GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1997

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HOUSE BILL 435

Short Title: State Health Plan Tech Amds/AB. (Public)

Sponsors: Representatives Dockham; and Brawley.

Referred to: Insurance.

March 10, 1997

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL CHANGES IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.1(1a) reads as rewritten:

"(1a) Covered Services. – Any medically necessary, reasonable, and customary items of service, at least a portion of the expense of which is covered under at least one of the plans covering the person for whom claim is made or service provided. ~~To the extent legally possible, it~~ It shall be synonymous with allowable ~~expenses.~~ expenses, and with benefit or benefits."

Section 2. G.S. 135-40.1(7.1) reads as rewritten:

"(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, associations of health care providers, and other major United States insurers of health care expenses on a consensus of medical value and accepted standard medical treatment.~~ The use of a service, supply, drug, or device not recognized as standard medical care for the condition, disease, illness, or injury being treated as determined by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor. Determinations are made after independent review of scientific data. Opinions of experts in a particular field and opinions and assessments of nationally recognized review organizations may also be considered by the Plan but are not determinative or conclusive. The fact that an experimental/investigational treatment is the only available treatment for a particular condition will not result in coverage if the treatment is experimental/investigational in the treatment of the particular condition, nor is it relevant for purposes of coverage that the member has tried other more conventional therapies without success. The following criteria are the basis for determination that a service or supply is investigational. If a service or supply meets one or more of these criteria, it is deemed experimental/investigational:

a. Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of the condition being treated, except that of label use of chemotherapeutic drugs is provided in accordance with the requirements of G.S. 135-40.6(8)(a). Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.

b. There is insufficient or inconclusive scientific evidence in peer review medical literature to permit the Plan's evaluation of the therapeutic value of the service or supply.

c. There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes.

d. Is provided as part of a research or clinical trial.

e. Are provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives.

f. Are subject to approval or review of an Institutional Review Board or other body that approves or reviews research.

g. Are provided pursuant to informed consent documents that describe the service as experimental, investigational, or part of a research study."

Section 3. G.S. 135-40.6(6)i. reads as rewritten:

"i. No benefits are payable for organ transplants not listed in G.S. 135-40.6(5)a, nor will benefits be payable for surgical procedures or organ transplants determined ~~in the opinion of the~~ by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor to be experimental."

Section 4. G.S. 135-40.7 is amended by adding the following subdivisions:

"(19) Any service, treatment, facility, equipment, drugs, supply, or procedure that is experimental or investigational as defined in G.S. 1350-40.1(7.1).

(20) Complications arising from noncovered services.

(21) Charges related to a noncovered service, even if the charges would have been covered if rendered in connection with a covered service."

Section 5. G.S. 135-40.6(6)j. reads as rewritten:

"j. No benefits are payable for radial keratotomy surgical ~~procedures.~~ procedures or for services to correct vision when performed in lieu of the use of corrective lenses."

Section 6. G.S. 135-40.6A(c) reads as rewritten:

"(c) No procedure for prior approval may be established except as provided by this ~~section~~ Article as it may be amended from time to time."

Section 7. 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 accommodations, 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. Under the DRG reimbursement system, the coinsurance shall be based on the lower of the DRG amount or charges.

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 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. Repealed by Session Laws 1991, c. 427, s. 31.

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

Section 8. 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). 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~~ 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).~~ a penalty of fifty percent (50%) of the eligible expenses up to five hundred dollars ($500.00) per admission and the denial of

services that were not medically necessary or appropriate, as determined by the Claims Processor. 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. Failure to secure certification for inpatient hospitalization shall not result in a penalty to the employee or individual when approval would have been given if requested."

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

"(17a) Skilled Care. – Medically necessary services that can only be rendered under State law or regulation by licensed health professionals such as a medical doctor, physician's assistant, physical therapist, occupational therapist, speech therapist, certified clinical social worker, certified nurse midwife, licensed practical nurse, or registered nurse."

Section 10. G.S. 135-40.6(3) reads as rewritten:

"(3) Skilled Nursing Facility Benefits. – The Plan will pay benefits in a skilled nursing facility licensed under applicable State laws 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 medically

necessary skilled nursing care on a continuing daily 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~~ and the patient requires 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.

For facilities not qualified for delivery of services covered by the benefits of Title XVIII of the Social Security Act (Medicare), neither the Plan nor any of its members shall be billed or held liable by such facilities for charges that otherwise would be covered by Medicare."

Section 11. G.S. 135-40.6(8)c. reads as rewritten:

"c. Home Health Agency Services: Services provided in a covered individual's home, when ordered by the attending physician ~~who certifies that~~ and hospital or skilled nursing facility confinement would be required for the patient 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 which are an adjunct to or extension of concurrent medically necessary skilled services 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."

Section 12. 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~~ for an individual whom continual hospital confinement would be required without the care and treatment specified by this coverage."

