GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

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SENATE BILL 1565

Short Title: State Employee Health Plan Changes. (Public)

Sponsors: Senator Royall.

Referred to: Appropriations.

June 6, 1990

A BILL TO BE ENTITLED

AN ACT TO MAKE ADMINISTRATIVE CHANGES AND CLARIFICATIONS, TO MODIFY PART-TIME AND TEMPORARY EMPLOYEE COVERAGES, TO PROVIDE BENEFITS FOR GENERAL HEALTH PHYSICAL EXAMINATIONS AND IMMUNIZATIONS, AND TO PROVIDE LONG-TERM CARE BENEFITS IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-39.4A(a) reads as rewritten:

"(a) The Plan shall have an Executive Administrator. Except for the provisions of G.S. 126-4(5), and Articles 5, 6, 7, 13, and 14 of Chapter 126 of the General Statutes, the provisions of that Chapter do not apply to the position of Executive Administrator."

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

"(f) The Executive Administrator may ~~employ~~ appoint 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. Except for the provisions of G.S. 126-4(1) through G.S. 126-4(5), G.S. 126-4(8), G.S. 126-7, and Articles 5, 6, 7, 13, and 14 of Chapter 126 of the General Statutes, that Chapter does not apply to the positions of deputy administrator, assistant administrator, director, deputy director, assistant director, supervisor, or any other decision-making position appointed by the Executive Administrator, nor to the positions of confidential secretary to the Executive Administrator or to any other decision-making position, or to any other positions of a like nature, notwithstanding G.S. 126-5. 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 is amended by adding a new subdivision to read:

"(19) Determine administrative and medical policies that are not in direct conflict with Part 3 of this Article upon the advice of the Claims Processor and upon the advice of the Plan's consulting actuary when Plan costs are involved."

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. 135-39.10 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~~."

Sec. 7. Effective October 1, 1989, G.S. 135-40.1(3)b reads as rewritten:

"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."

Sec. 8. G.S. 135-40.1(7a) is recodified to be G.S. 135-40.1(7b) and a new subdivision is added to G.S. 135-40.1 to read:

"(7b) 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 only 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 U.S. insurers of health care expenses on a consensus of medical value and accepted standard medical treatment.

Sec. 9. G.S. 135-40.2 reads as rewritten:

"**§ 135-40.2. Eligibility.**

(a) The following persons are eligible for coverage under the Plan, on a noncontributory basis, subject to the provisions of G.S. 135-40.3:

(1) All permanent full-time employees of an employing unit who meet the following conditions:

a. Paid from general or special State funds, or

b. Paid from non-State funds and in a group for which his or her employing unit has agreed to provide coverage.

Employees of State agencies, departments, institutions, boards, and commissions not otherwise covered by the Plan who are employed in permanent job positions on a recurring basis and who work 30 or more hours per week for nine or more months per calendar year are covered by the provisions of this subdivision.

(1a) Permanent hourly employees as defined in G.S. 126-5(c4) who work at least one-half of the workdays of each pay period.

(2) Retired teachers, State employees, and members of the General Assembly.

(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.

(3) Repealed by Session Laws 1985 (Reg. Sess., 1986), c. 1020, s. 29(b), effective January 1, 1988.

(3a) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(4) Members of the General Assembly.

(a1) The following persons are eligible for coverage under the Plan on a partially contributory basis, subject to the provisions of G.S. 135-40.3:

(1) All permanent part-time employees designated as one-half time or more of an employing unit who meet the conditions set out in subdivision (a)(1) of this section and who are not otherwise covered by the provisions of that subdivision, shall be eligible for coverage on a fifty percent (50%) noncontributory basis.

(b) The following person shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of G.S. 135-40.3:

(1) Repealed by Session Laws 1983, c. 761, s. 255, effective upon the convening of the 1985 Regular Session.

(2) Former members of the General Assembly who enroll before October 1, 1986.

(2a) For enrollments after September 30, 1986, former members of the General Assembly if covered under the Plan at termination of membership in the General Assembly.

(3) Surviving spouses of deceased former members of the General Assembly who enroll before October 1, 1986.

(3a) Employees of the General Assembly, not otherwise covered by this section, as determined by the Legislative Services Commission, except for legislative interns and pages.

(3b) For enrollments after September 30, 1986, surviving spouses of deceased former members of the General Assembly, if covered under the Plan at the time of death of the former member of the General Assembly.

(4) All permanent part-time employees ~~(designated as half-time or more)~~ designated as less than one-half time and all temporary employees of an employing unit who meets the conditions outlined in subdivision ~~(a)(1)a.~~ (a)(1) above, and who are not otherwise covered by the provisions of ~~G.S. 135-40.2(a)(1)~~subdivisions (a)(1) or (a1)(1) of this section.

(4a) Permanent hourly employees as defined in G.S. 126-5(c4) who work less than one-half of the workdays of each pay period.

