AN ACT concerning insurance.

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

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 women 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 women 35 to 39 years of age.

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

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

(4) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

These benefits shall be at least as favorable as for other radiological examinations and subject to the same dollar limits, deductibles, and co-insurance factors. For purposes of this Section, "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.

(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.

(Source: P.A. 94-121, eff. 7-6-05.)

Section 10. The Health Maintenance Organization Act is amended by changing Section 4-6.1 as follows:

(215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)

Sec. 4-6.1. Mammograms; mastectomies.

(a) Every contract or evidence of coverage issued by a Health Maintenance Organization for persons who are residents of this State shall contain coverage for screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer. The coverage shall be as follows:

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

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

(3) A mammogram at the age and intervals considered medically necessary by the woman's health care provider for women 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) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

These benefits shall be at least as favorable as for other

radiological examinations and subject to the same dollar limits, deductibles, and co-insurance factors. For purposes of this Section, "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.

(b) No contract or evidence of coverage issued by a health maintenance organization that provides for the surgical procedure known as a mastectomy shall be issued, amended, delivered, or renewed in this State on or after the effective date of this amendatory Act of the 92nd General Assembly unless that coverage also provides for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that the mastectomy is performed after the effective date of this amendatory Act. 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 enrollee upon enrollment and annually thereafter. A health maintenance organization may not deny to an enrollee 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. A health maintenance organization 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.

(Source: P.A. 94-121, eff. 7-6-05.)

Section 99. Effective date. This Act takes effect upon becoming law.