GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1991

H **2**

HOUSE BILL 279
Committee Substitute Favorable 6/12/91

Short Title: Health Benefits. (Public)

Sponsors:

Referred to:

March 21, 1991

A BILL TO BE ENTITLED

AN ACT TO MAKE BENEFIT, ELIGIBILITY, CLARIFYING, AND OTHER TECHNICAL CHANGES IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. (a) Effective October 1, 1991, G.S. 135-40.1(3) reads as rewritten:

"(3) Dependent Child. – A natural, legally adopted, or foster child of the employee and/or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support. Dependent child shall also include any child under age 19 who has reached his or her 18th birthday, provided the employee was legally responsible for such child's maintenance and support on his or her 18th birthday.

A foster child is covered (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (iii) if the Claims Processor accepts the foster child as a participant through a separate written document identifying the foster child by name and

specifically recognizing the foster child relationship, and (iv) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of, the child(ren), are not eligible participants.

Coverage may be extended beyond the 19th birthday under the following conditions:

a. If the dependent is a full-time student, between the ages of 19 and 26, who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction.

b. The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living and (i) such handicap developed or began to develop before the dependent's 19th birthday, ~~and (ii) the dependent was covered by the Plan and/or the Predecessor Plan when such handicap began and there has been no lapse in coverage since that time or, the dependent was not covered by the Predecessor Plan at the time the handicap began, but was subsequently covered by the Predecessor Plan and there has been no lapse in coverage since that time.~~ or (ii) such handicap developed or began to develop before the dependent's 26th birthday if the dependent was covered by the Plan in accordance with G.S. 135-40.1(3)a."

(b) Dependents excluded from coverage under the Teachers' and State Employees' Comprehensive Major Medical Plan because of G.S. 135-40.1(3)b. before its amendment by this act may be enrolled in the Plan in accordance with the provisions of G.S. 135-40.1(7) upon the effective date of this act.

Sec. 2. G.S. 135-39.4A(f) reads as rewritten:

"(f) The Executive Administrator may employ such clerical and professional staff, and such other assistance as may be necessary to assist the Executive Administrator and the Board of Trustees in carrying out their duties and responsibilities under this Article. The Executive Administrator may also negotiate, renegotiate and execute contracts with third parties in the performance of his duties and responsibilities under this Article; provided any contract negotiations, renegotiations and execution with a Claims Processor or with an optional prepaid hospital and medical benefit plan or with a preferred provider of institutional or professional hospital and medical care shall be done only after consultation with the Committee on Employee Hospital and Medical Benefits."

Sec. 3. G.S. 135-39.5 reads as rewritten:

"**§ 135-39.5. Powers and duties of the Executive Administrator and Board of Trustees.**

The Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan shall have the following powers and duties:

(1) Supervising and monitoring of the Claims Processor.
(2) Providing for enrollment of employees in the Plan.
(3) Communicating with employees enrolled under the Plan.
(4) Communicating with health care providers providing services under the Plan.
(5) Making payments at appropriate intervals to the Claims Processor for benefit costs and administrative costs.
(6) Conducting administrative reviews under G.S. 135-39.7.
(7) Annually assessing the performance of the Claims Processor.
(8) Preparing and submitting to the Governor and the General Assembly cost estimates for the health benefits plan, including those required by Article 15 of Chapter 120 of the General Statutes.
(9) Recommending to the Governor and the General Assembly changes or additions to the health benefits program and health care cost containment programs, together with statements of financial and actuarial effects as required by Article 15 of Chapter 120 of the General Statutes.
(10) Working with State employee groups to improve health benefit programs.
(11) Repealed by Session Laws 1985, c. 732, s. 9.
(12) Determining basis of payments to health care providers, including payments in accordance with G.S. 58-260.6.
(13) Requiring bonding of the Claims Processor in the handling of State funds.
(14) Repealed by Session Laws 1985, c. 732, s. 7.
(15) In case of termination of the contract under G.S. 135-39.5A, to select a new Claims Processor, after competitive bidding procedures approved by the Department of Administration.
(16) Notwithstanding the provisions of Part 3 of this Article, to formulate and implement cost-containment measures which are not in direct conflict with that Part.
(17) Implementing pilot programs necessary to evaluate proposed cost containment measures which are not in direct conflict with Part 3 of this Article, and expending funds necessary for the implementation of such programs.
(18) Authorizing coverage for alternative forms of care not otherwise provided by the Plan in individual cases when medically necessary, medically equivalent to services covered by the Plan, and when such alternatives would be less costly than would have been otherwise.
(19) Establishing and operating a hospital <u>and other provider</u> bill audit program and a fraud detection program.
<u>(20) Determining administrative and medical policies that are not in direct conflict with Part 3 of this Article upon the advice of the Claims</u>

