



# Illinois Insurance Facts

Illinois Department of Financial and Professional Regulation  
Division of Insurance

## Women's Health Care Issues

Revised  
December 2009

**Note:** This information was developed to provide consumers with general information and guidance about insurance coverages 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.

Women have special health care needs. The State of Illinois has passed the following laws related specifically to female health care issues and insurance requirements.

The following state laws do not apply to self-insured employers or to trusts or insurance policies written outside Illinois. However, for HMOs, the laws do apply in certain situations to contracts written outside of Illinois if the HMO member is a resident of Illinois and the HMO has established a provider network in Illinois. To determine if your HMO provides the benefits required by the following laws, you should contact the HMO directly or check your certificate of coverage.

Some of the laws apply to the Limited Health Services Act, the Voluntary Health Services Plan Act, the State Employees Act, the Counties Code, the Illinois Municipal Code and the School Code. Each law has been noted with the applicable code citations.

### Birth Control

Effective January 1, 2004 all individual and group health insurance and HMO policies that provide coverage for outpatient services and outpatient prescription drugs or devices, must also provide coverage for all outpatient contraceptive services and all outpatient contraceptive drugs and devices approved by the Food and Drug Administration. Deductibles, coinsurance, waiting periods are the same as those imposed for any other outpatient prescription drug or device under the policy.

*215 ILCS 5/356z.4 Insurance Code*

*215 ILCS 125/5-3 HMO Act*

*215 ILCS 165/10 Voluntary Health Services Plan Act*

*5/ILCS 375/6.11 State Employees Act*

### Breast Exams, Mammograms, Screenings

**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** at least once every three years for women age 20 to 39 and annually for women age 40 and older.

*215 ILCS 5/356g.5 Insurance Code*

*215 ILCS 125/4-6.5 HMO Act*

*215 ILCS 165/10 – Voluntary Health Services Plan Act*

*5/ILCS 375/6.11 State Employees Act*

*55 ILCS 5/5-1069.3 – Counties Code*

*65 ILCS 5/10-4-2.3 – Illinois Municipal Code*

*105 ILCS 5/10-22.3f – School Code*

**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;
- 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.

***Mammograms - Cost to Consumer (Public Act 95-1045)***

Beginning March 27, 2009, 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). 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. [215 ILCS 5/356g(a-5) and 215 ILCS 125/4-6.1]

**NOTE:** For policies issued prior to March 27, 2009, this cost-sharing prohibition will apply to your policy as soon as your policy is amended or renewed – check with your insurance agent, employer, or insurance company for the date this law will become effective for your policy.

- Until this law applies to your policy, the insurance company or HMO must provide coverage for mammograms and screenings that is at least as favorable as coverage for other radiological examinations (*e.g.*, subject to the same dollar limits, deductibles and co-pay requirements).
- 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.

**Ultrasound Screening** - If a routine mammogram reveals heterogeneous or dense breast tissue, coverage must be provided 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) Insurance Code  
215 ILCS 125/4-6.1(a) HMO Act  
215 ILCS 165/10 Voluntary Health Services Plans Act  
5/ILCS 375/6.11 State Employees Act  
55 ILCS 5/5-1069(d) Counties Code  
65 ILCS 5/10-4-2(d) Illinois Municipal Code  
105 ILCS 5/10-22.3f School Code

## Breast Fibrocystic Condition

At least 50% of women of reproduction age have **fibrocystic condition**, the presence of lumps in the breast that may be painful and tender. 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 with fibrocystic condition, unless a breast biopsy indicates the individual is likely to incur breast cancer or the medical history shows the condition to be chronic.

215 ILCS 5/356n Insurance Code  
215 ILCS 125/4-16 HMO Act

## Breast Surgery

**Mastectomy – Breast Reconstruction** – 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 prosthesis 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 mastectomy, including lymph edemas. The coverage may be subject to annual deductibles and coinsurance provisions as deemed appropriate and consistent with other benefits covered under the insurance.

215 ILCS 5/356g(b) Insurance Code  
215 ILCS 125/4-6.1(b) HMO Act  
215 ILCS 165/10 Voluntary Health Services Plans Act  
5 ILCS 375/6.11 State Employees Act  
55 ILCS 5/5-1069(d-15) Counties Code  
65 ILCS 5/10-4-2(d-15) Illinois Municipal Code  
105 ILCS 5/10-22.3f – Schools Code

**Post mastectomy hospital stay** – All group and individual health insurance and HMO policies must allow the attending physician to determine the length of hospital stay following a **mastectomy**, the removal of a breast. The insurance company or HMO must provide coverage as long as the attending physician determines the length of stay to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and an evaluation of the patient.

