GENERAL ASSEMBLY OF NORTH CAROLINA
1987 SESSION

CHAPTER 857
SENATE BILL 1395

AN ACT TO REVISE THE ADMINISTRATION OF THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-38(c) reads as rewritten:

"(c) The Committee shall ~~recommend to the General Assembly programs for hospital, medical care and disability salary continuation benefits as provided in this Article. The Committee may consult with the Board of Trustees of the Retirement System concerning the Disability Salary Continuation Plan, and with the Board of Trustees and the Executive Administrator of the Teachers' and State Employees' Comprehensive Major Medical Plan in connection with the Comprehensive Major Medical Plan, and these two Boards and the Executive Administrator, and their directors, staff, and contractors~~ review programs of hospital, medical and related care provided by Part 3 of this Article as recommended by the Executive Administrator and Board of Trustees of the Plan. The Executive Administrator and the Board of Trustees shall provide the Committee with any information or assistance requested by the Committee in performing its duties under this Article."

Sec. 2. G.S. 135-39(f) reads as rewritten:

"(f) The members of the Board of Trustees shall receive one hundred dollars ($100.00) per day, except employees eligible to enroll in the Plan, whenever the full Board of Trustees holds a public session, and travel allowances under G.S. 138-6 when traveling to and from meetings of the Board of Trustees or hearings under G.S. 135-39.7, but shall not receive any subsistence allowance or per diem under G.S. 138-5, except when holding a meeting or hearing where this section does not provide for payment of one hundred dollars ($100.00) per day."

Sec. 3. G.S. 135-39.2 reads as rewritten:

"**§ 135-39.2. Officers, quorum, meetings.–**(a) The Board of Trustees shall elect from its own membership ~~for a one-year term a chairman and vice-chairman, and shall elect a secretary.~~ such officers as it sees fit.

(b) Six members of the Board of Trustees in office shall constitute a quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees present, except as otherwise provided in this Part.

(c) ~~The Board of Trustees shall meet initially upon the call of the Governor.~~ Meetings may be called by the Chairman, or at the written request of three members."

Sec. 4. G.S. 135-39.3A is repealed.

Sec. 5. G.S. 135-39.4A reads as rewritten:

"**§ 135-39.4A. Executive Administrator.–**(a) The Plan shall have an Executive Administrator.

(b) The Executive Administrator shall be appointed by the ~~Commissioner of Insurance, upon the advice of the Committee on Employee Hospital and Medical Benefits, for a two-year term beginning July 1, 1985, and biennially thereafter, subject to confirmation by the General Assembly in joint session or by joint resolution or bill. The Commissioner of Insurance shall, except for the initial appointment, submit the name of the nominee to the General Assembly no later than May 1 of each odd-numbered year.~~ Commissioner of Insurance. The term of employment and salary of the Executive Administrator shall be set by the Commissioner of Insurance upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.

~~(c)~~ The Executive Administrator may be removed from office by the Commissioner of Insurance, upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits, and any vacancy in the office of Executive Administrator may be filled by the Commissioner of Insurance with the term of employment and salary set upon the advice of an executive committee of the Committee on Employee Hospital and Medical Benefits.

~~(d) Whenever a vacancy in the office of Executive Administrator shall occur (including if the initial appointment is not confirmed by the General Assembly before the 1985 Regular Session adjourns until 1986), other than by expiration of term, the Commissioner of Insurance shall, upon the advice of the Committee on Employee Hospital and Medical Benefits, submit a nominee to the General Assembly, for confirmation in joint session or by joint resolution or bill, to serve the remainder of the unexpired term. If there is such a vacancy in the office of Executive Administrator and the General Assembly is not in session, or has adjourned for more than 10 days, the Commissioner of Insurance may, upon the advice of the Committee on Employee Hospital and Medical Benefits, appoint an Executive Administrator to serve on an interim basis until the twentieth day of legislative session after the appointment is made.~~

~~(e) Whenever there is a vacancy in the office of Executive Administrator, the Commissioner of Insurance shall be ex officio Executive Administrator until the vacancy is filled in accordance with this section.~~

(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 shall be done only after consultation with the Committee on Employee Hospital and Medical Benefits.