(5) The spouses and eligible dependent children of enrolled employees, retirees, and members of the General Assembly.

(6) Blind persons licensed by the State to operate vending facilities under contract with the Department of Human Resources, Division of Services for the Blind and its successors, who are:

a. Operating such a vending facility;

b. Former operators of such a vending facility whose service as an operator would have made these operators eligible for an early or service retirement allowance under Article 1 of this Chapter had they been members of the Retirement System; and

c. Former operators of such a vending facility who attain five or more years of service as operators and who become eligible for and receive a disability benefit under the Social Security Act upon cessation of service as an operator.

(7) Repealed by Session Laws 1985 (Reg. Sess., 1986), c. 1020, s. 29(j), effective October 1, 1986.

(8) Surviving spouses of deceased retirees and surviving spouses of deceased teachers, State employees, and members of the General Assembly provided the death of the former Plan member occurred after September 30, 1986, and the surviving spouse was covered under the Plan at the time of death.

(9) Repealed by Session Laws 1987, c. 857, s. 11.1.

(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 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 subdivision (8) of this subsection if the spouse or dependent child was enrolled before October 1, 1986.

(c) No person shall be eligible for coverage as an employee or retired employee and as a dependent of an employee or retired employee at the same time. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time.

(d) Former employees who are receiving disability retirement benefits or disability income benefits pursuant to Article 6 of Chapter 135 of the General Statutes, provided the former employee has at least five years of retirement membership service at the time of disability, shall be eligible for the benefit provisions of this Plan, as set forth in this Part, on the same basis as a retired employee. Such coverage shall terminate as of the end of the month in which such former employee is no longer eligible for disability retirement benefits or disability income benefits pursuant to Article 6 of this Chapter.

(e) Employees on official leave of absence without pay may elect to continue this group coverage at group cost provided that they pay the full employee and employer contribution through the employing unit during the leave period.

(f) For the support of the benefits made available to any member vested at the time of retirement, their spouses or surviving spouses, and the surviving spouses of employees who are receiving a survivor's alternate benefit under G.S. 135-5(m) of those associations listed in G.S. 135-27(a), licensing and examining boards under G.S. 135-1.1, the North Carolina Art Society, Inc., and the North Carolina Symphony Society, Inc., each association, organization or board shall pay to the Plan the full cost of providing these benefits under this section as determined by the Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan. In addition, each association, organization or board shall pay to the Plan an amount equal to the cost of the benefits provided under this section to presently retired members of each association, organization or board since such benefits became available at no cost to the retired member.

(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.

(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan."

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. 135-40.5(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, 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 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~~ arthoscopic surgery when the diagnosis and the surgery can be performed in the same procedure and through the same incision). Second surgical opinions for coronary bypass 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. 12. Effective January 1, 1986, G.S. 135-40.6(2)f reads as rewritten:

"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. 13. (a) G.S. 135-40.6(8) is amended by adding two new subdivisions to read:

"s. Routine Diagnostic Examinations: Charges for routine diagnostic examinations and tests, including Pap smears, breast, colon 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 then 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, (not to exceed one hundred fifty dollars ($150.00) per fiscal year,) 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.

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

(b) 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 by this subsection.

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

No benefits are provided by this subsection 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."

(c) G.S. 135-40.6(9)d is repealed.

(d) 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 a 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 as provided in G.S. 135-40.6(8)s."

Sec. 14. (a) Article 3 of Chapter 135 of the General Statutes is amended by adding a new section to read:

"**§ 135-40.6C. Long-term care benefits.**

Long-term care benefits are subject to deductibles, elimination periods, and coinsurance provisions separate and apart from those provided for in G.S. 135-40.6. No limits on out-of-pocket expenses are provided for long-term care benefits provided by this section. Long-term care benefits are as follows:

(1) Nursing Home Benefits. The Plan will pay eighty percent (80%) of the reasonable and customary daily charges allowed by the Plan for skilled nursing care facilities and for intermediate nursing care facilities up to a maximum amount of sixty-five dollars ($65.00) per day for each day after the first 65 consecutive days for each nursing home stay. Such daily charges shall be inclusive of semiprivate room and board; skilled and semiskilled nursing services; routine laboratory tests and examinations; physical, occupational, and speech therapy; respiratory and other gas therapy; and drugs, injections, biologicals, fluids, solutions, and other routine medical supplies and equipment. Readmission to a nursing home within six months for the same or related cause or causes shall be considered a single nursing home stay for the purposes of this subsection. Benefits payable under this subsection are contingent upon compliance with the following conditions and will, in no instance, be paid under this subsection without compliance with each of the conditions:

a. Confinement to a nursing home is medically appropriate due to an illness, disease, or injury upon recommendation of an admitting physician other than a proprietor, employee, or agent of the nursing home; and

b. Confinement to a nursing home is for any overnight stay for which a charge for a day's stay is due and payable; and

c. Prior to confinement, the admitting physician secures approval certification from the Plan for the confinement.