Processor and upon the advice of the Plan's consulting actuary when Plan costs are involved.

(21) Supervising the payment of claims and all other disbursements under this Article, including the recovery of any disbursements that are not made in accordance with the provisions of this Article."

Sec. 4. G.S. 135-39.5B reads as rewritten:

"**§ 135-39.5B. Prepaid plans.**

The Executive Administrator and Board of Trustees may, after consultation with the Committee on Employee Hospital and Medical Benefits, provide for optional prepaid hospital and medical benefits plans. Benefits offered under such optional plans shall be comparable to those offered under the Plan. The amounts of State funds contributed for such optional plans shall not be more than the amounts contributed for each person eligible under G.S. 135-40.2 on a noncontributory Employee Only basis, with the person selecting an optional plan paying any excess, if necessary. The amount of State funds contributed to such optional plans shall also not exceed the amount of an optional plan's cost for Employee Only coverage. ~~The provisions of G.S. 57B-11 shall not apply to any optional prepaid hospital and medical benefits plans provided for by the Executive Administrator and Board of Trustees.~~ The Executive Administrator and Board of Trustees are authorized to assess and collect fees from participating optional plans provided by this section for administrative purposes and for risk management purposes. Such fees may be based upon the enrollees' risk factors and the number and types of contracts enrolled by each participating optional plan, and may be collected by the Plan in a manner prescribed by the Executive Administrator and Board of Trustees. In no instance shall benefits be paid under Part 3 of this Article for persons enrolled in an optional prepaid hospital and medical benefit plan authorized under this section on and after the effective date of enrollment in the optional prepaid plan, except in cases of continuous hospital confinement approved by the Executive Administrator."

Sec. 5. G.S. 135-39.6A reads as rewritten:

"**§ 135-39.6A. Premiums set.**

The Executive Administrator and Board of Trustees shall, from time to time, establish premium rates for the Comprehensive Major Medical Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish regulations for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits."

Sec. 6. G.S. 135-39.7 reads as rewritten:

"**§ 135-39.7. Administrative review.**

If, after exhaustion of internal appeal handling as outlined in the contract with the Claims Processor any person is aggrieved, the Claims Processor shall bring the matter to the attention of the Executive Administrator and Board of Trustees, which may make a binding decision on the matter in accordance with procedures established by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written summary of the decisions made pursuant to

this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a decision, and to any other parties requesting a written summary and approved by the Executive Administrator and Board of Trustees to receive a summary immediately following the issuance of a decision."

Sec. 7. G.S. 135-39.8 reads as rewritten:

"**§ 135-39.8. Rules and regulations.**

The Executive Administrator and Board of Trustees may issue rules and regulations to implement Parts 2 and 3 of this Article. Rules and regulations of the Board of Trustees shall remain in effect until amended or repealed by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees shall provide a written description of the rules and regulations issued under this section to all employing units, all health benefit representatives, the oversight team provided for in G.S. 135-39.3, all relevant health care providers affected by a rule or regulation, and to any other parties requesting a written description and approved by the Executive Administrator and Board of Trustees to receive a description on a timely basis."

Sec. 8. G.S. 135-39.10 reads as rewritten:

"**§ 135-39.10. Meaning of 'Executive Administrator and Board of Trustees'.**

Whenever in this Article the words 'Executive Administrator and Board of Trustees' appear, they mean that the Executive Administrator shall have the power, duty, right, responsibility, privilege or other function mentioned, after consulting with the Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical ~~Plan, or its Executive Committee.~~ Plan."