215 ILCS 5/356t Insurance Code  
215 ILCS 125/4-6.5) HMO Act  
215 ILCS 165/10 Voluntary Health Services Plan Act  
5 ILCS 375/6.11 State Employees Act  
55 ILCS 5/5-1069.3 Counties Code  
65 ILCS 5/10-4-2.3 Municipalities Act  
105 ILCS 5/10-22.3f Schools Code

**Breast Implants** - 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 after a mastectomy due to sickness or injury are not considered purely cosmetic.

*215 ILCS 5/356p Insurance Code*

*215 ILCS 125/4-6.2 HMO Act*

## **Breast Cancer Pain Medication and Therapy**

Beginning March 27, 2009, Public Act 95-1045 requires that 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.
- **NOTE:** For policies issued prior to March 27, 2009, this coverage requirement will apply to your policy as soon as your policy is amended or renewed – check with your insurance agent, employer, or insurance company for the date this requirement will become effective for your policy.

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*215 ILCS 5/356g.5-1 Insurance Code*

*215 ILCS 125/5-3HMO Act*

*215 ILCS 165/10 Voluntary Health Services Plans Act*

*5 ILCS 375/6.11 State Employees Act*

*55 ILCS 5/5-1069.3 Counties Code*

*65 ILCS 5/10-4-2.3 Municipality Code*

## **Domestic Abuse**

After January 1, 1998, no life, health or disability income insurance company may deny, refuse to issue or reissue, cancel, or restrict coverage **solely** because the individual:

- is the subject of abuse;
- has sought treatment for abuse; or
- has sought protection or shelter from abuse.

The insurance company may not charge higher premiums, deny a claim, or ask for information relating to the abuse. If the company obtains information regarding the abuse, the fact that the condition or treatment is abuse-related must be kept confidential.

An insurance company may restrict coverage or charge higher premiums for coverage based on an individual's physical or mental condition, no matter what the cause. For example, a company may decline to cover an individual who has a permanent disability as a result of abuse. In this case, the denial of coverage would be due to the permanent disability condition itself, not because the condition is abuse-related. (215 ILCS 5/155.22a)

## Genetic Testing

Effective June 23, 1997, a health insurer or HMO may not seek or use genetic testing information to deny health coverage. The company or HMO may only use genetic test information if it is provided voluntarily and if the test results are favorable. The company or HMO may not give the information to another party without permission.

*215 ILCS 5/356v Insurance Code*

*215 ILCS 125/5-3 HMO Act*

*215 ILCS 130/4003 Limited Health Services Act*

*215 ILCS 165/10 Voluntary Health Services Plans Act*

*410 ILCS 513/20 Genetic Information Privacy Act*

These restrictions on genetic testing information do **not** apply to life insurance policies.

## HPV Vaccine

Effective August 24, 2007, all individual and group health and HMO policies must provide coverage for the human papillomavirus vaccine. The law does not specify a benefit level.

*215 ILCS 5/356z.9 Insurance Code*

*215 ILCS 125/5-3 HMO Act*

*215 ILCS 165/10 Voluntary Health Services Plans Act*

*5 ILCS 375/6.11 State Employees Act*

*55 ILCS 5/51069.3 Counties Code*

*65 ILCS 5/10-4-2.3 Municipality Code*

*105 ILCS 5/10-22.3f Schools Code*

## Infertility

Group health insurance and HMO policies that cover more than 25 full-time employees, must provide coverage for the diagnosis and treatment of infertility. For more specific information regarding this mandate, please see the fact sheet entitled, [Insurance Coverage for Infertility Treatment](#).

*215 ILCS 5/356m Insurance Code*

*215 ILCS 125/5-3 HMO Act*

*5 ILCS 375/6.11 State Employees Act*

## Maternity

**Maternity Coverage** - HMOs must cover maternity care, including prenatal and post-natal care and care for complications of pregnancy and care with respect to a newborn. (50 IAC 5421.130e)

Other health insurance policies, including PPO policies, must provide coverage for complications of pregnancy. [50 IAC 2603.30(11)]

Federal law (Pregnancy Discrimination Act of 1978, which amended Title VII of the Civil Rights Act) requires employers with 15 or more employees to cover maternity. Note that employers may choose to self-insure this portion of the benefit or they may provide the coverage through the insurance policy.

**Maternity – Prenatal HIV Testing** - All group and individual health and HMO are required to cover prenatal HIV testing ordered by an attending physician, physician assistant or advanced practice registered nurse.

*215 ILCS 5/356z.1 Insurance Code  
215 ILCS 125/4-6.5 HMO Act  
215 ILCS 165/10 Voluntary Health Services Plan Act*

**Maternity – Post Parturition Care** - All group and individual health insurance and HMO policies must cover a minimum of 48 hours inpatient hospital stay following a vaginal delivery and 96 hours following a caesarian section for both mother and newborn. A shorter length of stay may be provided under certain conditions and if a post-discharge office visit or in-home nurse visit is provided and covered.