(g) The Executive Administrator shall be responsible for:

(1) Cost management programs;

(2) Education and illness prevention programs;

(3) Training programs for Health Benefit Representatives;

(4) Membership functions;
(5) Long-range planning;
(6) Provider and participant relations; and
(7) Communications.

(h) The Executive Administrator shall make reports and recommendations on the Plan to the President of the Senate, the Speaker of the House of Representatives and the Committee on Employee Hospital and Medical Benefits."

Sec. 6. G.S. 135-39.5(12) reads as rewritten:

"(12) Determining basis of payments to health care providers, including payments in accordance with G.S. 58-260.6."

Sec. 7. G.S. 135-39.5 is amended by adding a new section to read:

"(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."

Sec. 8. 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."

Sec. 9. G.S. 135-40.1(17) reads as rewritten:

"(17) Retired Employee (Retiree). – ~~Retired teachers and State employees~~ Retired teachers, State employees, and members of the General Assembly who are receiving monthly retirement benefits from any retirement system supported in whole or in part by ~~contribution~~ contributions of the State of North Carolina, so long as the retiree is enrolled. On and after January 1, 1988, a retired employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree."

Sec. 10. Effective January 1, 1988, G.S. 135-40.1(19) reads as rewritten:

"(19) Usual, Customary and Reasonable.–The meaning of the term 'UCR' shall be developed from criteria used for determining reasonable charges for services, including usual preoperative examination and customary postoperative care and care of usual complications, and shall be based on the usual charge made by an individual doctor for his or her private patients for a particular service, or the customary charge within the range of usual fees charged by most doctors of similar skill and training in North Carolina for the comparable service, whichever is the lower. A fee is reasonable if it meets the above two criteria. In cases of unusual complexity and cases involving supplemental skills of two or more doctors, reasonable charges will be determined by the Claims Processor upon advice of its medical advisors. The Executive Administrator and Board of Trustees may update usual, customary and reasonable charges, or other such comparable allowances, semi-annually for physicians who accept the Plan's UCR or other comparable allowances as payment in full, other than for the Plan's deductibles, coinsurance, or other amounts to be paid by members of the Plan; otherwise, the Executive Administrator and Board of Trustees shall not update usual, customary and reasonable charges, or other such comparable allowances more frequently than on an annual basis."

Sec. 11. (a) G.S. 135-40.2(a) is amended by adding a new subdivision to read:

"(2a) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986."

Sec. 11.1 G.S. 135-40.2(b)(9) is repealed.

Sec. 11.2 G.S. 135-40.2(b)(10) reads as rewritten:

"(10) Any eligible dependent child of the deceased retiree, teacher, State employee, or member of the General Assembly, provided the child was covered at the time of death of the retiree, teacher, State employee, or member of the General Assembly (or was in ~~esse~~ posse at the time and is covered at birth under this Part), or was covered under the Plan on September 30, 1986. Any eligible spouse or dependent child of a person eligible under ~~subdivisions (8) or (9)~~ subdivision (8) of this subsection if the spouse or dependent child was enrolled before October 1, 1986."

Sec. 12. G.S. 135-40.2 is amended by adding a new subsection (g) to read:

"(g) An eligible surviving spouse and any eligible dependent child of a deceased retiree, teacher, State employee, or member of the General Assembly shall be eligible for group benefits under this section without waiting periods for preexisting conditions provided coverage is elected within 90 days after the death of the former plan member."

Sec. 13. G.S. 135-40.3(d) reads as rewritten:

"(d) Types of Coverage Available.–There are ~~five~~ three types of coverage which an employee or retiree may elect.

(1) Employee Only.–Covers enrolled employees only. Maternity benefits are provided to employee only.

(2) Employee and Child(ren).–Covers enrolled employee and all eligible dependent children. Maternity benefits are provided to the employee only.

(3) Employee and Family.–Covers employee and spouse, and all eligible dependent children. Maternity benefits are provided to employee or enrolled spouse."

Sec. 14. G.S. 135-40.5 reads as rewritten:

"**§ 135-40.5. Benefits not subject to deductible or coinsurance.–(b) Ambulatory (Outpatient) Surgery.–**The Plan will pay one hundred percent (100%) of reasonable and customary charges for facility and ~~surgeon's~~ surgeon charges for surgery performed in an ambulatory surgical facility as defined by G.S. 131E-176(1) and (1a), or charges negotiated by the Plan, if that surgery is not normally performed on an outpatient basis. ~~Medical supplies, drugs, laboratory and other ancillary services and physicians' services will be covered under the comprehensive section of the Plan.~~

(c) Preadmission Testing.–The Plan will pay one hundred percent (100%) ~~if~~ of reasonable and customary charges for diagnostic, laboratory and x-ray examinations performed on an outpatient basis.

