

# SB2988



## 104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB2988

Introduced 1/27/2026, by Sen. Laura Ellman

### SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.62

Amends the Illinois Insurance Code. In provisions concerning coverage of preventive health services, requires coverage of spinal examinations for scoliosis.

LRB104 17962 BAB 31399 b

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by  
5 changing Section 356z.62 as follows:

6 (215 ILCS 5/356z.62)

7 Sec. 356z.62. Coverage of preventive health services.

8 (a) A policy of group health insurance coverage or  
9 individual health insurance coverage as defined in Section 5  
10 of the Illinois Health Insurance Portability and  
11 Accountability Act shall, at a minimum, provide coverage for  
12 and shall not impose any cost-sharing requirements, including  
13 a copayment, coinsurance, or deductible, for:

14 (1) evidence-based items or services that have in  
15 effect a rating of "A" or "B" in the current  
16 recommendations of the United States Preventive Services  
17 Task Force;

18 (2) immunizations that have in effect a recommendation  
19 from the Advisory Committee on Immunization Practices of  
20 the Centers for Disease Control and Prevention with  
21 respect to the individual involved;

22 (3) with respect to infants, children, and  
23 adolescents, evidence-informed preventive care and

1 screenings provided for in the comprehensive guidelines  
2 supported by the Health Resources and Services  
3 Administration;

4 (4) with respect to women, such additional preventive  
5 care and screenings not described in paragraph (1) of this  
6 subsection (a) as provided for in comprehensive guidelines  
7 supported by the Health Resources and Services  
8 Administration for purposes of this paragraph; ~~and~~

9 (5) immunizations and medical countermeasures that  
10 have in effect a recommendation within the State  
11 Guidelines for Communicable Disease Prevention issued by  
12 the Director of Public Health pursuant to Section 1.2 of  
13 the Communicable Disease Prevention Act, with respect to  
14 the individual involved. For this paragraph, the  
15 prohibition on cost-sharing requirements does not apply if  
16 and to the extent that the coverage would disqualify a  
17 high-deductible health plan from eligibility for a health  
18 savings account pursuant to Section 223 of the Internal  
19 Revenue Code; ~~and~~

20 (6) spinal examinations for scoliosis.

21 (b) For purposes of this Section, and for purposes of any  
22 other provision of State law, recommendations of the United  
23 States Preventive Services Task Force regarding breast cancer  
24 screening, mammography, and prevention issued in or around  
25 November 2009 are not considered to be current.

26 (c) For office visits:

1           (1) if an item or service described in subsection (a)  
2           is billed separately or is tracked as individual encounter  
3           data separately from an office visit, then a policy may  
4           impose cost-sharing requirements with respect to the  
5           office visit;

6           (2) if an item or service described in subsection (a)  
7           is not billed separately or is not tracked as individual  
8           encounter data separately from an office visit and the  
9           primary purpose of the office visit is the delivery of  
10          such an item or service, then a policy may not impose  
11          cost-sharing requirements with respect to the office  
12          visit; and

13          (3) if an item or service described in subsection (a)  
14          is not billed separately or is not tracked as individual  
15          encounter data separately from an office visit and the  
16          primary purpose of the office visit is not the delivery of  
17          such an item or service, then a policy may impose  
18          cost-sharing requirements with respect to the office  
19          visit.

20          (d) A policy must provide coverage pursuant to subsection  
21          (a) for plan or policy years that begin on or after the date  
22          that is one year after the date the recommendation or  
23          guideline is issued. If a recommendation or guideline is in  
24          effect on the first day of the plan or policy year, or if a  
25          recommendation becomes effective for an in-force policy under  
26          the circumstances described in subsection (d-5), the policy

1 shall cover the items and services specified in the  
2 recommendation or guideline through the last day of the plan  
3 or policy year unless either:

4 (1) a recommendation under paragraph (1) of subsection  
5 (a) is downgraded to a "D" rating; or

6 (2) the item or service is subject to a safety recall  
7 or is otherwise determined to pose a significant safety  
8 concern by a federal agency authorized to regulate the  
9 item or service during the plan or policy year.

