AN ACT concerning pharmaceutical benefits.

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 adding Section 356z.4 as follows:

(215 ILCS 5/356z.4 new)

Sec. 356z.4. Immunosuppresive agents. A group or individual policy of accident and health insurance amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 93rd General Assembly that provides coverage for organ transplants must provide coverage for immunosuppresive agents (anti-rejection medications). If the policy provides coverage for prescription drugs through the use of a drug formulary, the generic immunosuppresive agents must be included with the drug formulary. If the immunosuppresive agent is non-generic it must be included in the drug formulary as the least expensive co-payment level higher than the co-payment required for generic drugs.

Section 10. The Comprehensive Health Insurance Plan Act is amended by changing Section 8 as follows:

(215 ILCS 105/8) (from Ch. 73, par. 1308)

Sec. 8. Minimum benefits.

a. Availability. The Plan shall offer in an annually renewable policy major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the Plan shall pay an eligible person's covered expenses, subject to limit on the deductible and coinsurance payments authorized under paragraph (4) of subsection d of this Section, up to a lifetime benefit limit of $1,000,000 per covered individual.

The maximum limit under this subsection shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board. Any person who otherwise would qualify for coverage under the Plan, but is excluded because he or she is eligible for Medicare, shall be eligible for any separate Medicare supplement policy or policies which the Board may offer.

b. Outline of benefits. Covered expenses shall be limited to the usual and customary charge, including negotiated fees, in the locality for the following services and articles when prescribed by a physician and determined by the Plan to be medically necessary for the following areas of services, subject to such separate deductibles, co-payments, exclusions, and other limitations on benefits as the Board shall establish and approve, and the other provisions of this Section:

(1) Hospital services, except that any services provided by a hospital that is located more than 75 miles outside the State of Illinois shall be covered only for a maximum of 45 days in any calendar year. With respect to covered expenses incurred during any calendar year ending on or after December 31, 1999, inpatient hospitalization of an eligible person for the treatment of mental illness at a hospital located within the State of Illinois shall be subject to the same terms and conditions as for any other illness.

(2) Professional services for the diagnosis or treatment of injuries, illnesses or conditions, other than dental and mental and nervous disorders as described in paragraph (17), which are rendered by a physician, or by other licensed professionals at the physician's direction. This includes reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to produce a

symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

(2.5) Professional services provided by a physician to children under the age of 16 years for physical examinations and age appropriate immunizations ordered by a physician licensed to practice medicine in all its branches.

(3) (Blank).

(4) Outpatient prescription drugs that by law require a prescription written by a physician licensed to practice medicine in all its branches subject to such separate deductible, copayment, and other limitations or restrictions as the Board shall approve, including the use of a prescription drug card or any other program, or both.

(5) Skilled nursing services of a licensed skilled nursing facility for not more than 120 days during a policy year.

(6) Services of a home health agency in accord with a home health care plan, up to a maximum of 270 visits per year.

(7) Services of a licensed hospice for not more than 180 days during a policy year.

(8) Use of radium or other radioactive materials.

(9) Oxygen.

(10) Anesthetics.

(11) Orthoses and prostheses other than dental.

(12) Rental or purchase in accordance with Board policies or procedures of durable medical equipment, other than eyeglasses or hearing aids, for which there is no personal use in the absence of the condition for which it is prescribed.

(13) Diagnostic x-rays and laboratory tests.

(14) Oral surgery (i) for excision of partially or completely unerupted impacted teeth when not performed in connection with the routine extraction or repair of teeth; (ii) for excision of tumors or cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth; (iii) required for correction of cleft lip and palate and other craniofacial and maxillofacial birth defects; or (iv) for treatment of injuries to natural teeth or a fractured jaw due to an accident.

(15) Physical, speech, and functional occupational therapy as medically necessary and provided by appropriate licensed professionals.

(16) Emergency and other medically necessary transportation provided by a licensed ambulance service to the nearest health care facility qualified to treat a covered illness, injury, or condition, subject to the provisions of the Emergency Medical Systems (EMS) Act.

(17) Outpatient services for diagnosis and treatment of mental and nervous disorders provided that a covered person shall be required to make a copayment not to exceed 50% and that the Plan's payment shall not exceed such amounts as are established by the Board.

(18) Human organ or tissue transplants specified by the Board that are performed at a hospital designated by the Board as a participating transplant center for that specific organ or tissue transplant, including immunosuppresive agents as required under Section 356z.4 of the Illinois Insurance Code.