(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 shall be required for the following procedures otherwise covered by the Plan: ~~transurethral resection of the prostate, hemorrhoidectomy,~~ hysterectomy, ~~tonsillectomy and adenoidectomy, cholecystectomy,~~ revision of the nasal structure, coronary artery bypass surgery ~~thyroid surgery,~~ and surgery on the knee (except in procedures involving orthoscopic 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. 15. G.S. 135-40.6(1) reads as rewritten:

"(1) In-Hospital Benefits.–The Plan pays in-hospital benefits for each single confinement, when charged by a hospital, for room accommodation, including bed, board and general nursing care, but not to exceed the charge for semiprivate room or ward accommodations, or the rate negotiated for the Plan.

The Plan will pay the following covered charges, when charged by a hospital, for each confinement.

a. Intensive and cardiac nursing care.
b. All recognized drugs and medicines for use in the hospital.
c. Radiation services, including diagnostic x-rays, x-ray therapy, radiation therapy and treatment.
d. Clinical and pathological laboratory examinations.
e. Electrocardiograms and electroencephalograms.
f. Physical therapy.
g. Intravenous solutions.
h. Oxygen and oxygen therapy, plus the use of equipment.
i. Dressings, ordinary splints, plaster casts and sterile supplies.
j. Use of operating, delivery, recovery and treatment rooms and equipment.
k. Routine nursery charges, if the mother is eligible to receive maternity benefits.
l. Anesthetics and the administration thereof by the hospital's employee anesthesiologist.
m. Devices or appliances surgically inserted within the body.
n. Processing and administering of blood and blood plasma.
o. Children who are born under the coverage type (2), (3), or (5), as outlined in G.S. 135-40.3(d), and who remain continuously covered are entitled to benefits for treatment of illnesses or congenital defect, incubation or isolette care, and treatment of prematurity or postmaturity.

   If the mother is a covered individual, benefits are provided for the newborn's circumcision and routine nursery care.
p. When a covered individual is admitted to or transferred to a section of a hospital providing ambulant, convalescent, or rehabilitative care, benefits are provided up to the average number of days of service for treatment of the particular diagnosis or condition involved, or more if medical necessity requires.
q. The Plan pays benefits for laboratory testing and administration of blood provided to a covered individual.

   When a covered individual is the recipient of transplanted organs or bones, benefits are provided for services to the donor which are directly and specifically related to the transplantation.
r. Thirty days per fiscal year are provided for inpatient treatment of mental illness. Readmission for this condition within 365 days of last discharge shall be considered a single confinement. When furnished to

a patient in a skilled nursing facility, 30 days less the days of care already provided for the same illness in a hospital are provided. Additional inpatient treatment, based on individual consideration, may be provided if prior approval is obtained from the Claims Processor.

s. The use of nebulizers when authorized as medically necessary by the attending physician."

Sec. 16. 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 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, ~~and~~

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

"(4) Outpatient ~~Hospital~~ 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. ~~All hospital services for operative~~ Operative procedures.

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

d. ~~All hospital services in connection with pathological~~ Pathological examinations of tissue removed by resection or biopsy. Routine Pap smears are not covered.

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

No benefits are provided 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. 18. G.S. 135-40.6(8) reads as rewritten:

"(8) Other Covered Charges. –

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. 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.

b. Private Duty Nursing: Services of licensed nurses (not immediate relatives or members of the participant's household or private duty nursing used in lieu of or as a substitute for hospital staff nurses) ordered by the attending doctor for a condition requiring skilled nursing services. Private Duty Nursing ordered must be approved in advance by the Claims Processor as medically necessary. Allowances for Private Duty Nursing shall not exceed the Plan's usual, customary and reasonable allowances or ninety percent (90%) of the daily semiprivate rate at skilled nursing facilities as determined by the Plan.

c. Home Health Agency Services: Services provided in a covered individual's home, when ordered by the attending physician who certifies that hospital or skilled nursing facility confinement would be required without such treatment and cannot be readily provided by family members. Services may include medical supplies, equipment, appliances, therapy services (when provided by a qualified speech

therapist or licensed physiotherapist), and nursing services. Nursing services will be allowed for:

1. Services of a registered nurse (RN); or
2. Services of a licensed practical nurse (LPN) under the supervision of a RN; or
3. Services of a home health aide under the supervision of a RN, limited to four hours a day.