10 (d-5) Notwithstanding subsection (d), a policy, including  
11 an in-force policy, must provide coverage pursuant to  
12 paragraph (5) of subsection (a) within 15 business days after  
13 the date the State Guidelines for Communicable Disease  
14 Prevention are issued if the Guidelines reinstate any  
15 recommendation or portion thereof under paragraph (2) of  
16 subsection (a) that the Advisory Committee on Immunization  
17 Practices has reduced or withdrawn.

18 (e) Network limitations.

19 (1) Subject to paragraph (3) of this subsection,  
20 nothing in this Section requires coverage for items or  
21 services described in subsection (a) that are delivered by  
22 an out-of-network provider under a health maintenance  
23 organization health care plan, other than a  
24 point-of-service contract, or under a voluntary health  
25 services plan that generally excludes coverage for  
26 out-of-network services except as otherwise required by

1 law.

2 (2) Subject to paragraph (3) of this subsection,  
3 nothing in this Section precludes a policy with a  
4 preferred provider program under Article XX-1/2 of this  
5 Code, a health maintenance organization point-of-service  
6 contract, or a similarly designed voluntary health  
7 services plan from imposing cost-sharing requirements for  
8 items or services described in subsection (a) that are  
9 delivered by an out-of-network provider.

10 (3) If a policy does not have in its network a provider  
11 who can provide an item or service described in subsection  
12 (a), then the policy must cover the item or service when  
13 performed by an out-of-network provider and it may not  
14 impose cost-sharing with respect to the item or service.

15 (f) Nothing in this Section prevents a company from using  
16 reasonable medical management techniques to determine the  
17 frequency, method, treatment, or setting for an item or  
18 service described in subsection (a) to the extent not  
19 specified in the recommendation or guideline.

20 (g) Nothing in this Section shall be construed to prohibit  
21 a policy from providing coverage for items or services in  
22 addition to those required under subsection (a) or from  
23 denying coverage for items or services that are not required  
24 under subsection (a). Unless prohibited by other law, a policy  
25 may impose cost-sharing requirements for a treatment not  
26 described in subsection (a) even if the treatment results from

1 an item or service described in subsection (a). Nothing in  
2 this Section shall be construed to limit coverage requirements  
3 provided under other law.

4 (h) The Director may develop guidelines to permit a  
5 company to utilize value-based insurance designs. In the  
6 absence of guidelines developed by the Director, any such  
7 guidelines developed by the Secretary of the U.S. Department  
8 of Health and Human Services that are in force under 42 U.S.C.  
9 300gg-13 shall apply.

10 (i) For student health insurance coverage as defined at 45  
11 CFR 147.145, student administrative health fees are not  
12 considered cost-sharing requirements with respect to  
13 preventive services specified under subsection (a). As used in  
14 this subsection, "student administrative health fee" means a  
15 fee charged by an institution of higher education on a  
16 periodic basis to its students to offset the cost of providing  
17 health care through health clinics regardless of whether the  
18 students utilize the health clinics or enroll in student  
19 health insurance coverage.

20 (j) For any recommendation or guideline specifically  
21 referring to women or men, a company shall not deny or limit  
22 the coverage required or a claim made under subsection (a)  
23 based solely on the individual's recorded sex or actual or  
24 perceived gender identity, or for the reason that the  
25 individual is gender nonconforming, intersex, transgender, or  
26 has undergone, or is in the process of undergoing, gender

1 transition, if, notwithstanding the sex or gender assigned at  
2 birth, the covered individual meets the conditions for the  
3 recommendation or guideline at the time the item or service is  
4 furnished.

5 (k) This Section does not apply to grandfathered health  
6 plans, excepted benefits, or short-term, limited-duration  
7 health insurance coverage.

8 (Source: P.A. 103-551, eff. 8-11-23; 104-439, eff. 12-2-25.)