



# Illinois Department of Insurance

## Facts Sheet

### Breast Conditions

Updated -October 2017

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.

#### Breast Exams

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

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

**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** – 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, prior personal history of breast cancer, positive genetic testing, or other risk factors.
- (4) A comprehensive ultrasound screening and MRI 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.
- (5) A screening MRI when medically necessary, as determined by a physician licensed to practice medicine in all of its branches.

"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.

Coverage shall be provided at no cost to the insured if the insured uses a contracted provider and such coverage shall not be applied to an annual or lifetime maximum benefit.

**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 ACA 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 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 125/4-6.5 – 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** - There is no applicable federal law.

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

**Illinois Law** –All group and individual accident and 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. This does not apply to short-term travel, accident-only, limited, or specified-disease policies, Medicare, or any other coverage under State or federal governmental plans.
  - 215 ILCS 5/356g.5-1 – Insurers
  - 215 ILCS 125/5-3(a) – HMOs
  - 215 ILCS 165/10 – Voluntary Health Services Plans Act

**Federal Law** - There is no applicable federal law.

### **Breast Implant Removal**

**Illinois Law** – 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.

### **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>