(19) Naprapathic services, as appropriate, provided by a licensed naprapathic practitioner.

c. Exclusions. Covered expenses of the Plan shall not include the following:

(1) Any charge for treatment for cosmetic purposes other than for reconstructive surgery when the service is

incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or surgery for the repair or treatment of a congenital bodily defect to restore normal bodily functions.

(2) Any charge for care that is primarily for rest, custodial, educational, or domiciliary purposes.

(3) Any charge for services in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

(4) That part of any charge for room and board or for services rendered or articles prescribed by a physician, dentist, or other health care personnel that exceeds the reasonable and customary charge in the locality or for any services or supplies not medically necessary for the diagnosed injury or illness.

(5) Any charge for services or articles the provision of which is not within the scope of licensure of the institution or individual providing the services or articles.

(6) Any expense incurred prior to the effective date of coverage by the Plan for the person on whose behalf the expense is incurred.

(7) Dental care, dental surgery, dental treatment, any other dental procedure involving the teeth or periodontium, or any dental appliances, including crowns, bridges, implants, or partial or complete dentures, except as specifically provided in paragraph (14) of subsection b of this Section.

(8) Eyeglasses, contact lenses, hearing aids or their fitting.

(9) Illness or injury due to acts of war.

(10) Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to

a covered person each policy year.

(11) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(12) Routine maternity charges for a pregnancy, except where added as optional coverage with payment of an additional premium for pregnancy resulting from conception occurring after the effective date of the optional coverage.

(13) (Blank).

(14) Any expense or charge for services, drugs, or supplies that are: (i) not provided in accord with generally accepted standards of current medical practice; (ii) for procedures, treatments, equipment, transplants, or implants, any of which are investigational, experimental, or for research purposes; (iii) investigative and not proven safe and effective; or (iv) for, or resulting from, a gender transformation operation.

(15) Any expense or charge for routine physical examinations or tests except as provided in item (2.5) of subsection b of this Section.

(16) Any expense for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of the patient to pay.

(17) Any expense incurred for benefits provided under the laws of the United States and this State, including Medicare, Medicaid, and other medical assistance, maternal and child health services and any other program that is administered or funded by the Department of Human Services, Department of Public Aid, or Department of Public Health, military service-connected disability payments, medical services provided for members of the armed forces and their

dependents or employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States.

(18) Any expense or charge for in vitro fertilization, artificial insemination, or any other artificial means used to cause pregnancy.

(19) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures.

(20) Any expense or charge for sterilization or sterilization reversals.

(21) Any expense or charge for weight loss programs, exercise equipment, or treatment of obesity, except when certified by a physician as morbid obesity (at least 2 times normal body weight).

(22) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery.

(23) Any expense or charge for or related to organ or tissue transplants other than those performed at a hospital with a Board approved organ transplant program that has been designated by the Board as a preferred or exclusive provider organization for that specific organ or tissue transplant.

(24) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical speciality college for general use within the medical community.

d. Deductibles and coinsurance.

The Plan coverage defined in Section 6 shall provide for a choice of deductibles per individual as authorized by the

Board. If 2 individual members of the same family household, who are both covered persons under the Plan, satisfy the same applicable deductibles, no other member of that family who is also a covered person under the Plan shall be required to meet any deductibles for the balance of that calendar year. The deductibles must be applied first to the authorized amount of covered expenses incurred by the covered person. A mandatory coinsurance requirement shall be imposed at the rate authorized by the Board in excess of the mandatory deductible, the coinsurance in the aggregate not to exceed such amounts as are authorized by the Board per annum. At its discretion the Board may, however, offer catastrophic coverages or other policies that provide for larger deductibles with or without coinsurance requirements. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

e. Scope of coverage.

(1) In approving any of the benefit plans to be offered by the Plan, the Board shall establish such benefit levels, deductibles, coinsurance factors, exclusions, and limitations as it may deem appropriate and that it believes to be generally reflective of and commensurate with health insurance coverage that is provided in the individual market in this State.

(2) The benefit plans approved by the Board may also provide for and employ various cost containment measures and other requirements including, but not limited to, preadmission certification, prior approval, second surgical opinions, concurrent utilization review programs, individual case management, preferred provider organizations, health maintenance organizations, and other cost effective arrangements for paying for covered expenses.

f. Preexisting conditions.