Home health services shall be limited to 60 days per fiscal year, except that additional home health services may be provided on an individual basis if prior approval is obtained from the Claims Processor. Plan allowances for home health services shall be limited to licensed or Medicare certified home health agencies and shall not exceed ninety percent (90%) of the skilled nursing facility semiprivate rates as determined by the Plan, or charges negotiated by the Plan.

d. Licensed Ambulance Service: Local ambulance transportation:

To or from a hospital for inpatient care or outpatient accident care;

From a hospital to the nearest facility able to provide needed services not available at the transferring hospital; or

From a hospital to a skilled nursing facility.

The word 'local' means ambulance transportation of not more than 50 miles unless the ~~Administrator~~ Claims Processor authorizes ambulance transportation beyond this distance.

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 and agreements to rent or purchase shall be between the Administrator 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.

f. Dental Services: Dental surgery and appliances for mouth, jaw, and tooth restoration necessitated because of external violent and accidental means, such as the impact of moving body, vehicle

collision, or fall occurring while an individual is covered under G.S. 135-40.3. No benefits are provided in connection with injury incurred in the act of chewing, nor for damage or breakage of an appliance such as bridge or denture being cleaned or otherwise not in normal mouth usage at the time of accident, nor for appliances for orthodontic treatment when a class of malocclusion, other than orthognathic, or cross bite has been diagnosed. Benefits for temporomandibular joint (TMJ) disfunction appliance therapy are limited to cases where the TMJ disfunction has been diagnosed as solely resulting from accidental means as certified by the attending practitioner and approved by the Claims Processor.

Benefits shall include extractions, fillings, crowns, bridges, or other necessary therapeutic and restorative techniques and appliances to reasonably restore condition and function to that existing immediately prior to the accident. Injury or breakage of existing appliances such as bridges and dentures is limited to repair of such appliances unless certified as damaged beyond repair.

g. Medical Supplies: Colostomy bags, catheters, dressings, oxygen, syringes and needles, and other similar supplies.

h. Blood: Transfusions including cost of blood, plasma, or blood plasma expanders.

i. Physical Therapy: Recognized forms of physical therapy for restoration of bodily function, provided by a doctor, hospital, or by a licensed professional physiotherapist. No benefits are provided for eye exercises or visual training.

j. Inhalation Therapy: When provided by a doctor, hospital, or other organization.

k. Speech Therapy: Speech therapy provided by certified speech therapist. Benefits are provided only in connection with a condition, illness, or injury arising while continuously covered under this Plan.

l. Cataract Lenses: Cataract lenses prescribed as medically necessary for aphakia persons, including charges for necessary examinations and fittings. Benefits will be limited to one set of cataract lenses every 24 months for persons 18 years of age or older, and one set of cataract lenses every 12 months for persons less than 18 years of age.

m. Cardiac Rehabilitation: Charges not to exceed six hundred fifty dollars ($650.00) per fiscal year for cardiac testing and exercise therapy, when determined medically necessary by an attending physician and approved by the Claims Processor for patients with a medical history of myocardial infarction, angina pectoris, arrhythmias, cardiovascular surgery, hyperlipidemia, or hypertension, provided such charges are incurred in a medically supervised facility fully certified by the North Carolina Department of Human Resources.

n. Chiropractic Services: Limited to the alignment of the spine and releasing of pressure by manipulation in accordance with the definitions in ~~G.S. 90-143.1~~ G.S. 90-143. Maximum benefits for x-rays, manipulations, and modalities shall be one thousand dollars ($1,000) per fiscal year.

o. Foot Surgery: All foot surgery on bones and joints in excess of one thousand dollars ($1,000), except for emergencies, shall require prior approval from the Claims Processor.

p. Outpatient Diabetes Self-Care Programs: Charges, not to exceed three hundred dollars ($300.00) per fiscal year, when determined to be medically necessary by an attending physician and approved by the Executive Administrator and Claims Processor as meeting the standards of the National Diabetes Advisory Board for patients with a medical history of diabetes, provided such charges are incurred in a medically supervised facility.

q. Necessary medical services provided to terminally ill patients by duly licensed hospice organizations, when directed by the attending physician and approved in advance by the Claims Processor and the Executive Administrator."