Sec. 9. G.S. 135-40.1 is amended by adding a new subdivision to read:

"(7.1) Experimental/Investigational Medical Procedures. – The use of any treatment, procedure, facility, equipment, drug, device, or supply not recognized as having scientifically established medical value nor accepted as standard medical treatment for the condition being treated as determined by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor, nor any such items requiring federal or other governmental agency approval not granted at the time services were rendered. The Executive Administrator and Board of Trustees may overturn the advice of the Claims Processor upon convincing evidence from the American Medical Association, North Carolina Medical Society, the United States Health Care Financing Administration, medical technological journals, and other major United States insurers of health care expenses on a consensus of medical value and accepted standard medical treatment."

Sec. 10. Effective October 1, 1982, G.S. 135-40.3(b) is amended by adding a new subdivision to read:

"(3) Retiring employees and dependents enrolled when first eligible after an employee's retirement are subject to no waiting period for preexisting conditions under the Plan. Retiring employees not enrolled

or not adding dependents when first eligible after an employee's retirement may enroll later on the first of any following month, but will be subject to a 12-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section."

Sec. 11. G.S. 135-40.3(b) is amended by adding a new subdivision to read:

"(4) Employees and dependents reenrolled within 12 months after a termination of enrollment, regardless of the employing units involved, shall not be considered as newly-eligible employees or dependents for the purposes of waiting periods and preexisting conditions. Employees and dependents transferring from optional prepaid plans in accordance with G.S. 135-39.5B; employees and dependents immediately returning to service from an employing unit's approved periods of leave without pay for illness, injury, educational improvement, workers' compensation, parental duties, or for military reasons; employees and dependents immediately returning to service from a reduction in an employing unit's work force; retiring employees and dependents reenrolled in accordance with G.S. 135-40.3(b)(3); formerly-enrolled dependents reenrolling as eligible employees; formerly-enrolled employees reenrolling as eligible dependents; and employees and dependents reenrolled without waiting periods and preexisting conditions under specific rules and regulations adopted by the Executive Administrator and Board of Trustees in the best interests of the Plan shall not be considered reenrollments for the purpose of this subdivision. Furthermore, employees accepting permanent, full-time appointments who had previously worked in a part-time or temporary position and their qualified dependents shall not be covered by waiting periods and preexisting conditions under this division provided enrollment as a permanent, full-time employee is made when the employee and his dependents are first eligible to enroll."

Sec. 12. G.S. 134-40.3 is amended by adding a new subsection to read:

"(e) Notwithstanding any other provision of this section, no coverage under the Plan shall become effective prior to the payment of premiums required by the Plan."

Sec. 13. G.S. 135-40.5(d) reads as rewritten:

"(d) Second Surgical Opinions. – The Plan will pay one hundred percent (100%) of usual, reasonable and customary charges for one presurgical consultation by a second surgeon or other qualified physician as determined by the Claims Processor and Executive Administrator regarding the performance of nonemergency surgery. The Plan will also pay one hundred percent (100%) of the reasonable and customary charges for diagnostic, laboratory and x-ray examinations required by the second surgeon. Second surgical opinions for tonsillectomy and adenoidectomy procedures may be provided by Board-qualified pediatricians and family practitioners when qualified surgeons are not available to provide second surgical opinions. Should the first two opinions differ as to the necessity of surgery, the Plan will pay one hundred percent (100%) of reasonable and customary charges for the consultation of the third surgeon.