*215 ILCS 5/356s Insurance Code  
215 ILCS 125/4-6.4 HMO Act  
5 ILCS 375/6.8 State Employees Act  
55 ILCS 5/5-1069.2 Counties Code  
65 ILCS 5/10-4-2.2 Municipal Code  
105 ILCS 5/10-22.3e Schools Code*

## Osteoporosis

Effective January 1, 2005, group and individual health insurance and HMO policies must provide coverage for medically necessary bone mass measurement and for the diagnosis and treatment of osteoporosis. Coverage must be provided on the same terms and conditions that are applied to other medical conditions under the policy.

*215 ILCS 5/356z.6 Insurance Code  
215 ILCS 125/5-3 HMO Act  
215 ILCS 165/10 Voluntary Health Services Plans Act  
5 ILCS 375/6.11 State Employees Act  
55 ILCS 5/5-1069.3 Counties Code  
65 ILCS 5/10-4-2.3 Municipal Code  
105 ILCS 5/10-22.3f Schools Code*

## Ovarian Cancer Screening

Effective January 1, 2006 group health insurance and HMO policies must pay for surveillance tests for ovarian cancer for female insureds who are at risk for ovarian cancer. Under the law, an individual is considered at risk for ovarian cancer if she has:

- a family history with one or more first-degree relatives with ovarian cancer,
- a family history of clusters of women relatives with breast cancer,
- a family history of nonpolyposis colorectal cancer, or
- tested positive for BRCA1 or BRCA2 mutations.

Surveillance tests are annual tests using:

- CA-125 serum tumor marker testing,
- Transvaginal ultrasound,
- Pelvic examination.

*215 ILCS 5/356u Insurance Code*

*215 ILCS 125/4-6.5 HMO Act*

*215 ILCS 165/10 Voluntary Health Services Plans Act*

*5 ILCS 375/6.11 State Employees Act*

*55 ILCS 5/5-1069.3 Counties Code*

*65 ILCS 5/10-4-2.3 Municipal Code*

*105 ILCS 5/10-22.3f Schools Code*

## **PAP Smears**

Group health insurance and HMO policies must pay for an annual cervical smear or **PAP smear test** for female insureds.

*215 ILCS 5/356u Insurance Code*

*215 ILCS 125/4-6.5 HMO Act*

*215 ILCS 165/10 Voluntary Health Services Plans Act*

*5 ILCS 375/6.11 State Employees Act*

*55 ILCS 5/5-1069.3 Counties Code*

*65 ILCS 5/10-4-2.3 Municipal Code*

*105 ILCS 5/10-22.3f Schools Code*

## **Sexual Assault or Abuse**

Insurance companies and HMOs in Illinois must waive all deductibles and copayments for covered members who are victims of **sexual assault or abuse**. Insurers and HMOs must cover examination and testing of the victim to establish that sexual contact did or did not occur, to establish the presence or absence of sexually transmitted disease or infection, and to treat the injuries and trauma sustained by the victim of the offense.

*215 ILCS 5/356e Insurance Code*

*215 ILCS 125/4-4 HMO Act*

## **Woman's Principal Health Care Provider**

HMOs and some Preferred Provider Organizations ("gated" PPOs) require their members to select a Primary Care Physician (PCP) to manage all care. In addition, female enrollees may also designate an obstetrician or gynecologist, or a physician specializing in family practice as their **Woman's Principal Health Care Provider** (WPHCP). The WPHCP can provide services without a referral from the PCP, but the HMO or PPO can require that your primary care physician and your woman's principle health care provider have a referral arrangement with one another.

Both the PCP and WPHCP must be selected from a list of physicians who have contracted with the HMO or PPO to provide health care.

*215 ILCS 5/356r Insurance Code  
215 ILCS 125/5-3.1 HMO Act  
215 ILCS 165/10 Voluntary Health Services Plans Act  
5 ILCS 3756.7 State Employees Act  
55 ILCS 5/5-1069.5 Counties Code  
65 ILCS 5/10-4-2.5 Municipal Code  
105 ILCS 5/10-22.3d Schools Code*

## **For More Information**

Call our Consumer Services Section at (312) 814-2427 or  
our Office of Consumer Health Insurance toll free at (877) 527-9431  
or visit us on our website at <http://www.insurance.illinois.gov/>

### **Related Topics:**

[Maternity Benefits in Illinois](#)

[Insurance Coverage for Infertility Treatment](#)

[Mandated Benefits, Offers, and Coverages for Accident & Health Insurance And HMOs](#)