As used in this subsection, a nursing home is a facility or a part of a facility which is (a) operated under state law and which is qualified as a skilled nursing or intermediate nursing facility under Medicare; or is (b) a facility meeting the requirements for licensure as a nursing home under Chapter 131E of the North Carolina General Statutes.

(2) Custodial Benefits. The plan will pay fifty percent (50%) of the reasonable and customary daily charges allowed by the Plan for domiciliary care facilities, for adult day care facilities, and for home health care agencies up to a maximum amount of twenty dollars ($20.00) per day for each day after the first 45 consecutive days that such custodial care is provided. Benefits payable under this subsection are contingent upon compliance with the following conditions and will, in no instance, be paid under this subsection without compliance with each of the conditions:

a. Use of such custodial benefits is medically appropriate in a treatment plan established and certified initially and at least once every six months by an attending physician other than a proprietor, employee, or agent of one or more of the aforementioned facilities or agencies; and

b. Confinement to a nursing home would be medically appropriate without the custodial care proposed to be rendered by one or more of the aforementioned facilities or agencies; and

c. Prior to use of such custodial benefits, an attending physician secures approval certification from the Plan for the use of the benefits.

As used in this subsection, a domiciliary care facility is a facility which (i) is operated under state law to provide residential care for the aged or disabled whose principal need is a home which provides personal care appropriate to their age or disability; or (ii) meets the requirements for licensure as a domiciliary home under Chapter 131D of the North Carolina General Statutes.

As used in this subsection, an adult day care facility is a facility which (i) is operated under state law to provide group care for the aged or disabled in a setting away from their residence on a less than 24-hour basis when such aged or disabled would otherwise be in need of full-time personal care away from their residence; or (ii) meets the requirements for certification as an adult day care program under Chapter 131D of the North Carolina General Statutes. As used in this subsection, a home health care agency is a residential care agency which is (i) operated under state law and which is qualified as a home

health care agency under Medicare; or (ii) an agency meeting the requirements for licensure as a home health care agency under Chapter 131E of the North Carolina General Statutes.

(3) Limitations and Exclusions to Long-Term Care Benefits.

a. The benefits provided by this section are for the purpose of meeting the requirements for assistance from the loss of functional capacity associated with a chronic illness, disease, or disabling injury for extended periods of time; and are, in no way, intended to duplicate the benefits provided for acute medical care otherwise provided by G.S. 135-40.6 or any other provision of this Article. A loss of functional capacity can occur from: (i) an illness, disease, or disabling injury resulting in a physical incapacity to perform the activities of daily living; or (ii) an irreversible organic mental impairment resulting in a mental incapacity to perform the activities of daily living. Activities of daily living consist of routine functions involving personal care and mobility.

b. The Executive Administrator and Board of Trustees may limit the Plan's reimbursement for benefits provided under this section to amounts that would otherwise be allowed in accordance with G.S. 135-40.4.

c. The maximum lifetime benefits payable under this section are one hundred thousand dollars ($100,000) for each covered individual."

(b) G.S. 135-40.1(11) reads as rewritten:

"(11) Home Health Care Coverage. – Coverage for home care and treatment established and approved in writing by a physician who certifies that continual hospital or nursing home confinement would be required without the care and treatment specified by this coverage."

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

"(3) Skilled Nursing Facility Benefits. – The Plan will pay benefits under this section 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,

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."

(d) G.S. 135-40.6(8)c reads as rewritten:

"c. Home Health Agency Services: Services <u>not otherwise covered by G.S.. 135-40.6C that are</u> 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."

(e) G.S. 135-40.7(2) reads as rewritten:

"(2) Charges for care in a nursing home, home for the aged, convalescent home, or in any other facility or location for custodial or domiciliary care or for rest cures except as provided by G.S. 135-40.6C."

Sec. 15. 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."

Sec. 16. 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 out-of-pocket in excess of five hundred dollars ($500.00) per fiscal year."

Sec. 17. Effective July 1, 1990, G.S. 135-40.11(c)(1) reads as rewritten:

"(1) In the event of termination for any reason other than death, coverage under the Plan for an employee and his or her eligible spouse or dependent children, provided the eligible spouse or dependent children were covered under the Plan at termination of employment or were covered on September 30, 1986, may be continued for a period of not more than ~~18~~ 36 months following termination of employment on a fully contributory basis."

Sec. 18. 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)~~ is one million dollars ($1,000,000)."

Sec. 19. Unless otherwise stated, this act is effective upon ratification. Section 5 shall become effective October 1, 1982. Sections 9 and 18 shall become effective October 1, 1990. Sections 13 and 14 shall become effective October 1, 1991.