As used in this section and the provisions of G.S. 135-40.8(b), second surgical ~~opinions~~ opinions, and third surgical opinions when the first two opinions differ as to the necessity of surgery, shall be required for the following procedures otherwise covered by the ~~Plan:~~ Plan as the primary payer of health benefits: hysterectomy, revision of the nasal structure, coronary artery bypass surgery, and surgery on the knee (except in procedures involving ~~orthoscopic~~ arthroscopic surgery when the diagnosis and the surgery can be performed in the same procedure and through the same incision). Second surgical opinions for coronary by-pass surgery may be provided by doctors who are Board-qualified in internal medicine when qualified surgeons are not available to provide a second surgical opinion. The Claims Processor may waive the requirement for obtaining a second surgical opinion required by this subsection or required by G.S. 135-40.8(b) if the location and availability of surgeons qualified to provide second opinions creates an unjust hardship or if the medical condition of the patient would be adversely affected."

Sec. 14. Effective January 1, 1986, G.S. 135-40.6(2) reads as rewritten:

"(2) Limitations and Exclusions to In-Hospital Benefits. –

a. The services of physicians, surgeons and technicians not employed by or under contract to the hospital are not covered.

b. Any admission for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis, if no hospitalization would have been required except for such diagnostic services is not covered. However, benefits are provided at ninety percent (90%) of Plan benefits for diagnostic tests and procedures consistent with the symptoms or diagnosis for which admitted.

c. The Plan will not cover any admission to a hospital prior to the effective date of coverage or beginning prior to the expiration of any waiting period so long as the individual remains continuously in a hospital.

d. Hospitalization for custodial, domiciliary or sanitarium care, or rest cures, is not covered.

e. Hospitalization for dental care and treatment is not covered, except when a hospital setting is medically necessary.

f. Prior to admission for scheduled inpatient hospitalization, the admitting physician shall contact the Plan and secure approval certification for an inpatient admission, including a length of stay, based upon clinical criteria established by the medical community, before any in-hospital benefits are allowed under G.S. 135-40.8(a). Effective January 1, 1987, failure to secure certification, or denial of certification, shall result in in-hospital benefits being allowed at the rate maximum amount of out-of-pocket expenses established by G.S. 135-40.8(b). Denial of certification by the Plan shall be made only after contact with the admitting physician and shall be subject to appeal to the

Executive Administrator and Board of Trustees. Inpatient hospital admission and length of stay certifications required by this subdivision do not apply to inpatient admissions outside of the United States. While approval certification for inpatient admissions is required to be initiated by the admitting physician, the employee or individual covered by the Plan shall be responsible for insuring that the required certification is secured."

Sec. 15. Effective October 1, 1991, G.S. 135-40.6(2), as amended by Section 14 of this act, reads as rewritten:

"(2) Limitations and Exclusions to In-Hospital Benefits. –

a. The services of physicians, surgeons and technicians not employed by or under contract to the hospital are not covered.

b. Any admission for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis, if no hospitalization would have been required except for such diagnostic services is not covered. However, benefits are provided at ninety percent (90%) of Plan benefits for diagnostic tests and procedures consistent with the symptoms or diagnosis for which admitted.

c. The Plan will not cover any admission to a hospital prior to the effective date of coverage or beginning prior to the expiration of any waiting period so long as the individual remains continuously in a hospital.

d. Hospitalization for custodial, domiciliary or sanitarium care, or rest cures, is not covered.

e. Hospitalization for dental care and treatment is not covered, except when a hospital setting is medically necessary.

f. Prior to admission for scheduled inpatient hospitalization, the admitting physician shall contact the Plan and secure approval certification for an inpatient admission, including a length of stay, based upon clinical criteria established by the medical community, before any in-hospital benefits are allowed under G.S. 135-40.8(a). Immediately following an emergency or unscheduled inpatient hospitalization, the admitting physician shall contact the Plan and secure approval certification for the admission's length of stay before any in-hospital benefits are allowed under G.S. 135-40.8(a). Effective January 1, 1987, failure to secure certification, or denial of certification, shall result in in-hospital benefits being allowed at the rate maximum amount of out-of-pocket expenses established by G.S. 135-40.8(b). Denial of certification by the Plan shall be made only after contact with the admitting physician and shall be subject to appeal to the Executive Administrator and Board of Trustees.

Inpatient hospital admission and length of stay certifications required by this subdivision do not apply to inpatient admissions outside of the United States. While approval certification for inpatient admissions is required to be initiated by the admitting physician, the employee or individual covered by the Plan shall be responsible for insuring that the required certification is secured."