Sec. 19. G.S. 135-40.6A(b) reads as rewritten:

"(b) The Executive Administrator and Board of Trustees may establish procedures to require prior medical approvals for the following services:

(1) Skilled Nursing Facility Care (after the initial 30 days);
(2) Private Duty Nursing;
(3) Speech Therapy (unless rendered in an inpatient hospital);
(4) Physical Therapy (in the home);
(5) Argon Laser Trabeculoplasty;
(6) Radioallergosorbent Test (RAST);
(7) Surgical Procedures:
    a. Elepharoplasties
    b. Surgery for Hermaphroditism
    c. Excision of Keloids
    d. Reduction Mammoplasty
    e. Morbid Obesity Surgery
    f. Penile Prosthesis
    g. Excision of Gynecomastia
    h. Cochlear Implants
    i. Revision of the Nasal Structure
    j. Abdominoplasty
    k. Fimbrioplasty
    l. Tubotubal Anastomasis."

Sec. 20. 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, 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 out-of-pocket in excess of five hundred dollars ($500.00) per fiscal year."

Sec. 21. G.S. 135-40.10 reads as rewritten:

"**§ 135-40.10. Persons eligible for Medicare.–**(a) Benefits payable for covered expenses under this Plan in G.S. 135-40.5 through G.S. 135-40.9 will be reduced by any benefits payable for the same covered expenses under Medicare, so that Medicare will be the primary carrier except where compliance with federal law specifies otherwise.

(b) For those participants eligible for Medicare, the State's new Plan will be administered on a 'carve out' basis. The provisions of the new Plan are applied to the charges not paid by Medicare (Parts A & B). In other words, those charges not paid by Medicare would be subject to the deductible and coinsurance of the new Plan just as if the charges not paid by Medicare were the total bill.

~~All charges for outpatient surgery, preadmission testing and accidents are covered at one hundred percent (100%) subject to the Plan's provisions. Of course all payments are subject to usual, customary, and reasonable charges.~~

(c) For those individuals eligible for Part A (at no cost to them), benefits under this program will be reduced by the amounts to which the covered individuals would be entitled to under Parts A and B of Medicare, even if they choose not to enroll for Part B.

(d) Notwithstanding the foregoing provisions of this section or any other provisions of the Plan, the Executive Administrator and Board of Trustees may enter into negotiations with the Health Care Financing Administration, U.S. Department of Health and Human Services, in order to secure a more favorable coordination of the Plan's benefits with those provided by Medicare, including but not limited to, measures by which the Plan would provide Medicare benefits for all of its Medicare-eligible members in return for adequate payments from the federal government in providing such benefits. Should such negotiations result in an agreement favorable to the Plan and its Medicare-eligible members, the Executive Administrator and Board of Trustees may, after consultation with the Committee on Employee Hospital and Medical Benefits, implement such an agreement which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members."

Sec. 22. The Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan are directed to conduct a comprehensive feasibility and cost study on including a program of dental benefits under the Plan for eligible employees, retired employees, and dependents of employees and retired employees. The study shall include, but not be limited to, an analysis of how such benefits might be provided through a conventional form of insurance contract, on a self-insured basis, through prepaid alternatives, through an employee reimbursement program, or a combination of approaches, and evaluation as to whether such benefits should be on a mandatory or optional basis among eligible participants, a comparison of various dental benefit deductibles, copayments, annual and lifetime maximum benefits, and the types of benefits covered, a detailed cost-benefit analysis of orthodontic and prosthodontic benefits, a review of the basis for reimbursing dental expenses through usual, customary and reasonable allowances or through fixed

indemnity allowances, an analysis of how such a program of dental benefits might affect the hospital and medical benefits provided by the Plan, and a review of the possibilities for financing a program of dental benefits through fully contributory or partially contributory premiums on a pre-tax basis in light of the Plan's premium requirements for hospital and medical benefits. The Executive Administrator and Board of Trustees shall complete this study and make a report on the study's findings and recommendations to the Committee on Employee Hospital and Medical Benefits and the General Assembly's Fiscal Research Division no later than May 15, 1988.

