March 23, 2010, requires plans to cover preventive services without any cost-sharing for the enrollee when delivered by in-network providers. This federal law applies to plans issued on or after September 23, 2010, known as non-grandfathered plans. This does not apply to plans that were in place before the law was passed (called *grandfathered* plans). You can find out the date your insurance plan started by contacting your health insurance plan administrator. As part of this requirement, coverage of preventive mammograms, with no cost-sharing, every one to two years for women starting at age 40 must be provided.

The Affordable Care Act requires Medicare to cover a yearly mammography screening at no cost to women starting at age 40.

## ***Breast Fibrocystic Condition***

### **Illinois law**

An insurer or HMO may not refuse to cover an individual nor attach an exclusionary rider to a policy, **solely** because the individual has been diagnosed as having a fibrocystic breast condition, **unless** the condition is diagnosed by a breast biopsy that demonstrates an increased disposition to the development of breast cancer or unless the insured's medical history confirms a chronic, relapsing, symptomatic breast condition.

215 ILCS 5/356n – Insurers

215 ILCS 125/4-16 – HMOs

### **Federal law**

Under the Affordable Care Act, insurance companies may not deny coverage because of a pre-existing condition, as of January 1, 2014.

## ***Mastectomy- prosthetic devices and reconstructive surgery***

### **Illinois law**

All group and individual health insurance and HMO policies that provide coverage for mastectomies must also cover **prosthetic devices or reconstructive surgery** related to the mastectomy. Prosthetic devices include breast prostheses and bras. Reconstructive surgery includes reconstruction of the breast on which the mastectomy has been performed, as well as surgery and reconstruction of the other breast to produce symmetrical appearance. Coverage is also required for prosthetic devices and treatment for physical complications at all stages of the mastectomy, including lymphedemas. The coverage must be subject to the same deductible and coinsurance requirements applicable to the mastectomy.

215 ILCS 5/356g(b) – Insurers

215 ILCS 125/4-6.1(b) – HMOs

215 ILCS 165/10 – Voluntary Health Services Plans Act

This law does not apply to short-term travel, disability income, long term care, accident only or specified disease policies.

### **Federal law**

The federal Women’s Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage to also provide coverage for all states of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Deductibles and coinsurance amounts must be consistent with those established for other benefits under the plan or coverage. This law applies to group plans, including self insured employers. However, if your coverage is provided by a “church plan” or “governmental plan”, check with your plan administrator.

Additional information may be found at <http://www.dol.gov/ebsa/publications/whcra.html>.

This law does not apply to Medicare; however, Medicare covers breast reconstruction for women who have a mastectomy because of breast cancer.

## ***Post-Mastectomy Care***

### **Illinois law**

All group and individual health insurance and HMO policies that provide surgical coverage must provide coverage for **inpatient care following a mastectomy**. The insurance company or HMO must provide coverage for a length of stay determined by the attending physician to be medically necessary, in accordance with protocols and guidelines based on sound scientific evidence and an evaluation of the patient. Coverage also must be provided for a post-discharge physician office visit or in-home nurse visit within 48 hours of discharge.

215 ILCS 5/356t – Insurers  
215 ILCS 165/10 – Voluntary Health Services Plans Act

215 ILCS 125/4-6.5 – HMOs

This law does not apply to short-term travel, disability income, long term care, accident only or specified disease policies.

**Federal law**

There is no applicable federal law.

***Pain Medication and Pain Therapy for Breast Cancer  
(Public Act 95-1045)***

Beginning March 27, 2009, all group and individual health insurance and HMO policies must provide coverage for all medically necessary **pain medication and pain therapy** related to the treatment of breast cancer. The coverage must be provided on the same terms and conditions that are generally applicable to coverage provided for other conditions.

- “Pain therapy” is therapy that is medically based, includes reasonably defined goals (e.g., stabilizing or reducing pain), and provides for the periodic evaluation of the therapy’s effectiveness in meeting those goals.

215 ILCS 5/356g.5-1 – Insurers  
215 ILCS 165/10 – Voluntary Health Services Plans Act

215 ILCS 125/5-3(a) – HMOs

**Federal law**

There is no applicable federal law.

***Breast Implant Removal***

In Illinois, no individual or group health insurance or HMO policy may deny coverage for the **removal of breast implants** if:

- The implants were not inserted for purely cosmetic reasons; **and**
- It is medically necessary for the breast implants to be removed.

Implants inserted as reconstruction resulting from sickness or injury are not considered purely cosmetic.

215 ILCS 5/356p – Insurers

215 ILCS 125/4-6.2 – HMOs

This law does not apply to Voluntary Health Services Plans, short-term travel, disability income, long term care, accident only or specified disease policies.

**Federal law**

There is no applicable federal law.

***BRCA Counseling***

**Federal law**

Section 2713 of the Affordable Care Act (ACA), signed on March 23, 2010, requires plans to cover preventive services without any cost-sharing for the enrollee when delivered by in-network

providers. This federal law applies to plans issued on or after September 23, 2010, known as non-grandfathered plans.

Under the ACA, women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes must be provided coverage for genetic counseling and evaluation for BRCA testing.

### ***Breast Cancer Chemoprevention Counseling***

#### **Federal law**

Section 2713 of the Affordable Care Act (ACA), signed on March 23, 2010, requires plans to cover preventive services without any cost-sharing for the enrollee when delivered by in-network providers. This federal law applies to plans issued on or after September 23, 2010, known as non-grandfathered plans.

Under the ACA, counseling about medications for women at higher risk of developing breast cancer must be covered.

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#### **For More Information**

Call the Office of Consumer Health Insurance toll free at (877) 527-9431  
or visit us on our website at <http://insurance.illinois.gov>