Sec. 16. Effective July 1, 1985, G.S. 135-40.7 is amended by adding a new subdivision to read:

"(16a) Charges in excess of negotiated rates allowed for preferred providers of institutional and professional medical care and services in accordance with the provisions of G.S. 135-40.4, when such preferred providers are reasonably available to provide institutional and professional medical care."

Sec. 17. G.S. 135-40.8(b) reads as rewritten:

"(b) Where a covered individual fails to obtain a second surgical opinion as required under the Plan, or where a covered individual elects to have a surgery performed that conflicts with a majority opinion of the rendered consultations that the surgery requiring a second or third surgical opinion is not necessary, the covered individual shall be responsible for fifty percent (50%) of the eligible expenses, provided, however, that no covered individual shall be required to pay, in addition to the expenses in subsection (a) above out-of-pocket in excess of five hundred dollars ($500.00) per fiscal year."

Sec. 18. G.S. 135-40.1(2) reads as rewritten:

"(2) Deductible. – Deductible shall mean an amount of covered expenses during a fiscal year which must be incurred after which benefits (subject to the deductible) becomes payable. The deductible for an employee, retired employee and/or his or her dependents shall be ~~one~~ two hundred fifty dollars ~~($150.00)~~ ($250.00) for each fiscal year.

The deductible applies separately to each covered individual in each fiscal year, subject to an aggregate maximum of ~~four~~ seven hundred fifty dollars ~~($450.00)~~ ($750.00) per family (employee or retiree and his or her covered dependents) in any fiscal year.

If two or more family members are injured in the same accident only one deductible is required for charges related to that accident during the benefit period."

Sec. 19. G.S. 135-40.4 reads as rewritten:

"**§ 135-40.4. Benefits in general.**

In the event a covered person, as a result of accidental bodily injury, disease or pregnancy, incurs covered expenses, the Plan will pay benefits up to the amounts described in G.S. 135-40.5 through G.S. 135-40.9.

The Plan is divided into two parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive plan and includes those benefits which are subject to both a ~~one~~ two hundred fifty dollar ~~($150.00)~~

($250.00) deductible for each covered individual to an aggregate maximum of ~~four~~ seven hundred fifty dollars ~~($450.00)~~ ($750.00) per family and coinsurance of ~~90%/10%.~~ 80%/20%. There is a limit on out-of-pocket expenses under the second part.

Notwithstanding the provisions of this Article, the Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan may begin the process of negotiating prospective rates of charges that are to be allowed under the Plan with preferred providers of institutional and professional medical care and services. The Executive Administrator and Board of Trustees shall, under the provisions of G.S. 135-39.5(12), pursue such preferred provider contracts on a timely basis and shall make monthly reports to the President of the Senate, the Speaker of the House of Representatives, and the Committee on Employee Hospital and Medical Benefits on its progress in negotiating such prospective rates for allowable charges."

Sec. 20. G.S. 135-40.5(b) is repealed.

Sec. 21. The first paragraph of G.S. 135-40.6 is deleted and the following paragraph is inserted:

"The following benefits are subject to a deductible of two hundred fifty dollars ($250.00) per covered individual to an aggregate maximum of seven hundred fifty dollars ($750.00) per family per fiscal year and are payable on the basis of eighty percent (80%) by the Plan and twenty percent (20%) by the covered individual up to a maximum of one thousand dollars ($1,000) out-of-pocket per fiscal year:".

Sec. 22. G.S. 135-40.6(2) is amended by adding a new subdivision to read:

"g. The Plan does not cover the first fifty dollars ($50.00) of allowable emergency room charges when admission to a hospital pursuant to the emergency room use does not immediately follow."

Sec. 23. G.S. 135-40.6(2)b. reads as rewritten:

"b. Any admission for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis, if no hospitalization would have been required except for such diagnostic services is not covered. However, benefits are provided at ~~ninety~~ eighty percent ~~(90%)~~ (80%) of Plan benefits for diagnostic tests and procedures consistent with the symptoms or diagnosis for which admitted."