Sec. 23. (a) The annual employer contributions, payable monthly, to the Teachers' and State Employees' Comprehensive Major Medical Plan for each fiscal year of the 1987-89 biennium, as contained in Chapter 738, Session Laws of 1987, are intended by the General Assembly to be maximum amounts payable by employers to the Plan. Should the Plan's financial experience through fiscal year 1987-88 require additional support for fiscal year 1988-89, notice is hereby given by the 1987 Session of the General Assembly that:

(1) the Plan's benefits will be reduced for 1988-89;

(2) the Plan's noncontributory premiums for eligible employees and retired employees will be replaced with partially contributory premiums for 1988-89;

(3) eligible employees and retired employees will be provided an amount up to the authorized maximum employer contributions for 1988-89 in order to secure their own individual plans of hospital and medical benefits by making irrevocable elections not to participate in the Plan; or

(4) any combination of the foregoing alternatives to insure the intention of the General Assembly in maximizing the amount of employer contributions to the Plan for the 1987-89 biennium.

(b) The Executive Administrator shall inform, in writing, all employees and retired employees enrolled in the Plan of the General Assembly's intentions in the foregoing subsection (a), along with a statement of the amount of additional employer contributions to the Plan provided by the 1987 Session of the General Assembly for fiscal year 1987-88 and fiscal year 1988-89 as a part of the total compensation package for employees and retired employees.

Sec. 24. G.S. 135-40.7A(b) is rewritten to read:

"(b) Notwithstanding any other provisions of this Part, the maximum benefit for each covered individual for treatment of chemical dependency is as follows:

30 Consecutive Days	$ 3,900
Fiscal Year	6,500
Lifetime	20,000

Daily benefits are limited to one hundred thirty dollars ($130.00) except for medical detoxification treatment under rules established by the Executive Administrator and Board of Trustees."

Sec. 25. The Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan are directed to conduct a comprehensive feasibility and cost study on the use of a mail order drug program by the Plan for dispensing outpatient prescription maintenance drugs for the treatment of chronic or long-term illnesses or medical conditions. The study shall include, but not be limited to:

(1) a comparison of unit drug costs between a mail order drug program and community pharmacies;
(2) a comparison between the amount of generic drugs dispensed by a mail order drug program and community pharmacies;
(3) a comparison of drug volumes dispensed between a mail order drug program and community pharmacies;
(4) a comparison between the expected patient utilization of drugs from a mail order drug program and community pharmacies;
(5) a review of possible exposure to spillage or wastage from a mail order drug program resulting from either noncompliance with physician treatments or a modification of a physician's treatment plan;
(6) a review of automatic refill practices of a mail order drug program;
(7) a review of the time lapse between a drug order and receipt under a mail order drug program; and
(8) a comparison of the advantages and disadvantages of a mail order drug program self-administered by the Plan or State as opposed to the use of a third-party administrator.

The Executive Administrator and Board of Trustees shall complete this study and make a report on the study's findings and recommendations to the Committee on Employee Hospital and Medical Benefits and the General Assembly's Fiscal Research Division no later than May 15, 1988.

Sec. 25.1. (a) The Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan are directed to conduct a detailed study on the further inclusion of organ transplants for coverage by the Plan and report their findings and recommendations to the Legislative Committee on Employee Hospital and Medical Benefits upon the convening of the 1989 Session of the General Assembly.

(b) North Carolina Memorial Hospital and the University of North Carolina at Chapel Hill's School of Medicine may use any medical research and treatment funds available to them to cover the cost of heart transplants for employees, retired employees, and their dependents covered by the Teachers' and State Employees' Comprehensive Major Medical Plan on and after January 1, 1987. The Hospital and School of Medicine shall provide to the Plan any diagnostic and treatment information on such transplants as is deemed appropriate by the Plan, the Hospital, and the School of Medicine.

(c) This section is effective upon ratification.

Sec. 26. Except as otherwise provided in this act, this act shall become effective July 1, 1987, and shall apply to claims incurred on or after September 1, 1987.

In the General Assembly read three times and ratified this the 14th day of August, 1987.