(1) Except for federally eligible individuals qualifying for Plan coverage under Section 15 of this Act or eligible persons who qualify for the waiver authorized in paragraph (3) of this subsection, plan coverage shall exclude charges or expenses incurred during the first 6 months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received during the 6 month period immediately preceding the effective date of coverage.

(2) (Blank).

(3) Waiver: The preexisting condition exclusions as set forth in paragraph (1) of this subsection shall be waived to the extent to which the eligible person (a) has satisfied similar exclusions under any prior individual health insurance policy that was involuntarily terminated because of the insolvency of the issuer of the policy and (b) has applied for Plan coverage within 90 days following the involuntary termination of that individual health insurance coverage.

g. Other sources primary; nonduplication of benefits.

(1) The Plan shall be the last payor of benefits whenever any other benefit or source of third party payment is available. Subject to the provisions of subsection e of Section 7, benefits otherwise payable under Plan coverage shall be reduced by all amounts paid or payable by Medicare or any other government program or through any health insurance coverage or group health plan, whether by insurance, reimbursement, or otherwise, or through any third party liability, settlement, judgment, or award, regardless of the date of the settlement, judgment, or award, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and

whether the settlement, judgment, or award is payable to the covered person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, and by all hospital or medical expense benefits paid or payable under any worker's compensation coverage, automobile medical payment, or liability insurance, whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any State or federal law or program.

(2) The Plan shall have a cause of action against any covered person or any other person or entity for the recovery of any amount paid to the extent the amount was for treatment, services, or supplies not covered in this Section or in excess of benefits as set forth in this Section.

(3) Whenever benefits are due from the Plan because of sickness or an injury to a covered person resulting from a third party's wrongful act or negligence and the covered person has recovered or may recover damages from a third party or its insurer, the Plan shall have the right to reduce benefits or to refuse to pay benefits that otherwise may be payable by the amount of damages that the covered person has recovered or may recover regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury.

During the pendency of any action or claim that is brought by or on behalf of a covered person against a third party or its insurer, any benefits that would otherwise be payable except for the provisions of this paragraph (3) shall be paid if payment by or for the third party has not yet been made and the covered person or, if incapable, that person's legal representative

agrees in writing to pay back promptly the benefits paid as a result of the sickness or injury to the extent of any future payments made by or for the third party for the sickness or injury. This agreement is to apply whether or not liability for the payments is established or admitted by the third party or whether those payments are itemized.

Any amounts due the plan to repay benefits may be deducted from other benefits payable by the Plan after payments by or for the third party are made.

(4) Benefits due from the Plan may be reduced or refused as an offset against any amount otherwise recoverable under this Section.

h. Right of subrogation; recoveries.

(1) Whenever the Plan has paid benefits because of sickness or an injury to any covered person resulting from a third party's wrongful act or negligence, or for which an insurer is liable in accordance with the provisions of any policy of insurance, and the covered person has recovered or may recover damages from a third party that is liable for the damages, the Plan shall have the right to recover the benefits it paid from any amounts that the covered person has received or may receive regardless of the date of the sickness or injury or the date of any settlement, judgment, or award resulting from that sickness or injury. The Plan shall be subrogated to any right of recovery the covered person may have under the terms of any private or public health care coverage or liability coverage, including coverage under the Workers' Compensation Act or the Workers' Occupational Diseases Act, without the necessity of assignment of claim or other authorization to secure the right of recovery. To enforce its subrogation right, the Plan may (i) intervene or join in an action or proceeding

brought by the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, against any third party or the third party's insurer that may be liable or (ii) institute and prosecute legal proceedings against any third party or the third party's insurer that may be liable for the sickness or injury in an appropriate court either in the name of the Plan or in the name of the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors.

(2) If any action or claim is brought by or on behalf of a covered person against a third party or the third party's insurer, the covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, shall notify the Plan by personal service or registered mail of the action or claim and of the name of the court in which the action or claim is brought, filing proof thereof in the action or claim. The Plan may, at any time thereafter, join in the action or claim upon its motion so that all orders of court after hearing and judgment shall be made for its protection. No release or settlement of a claim for damages and no satisfaction of judgment in the action shall be valid without the written consent of the Plan to the extent of its interest in the settlement or judgment and of the covered person or his personal representative.