Sec. 24. G.S. 135-40.6(4) reads as rewritten:

"(4) Outpatient Benefits. – The Plan pays for services rendered in the outpatient department of a hospital, in a doctor's office, in an ambulatory surgical facility, or elsewhere as determined by the Executive Administrator, as follows:

a. Accidental injury: All covered services. Dental services are excluded except for oral surgery specifically listed in subsection (5)c of this section.

b. Operative procedures.

c. All hospital services for radiation therapy, treatment by use of x-rays, radium, cobalt and other radioactive substances.

d. Pathological examinations of tissue removed by resection or biopsy. Routine Pap smears are not ~~covered.~~ covered by this subdivision.

e. Charges for diagnostic x-rays, clinical laboratory tests, and other diagnostic tests and procedures such as electrocardiograms and electroencephalograms.

No benefits are provided in this subdivision for screening examinations and routine physical examinations to assess general health status in the absence of specific symptoms of active illness, routine office visits or for doctor's services for diagnostic procedures covered under surgical benefits."

Sec. 25. G.S. 135-40.6(7)a. reads as rewritten:

"a. Services of Doctors. – The Plan pays the usual, reasonable and customary charges for covered inpatient medical (nonsurgical) services. Services are covered if the individual is hospital-confined and is eligible for hospitalization benefits as described in this section. Benefits are provided for exactly the same number of days as the individual is entitled to under this section, except that medical benefits are provided on both the day of admission and the day of discharge.

In the event a covered individual is treated by two or more co-attending doctors during the same hospital confinement for a medical (nonsurgical) condition, benefits are limited to payment for services provided by the primary attending doctor, except where need is established for supplementary skills for treatment of separate and distinct diagnoses or conditions.

Home, office, and skilled nursing facility visits including (i) charges for injected medications, (ii) inpatient care by attending medical doctors, radiologists, pathologists,and consultants during such time as hospital benefits are paid under any section of this Plan, (iii) care in the outpatient department of a hospital, and (iv) administration of shock therapy (drug or electric) including the services of anesthesiologists provided on an office or hospital outpatient basis for treatment of acute psychotic reaction or severe depression. The Plan does not cover the first ten dollars ($10.00) of allowable charges for each home, office, or skilled nursing facility visit."

Sec. 26. G.S. 135-40.6(7)d. reads as rewritten:

"d. Outpatient Psychiatric Care. – The Plan will pay eighty percent (80%) UCR for outpatient psychiatric care, not to exceed 50 visits and two thousand two hundred dollars ($2,200) per fiscal year. This benefit is subject to the ~~one~~ two hundred fifty dollars ~~($150.00)~~ ($250.00) deductible. Payments made for this benefit

are not eligible towards the maximum out-of-pocket expenditure."

Sec. 27. G.S. 135-40.6(8) is amended by adding two new subdivisions to read:

"s. Routine Diagnostic Examinations: Allowable charges for routine diagnostic examinations and tests, including Pap smears, breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 55 years, and once a year for covered individuals age 55 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities or to comply with governmental licensing requirements. The maximum amount payable under this subdivision is one hundred fifty dollars ($150.00) per fiscal year.

t. Immunizations for the prevention of contagious diseases as generally accepted medical practices would dictate when directed by an attending physician."

Sec. 28. Effective January 1, 1992, G.S. 135-40.6(8)a. reads as rewritten:

"a. Prescription Drugs: ~~Prescription legend drugs in excess of the first two dollars ($2.00) per prescription for generic drugs and brand name drugs without a generic equivalent and in excess of the first three dollars ($3.00) per prescription for brand name drugs for use outside of a hospital or skilled nursing facility.~~ The Plan's allowable charges for prescription legend drugs to be used outside of a hospital or skilled nursing facility are ninety percent (90%) of the average wholesale price. A dispensing fee for qualified providers shall be determined by the Executive Administrator and Board of Trustees. The Plan will pay allowable charges for each outpatient prescription drug less a copayment to be paid by each covered individual equal to the provider dispensing fee set by the Executive Administrator and Board of Trustees. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and

Cosmetic Act, is required to bear the legend: 'Caution: Federal Law Prohibits Dispensing Without Prescription.' Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though prescription is not required."

