Illinois Insurance Facts

Illinois Department of Insurance

Women's Health Care Issues

Revised August 2012

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.**

This fact sheet provides information regarding state and federal required health plan coverage of services specific to women.

The 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 state 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.

Preventive Health Services

The federal Affordable Care Act (ACA), which applies to self insured employer health plans as well as fully insured health plans, requires coverage of preventive health services, many specific to women, without cost-sharing *when received from a network provider*. Coverage for the following services is required for most non-grandfathered group and individual coverage in plan years (or, in the individual market, policy years) beginning on or after September 23, 2010. A "grandfathered" plan is a plan that existed on March 23, 2010.

1. **Anemia** screening on a routine basis for pregnant women
2. **Bacteriuria** urinary tract or other infection screening for pregnant women
3. **BRCA** counseling about genetic testing for women at higher risk
4. **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
5. **Breast Cancer Chemoprevention** counseling for women at higher risk
6. **Cervical Cancer** screening for sexually active women
7. **Chlamydia Infection** screening for younger women and other women at higher risk
8. **Folic Acid** supplements for women who may become pregnant
9. **Gonorrhea** screening for all women at higher risk
10. **Hepatitis B** screening for pregnant women at their first prenatal visit
11. **Osteoporosis** screening for women over age 60 depending on risk factors

12. **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
13. **Tobacco use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
14. **Syphilis** screening for all pregnant women or other women at increased risk

The following services were added recently added for plan years starting on or after August 1, 2012. For example, if a plan or policy renews on January 1st, the new benefit will be provided effective January 1, 2013.

1. **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
2. **Contraception**: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
3. **Domestic and interpersonal violence** screening and counseling for all women
4. **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
5. **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women
6. **Human Papillomavirus (HPV) DNA Test**: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
7. **Sexually Transmitted Infections (STI)** counseling for sexually active women
8. **Well-woman visits** to obtain recommended preventive services for women under 65

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 and 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 cover 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)
Effective 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]

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 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 a mastectomy, the removal of a breast, 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 lymphedemas. The coverage may be subject to annual deductibles and coinsurance provisions as deemed appropriate and consistent with other benefits covered under the policy.

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
Federal Women's Health and Cancer Rights Act of 1998 – applies to self insured employers. Illinois law follows the federal law. Information regarding the federal law may be found at http://www.dol.gov/ebsa/publications/whcra.html.

Post Mastectomy Hospital Stay – All group and individual health insurance and HMO policies must allow the attending physician to determine the length of a **hospital stay following a mastectomy**. 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

Effective 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.

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

Effective January 1, 1998, no life, health or disability income insurance company may deny, refuse to issue or reissue, cancel, or restrict coverage *solely* because an 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 for an individual insurance policy 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 provide 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
Federal Genetic Information Nondiscrimination Act of 2008 prohibits discrimination by group health plans and health insurers based on genetic information. Information regarding the federal law may be found at http://www.dol.gov/ebsa/publications/gina.html.

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 (HPV) 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 policies and HMOs 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 Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at http://www.insurance.illinois.gov/.

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