(3) In the event that the covered person or his personal representative fails to institute a proceeding against any appropriate third party before the fifth month before the action would be barred, the Plan may, in its own name or in the name of the covered person or personal representative, commence a proceeding against any appropriate third party for the recovery of damages

on account of any sickness, injury, or death to the covered person. The covered person shall cooperate in doing what is reasonably necessary to assist the Plan in any recovery and shall not take any action that would prejudice the Plan's right to recovery. The Plan shall pay to the covered person or his personal representative all sums collected from any third party by judgment or otherwise in excess of amounts paid in benefits under the Plan and amounts paid or to be paid as costs, attorneys fees, and reasonable expenses incurred by the Plan in making the collection or enforcing the judgment.

(4) In the event that a covered person or his personal representative, including his guardian, conservator, estate, dependents, or survivors, recovers damages from a third party for sickness or injury caused to the covered person, the covered person or the personal representative shall pay to the Plan from the damages recovered the amount of benefits paid or to be paid on behalf of the covered person.

(5) When the action or claim is brought by the covered person alone and the covered person incurs a personal liability to pay attorney's fees and costs of litigation, the Plan's claim for reimbursement of the benefits provided to the covered person shall be the full amount of benefits paid to or on behalf of the covered person under this Act less a pro rata share that represents the Plan's reasonable share of attorney's fees paid by the covered person and that portion of the cost of litigation expenses determined by multiplying by the ratio of the full amount of the expenditures to the full amount of the judgement, award, or settlement.

(6) In the event of judgment or award in a suit or claim against a third party or insurer, the court shall first order paid from any judgement or award the

reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees. After payment of those expenses and attorney's fees, the court shall apply out of the balance of the judgment or award an amount sufficient to reimburse the Plan the full amount of benefits paid on behalf of the covered person under this Act, provided the court may reduce and apportion the Plan's portion of the judgement proportionate to the recovery of the covered person. The burden of producing evidence sufficient to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking the reduction. The court may consider the nature and extent of the injury, economic and non-economic loss, settlement offers, comparative negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The Plan shall pay its pro rata share of the attorney fees based on the Plan's recovery as it compares to the total judgment. Any reimbursement rights of the Plan shall take priority over all other liens and charges existing under the laws of this State with the exception of any attorney liens filed under the Attorneys Lien Act.

(7) The Plan may compromise or settle and release any claim for benefits provided under this Act or waive any claims for benefits, in whole or in part, for the convenience of the Plan or if the Plan determines that collection would result in undue hardship upon the covered person.

(Source: P.A. 91-639, eff. 8-20-99; 91-735, eff. 6-2-00; 92-2, eff. 5-1-01; 92-630, eff. 7-11-02.)

Section 15. The Health Maintenance Organization Act is

amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 367i, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance

Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest

in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this

subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 91-357, eff. 7-29-99; 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00; 92-764, eff. 1-1-03.)

Section 20. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356r, 356t, 356u,

356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00; 92-130, eff. 7-20-01; 92-440, eff. 8-17-01; 92-651, eff. 7-11-02; 92-764, eff. 1-1-03.)

Section 25. The Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act is amended by changing Section 3.15 as follows:

(320 ILCS 25/3.15) (from Ch. 67 1/2, par. 403.15)

Sec. 3.15. "Covered prescription drug" means (1) any cardiovascular agent or drug; (2) any insulin or other prescription drug used in the treatment of diabetes, including syringe and needles used to administer the insulin; (3) any prescription drug used in the treatment of arthritis, (4) beginning on January 1, 2001, any prescription drug used in the treatment of cancer, (5) beginning on January 1, 2001, any prescription drug used in the treatment of Alzheimer's disease, (6) beginning on January 1, 2001, any prescription drug used in the treatment of Parkinson's disease, (7) beginning on January 1, 2001, any prescription drug used in the treatment of glaucoma, (8) beginning on January 1, 2001, any prescription drug used in the treatment of lung disease and smoking related illnesses, ~~and~~ (9) beginning on July 1, 2001, any prescription drug used in the treatment of osteoporosis, and (10) beginning January 1, 2004, immunosuppresive agents (anti-rejection medication) used in connection with organ transplants. The specific agents or products to be included under such categories shall be listed in a handbook to be prepared and distributed by the

Department. The general types of covered prescription drugs shall be indicated by rule.

(Source: P.A. 91-699, eff. 1-1-01; 92-10, eff. 6-11-01; 92-790, eff. 8-6-02.)