Sec. 29. Effective January 1, 1992, G.S. 135-40.6(9)d. is repealed.

Sec. 30. G.S. 135-40.7(12) reads as rewritten:

"(12) Charges incurred for any medical observations or diagnostic study when no disease or injury is revealed, unless proof satisfactory to the Claims Processor is furnished that (i) the claim is in order in all other respects, (ii) the covered individual had a definite symptomatic condition of disease or injury other than hypochondria, and (iii) the medical observation and diagnostic studies concerned were not undertaken as a matter of routine physical examination or health ~~checkup.~~ checkup as provided in G.S. 135-40.6(8)s."

Sec. 31. Effective January 1, 1992, G.S. 135-40.6(1)r., 135-40.6(7)d., and 135-40.6A(a)(2) are repealed.

Sec. 32. Effective January 1, 1992, Article 3 of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-40.7B. Special provisions for mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of mental illness shall be covered under this section: allowable institutional and professional charges for inpatient psychiatric care, outpatient psychotherapy, intensive outpatient crisis management, partial hospitalization treatment, and residential care and treatment. The benefits provided by this section are separate and apart from those provided by G.S. 135-40.7A.

(c) Notwithstanding any other provisions of this Part, the following providers are authorized to provide necessary care and treatment for mental illness under this section: licensed psychiatrists and doctors of psychology licensed or certified in their states of practice, psychiatric nurses or social workers under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology, licensed psychiatric hospitals and licensed general hospitals providing psychiatric treatment programs and certified residential treatment facilities, community mental health centers, and partial hospitalization facilities.

(d) Benefits provided under this section shall be subject to a managed, individualized care component consisting of (i) inpatient utilization review through preadmission and length-of-stay certification for scheduled inpatient admissions and length-of-stay reviews for unscheduled inpatient admissions, and (ii) a network of qualified, available providers of inpatient and outpatient psychiatric treatment psychotherapy. Where qualified preferred providers of inpatient and outpatient care are

reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6."

Sec. 33. G.S. 135-40.8(a) reads as rewritten:

"(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays ~~ninety~~ eighty percent ~~(90%)~~ (80%) of the eligible expenses outlined in G.S. 135-40.6. The covered individual is then responsible for the remaining ~~ten~~ twenty percent ~~(10%)~~ (20%) until ~~three hundred dollars ($300.00),~~ one thousand dollars ($1,000), in excess of the deductible, has been paid out-of-pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses."

Sec. 34. Effective January 1, 1992, G.S. 135-40.8 is amended by adding a new subsection to read:

"(d) Where a network of qualified preferred providers of inpatient and outpatient hospital care is reasonably available for use by those individuals covered by the Plan, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year per covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6."

Sec. 35. G.S. 135-40.9 reads as rewritten:

"**§ 135-40.9. Maximum benefits.**

The maximum lifetime benefit for each covered individual will be ~~five hundred thousand dollars ($500,000).~~ one million dollars ($1,000,000)."

Sec. 36. G.S. 135-40.1(12)d. reads as rewritten:

"d. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, a hotel, or the like. Hospitals classified and accredited as psychiatric hospitals by the Joint Commission on Accreditation of ~~Hospitals~~ Healthcare Organizations will be deemed to be hospitals for the purpose of this Plan."

Sec. 37. G.S. 135-40.6(3) reads as rewritten:

"(3) Skilled Nursing Facility Benefits. – The Plan will pay benefits in a skilled nursing facility which qualifies for delivery of benefits under Title ~~XVII~~ XVIII of the Social Security Act (Medicare), as follows:

After discharge from a hospital for which inpatient hospital benefits were provided by this Plan for a period of not less than three days, and treatment consistent with the same illness or condition for which the covered individual was hospitalized, the daily charges will be paid for room and board in a semiprivate room or any multibed unit up to the maximum benefit specified in subsection (1) of this section, less the days of care already provided for the same illness in a hospital. Plan allowances for total daily charges may be negotiated but will not

exceed the daily semiprivate hospital room rate as determined by the Plan.

Credit will be allowed toward private room charges in an amount equal to the facility's most prevalent charge for semiprivate accommodations. Charges will also be paid for general nursing care and other services which would ordinarily be covered in a general hospital. In order to be eligible for these benefits, admission must occur within 14 days of discharge from the hospital.

In order to qualify for benefits provided by a skilled nursing facility, the following stipulations apply:

a. The services are medically required to be given on an inpatient basis because of the covered individual's need for skilled nursing care on a continuing basis for any of the conditions for which he or she was receiving inpatient hospital services prior to transfer from a hospital to the skilled nursing facility or for a condition requiring such services which arose after such transfer and while he or she was still in the facility for treatment of the condition or conditions for which he or she was receiving inpatient hospital services,

b. Only on prior referral by and so long as, the patient remains under the active care of an attending doctor who certifies that continual hospital confinement would be required without the care and treatment of the skilled nursing facility, and

c. Approved in advance by the Claims Processor."

Sec. 38. G.S. 135-40.6(8)e. reads as rewritten:

"e. Prosthetic and Orthopedic Appliances and Durable Medical Equipment: Appliances and equipment including corrective and supportive devices such as artificial limbs and eyes, wheelchairs, traction equipment, inhalation therapy and suction machines, hospital beds, braces, orthopedic corsets and trusses, and other prosthetic appliances or ambulatory apparatus which are provided solely for the use of the participant. Eligible charges include repair and replacement when medically necessary. Benefits will be provided on a rental or purchase basis at the sole discretion of the ~~Administrator~~ Claims Processor and agreements to rent or purchase shall be between the ~~Administrator~~ Claims Processor and the supplier of the appliance.

For the purposes of this subdivision, the term 'durable medical equipment' means standard equipment normally used in an institutional setting which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. Decisions of the

Claims Processor, the Executive Administrator and Board of Trustees as to compliance with this definition and coverage under the Plan shall be final."

Sec. 39. G.S. 135-40.6A(a) is amended by adding a new subdivision to read:

"(8) Hospice Services in accordance with G.S. 135-40.6(8)q."

Sec. 40. G.S. 135-40.7(14) reads as rewritten:

"(14) Charges for cosmetic surgery or treatment except that charges for cosmetic surgery or treatment required for correction of damage caused by accidental injury sustained by the covered individual while ~~this insurance or its predecessor~~ coverage under this plan is in force on his or her account or to correct congenital deformities or anomalies shall not be excluded if they otherwise qualify as covered medical expenses."

Sec. 41. Effective January 1, 1992, G.S. 135-40.6(5)a. reads as rewritten:

"a. Surgery: Cutting procedures, treatment of fractures, transfusions, operative preparation for diagnostic x-ray examinations, surgical implantation radiation sources, major endoscopic examinations, biopsies, surgical sterilization, other standard services and operations.

For the purpose of this subdivision, the term 'standard services and operations' includes the following organ transplants: liver, heart, corneal, bone marrow, lung, heart-lung, pancreas, and kidney. All other organ transplants shall be considered nonreimbursable under the Plan. Benefits for the above listed organ transplants shall be payable only in accordance with rules established by the Executive Administrator and Board of Trustees. The Executive Administrator and Board of Trustees may limit the Plan's reimbursement for selected organ transplants to amounts that would otherwise be allowed in accordance with G.S. 135-40.4."

Sec. 42. Effective January 1, 1985, G.S. 135-40.11(a) is amended by adding a new subdivision to read:

"(7) The last day of the month in which an employee who is Medicare-eligible selects Medicare to be the primary payer of medical benefits. Coverage for a Medicare-eligible spouse of an employee shall also cease the last day of the month in which Medicare is selected to be the primary payer of medical benefits for the Medicare-eligible spouse."

Sec. 43. Unless otherwise stated, this act becomes effective July 1, 1991.