Section 13. G.S. 135-40.7(5) reads as rewritten:

"(5) Charges for any care, treatment, services or supplies other than those which are ~~certified by a physician who is attending the individual as being required for the~~ deemed medically necessary and appropriate treatment of the injury or ~~disease.~~ disease by the Executive Administrator and Board of Trustees upon the advice of the Claims Processor. This subdivision shall not be construed, however, to require certification by an attending physician for a service provided by an advanced practice registered nurse acting within the nurse's lawful scope of practice, subject to the limitations of G.S. 135-40.6(10)."

Section 14. G.S. 135-40.7B reads as rewritten:

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

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness and chemical dependency 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 chemical dependency and mental illness shall be covered under this section: allowable institutional and professional charges for inpatient ~~psychiatric~~ care, outpatient ~~psychotherapy,~~ care intensive outpatient ~~crisis management,~~ program services, partial hospitalization treatment, and residential care and ~~treatment.~~ treatment:

(1) For mental illness treatment:
  a. Licensed psychiatric hospitals;
  b. Licensed psychiatric beds in licensed general hospitals;
  c. Licensed residential treatment facilities;
  d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
  e. Licensed intensive outpatient treatment programs; and
  f. Licensed partial hospitalization programs.

(2) For chemical dependency treatment:
  a. Licensed chemical dependency units in licensed psychiatric hospitals;
  b. Licensed chemical dependency hospitals;
  c. Licensed chemical dependency treatment facilities;

d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; and
g. Medical detoxification facilities or units.

~~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~~ and no others may provide necessary outpatient care and treatment for mental ~~illness~~ health under this section:

(1) ~~Licensed psychiatrists;~~ Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;
(2) Licensed or certified doctors of psychology;
(3) Certified clinical social workers;
(3a) Licensed professional counselors;
(4) ~~Psychiatric nurses;~~ Certified clinical specialists in psychiatric and mental health nursing;
(4a) Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
~~(5) Other social workers under the direct employment and supervision of a licensed psychiatrist or licensed doctor of psychology;~~
(6) Psychological associates with a ~~master's~~ masters degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology; and
~~(7) Licensed psychiatric hospitals and licensed general hospitals providing psychiatric treatment programs;~~
~~(8) Certified residential treatment facilities, community mental health centers, and partial hospitalization facilities; and~~
(9) Certified fee-based practicing pastoral counselors.

(c1) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary outpatient care and treatment for chemical dependency under this section:

(1) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, in facilities described in subdivision (b)(2) of this section, in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of Chapter 122C of the General Statutes or in North Carolina area programs in substance abuse services are authorized to provide treatment for chemical dependency under this section:

a. Licensed physicians including, but not limited to physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the direct supervision of such physicians, psychologists, or psychiatrists;
f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers; until (sunset date);
h. Certified clinical specialists in psychiatric and mental health nursing; until (sunset date);
i. Licensed professional counselors; and
j. Certified fee-based practicing pastoral counselors until July 1, 1999, (sunset date).

(2) The following providers with appropriate substance abuse, training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, are authorized to provide treatment for chemical dependency in outpatient practice settings:
a. Licensed physicians who are certified in substance abuse by the American Society of Addition Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors with a masters degree in a related field working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
f. Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers; until (sunset date);
h. Certified clinical specialists in psychiatric and mental health nursing; until (sunset date);
i. Licensed professional counselors;
j. Licensed fee-based practicing pastoral counselors until July 1, 1999; and

k. In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:

1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and
3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(d) Benefits provided under this section shall be subject to a ~~managed, individualized care component~~ case management program for medical necessity and medical appropriateness consisting of (i) precertification of outpatient visits beyond 26 visits each Plan year, (ii) all electroconvulsive treatment, (iii) inpatient utilization review through preadmission and length-of-stay certification for ~~scheduled inpatient~~ nonemergency admissions to the following levels of care: inpatient units, partial hospitalization programs, residential treatment centers, chemical dependency detoxification and treatment programs, and intensive outpatient programs, (iv) ~~and~~ length-of-stay ~~reviews for unscheduled~~ certification of emergency inpatient admissions, and ~~(ii)~~ (v) a network of qualified, available providers of inpatient and outpatient psychiatric and chemical dependency ~~treatment psychotherapy.~~ treatment. Care which is not both medically necessary and medically appropriate will be noncertified and benefits will be denied. 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.

(e) For the purpose of this section, ‘emergency' is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others."

Section 15. G.S. 135-40.7A is repealed.

Section 16. G.S. 135-40.1(7) reads as rewritten:

"(7) Enrollment. – New employees must enroll themselves and their dependents within 30 days from the date of ~~employment.~~ employment or from first becoming eligible on a noncontributory basis. Coverage may become effective on the first day of the month following date of entry on payroll or on the first day of the following month. New employees

not enrolling themselves and their dependents within 30 days, or not adding dependents when first eligible as provided herein may enroll on the first day of any month but will be subject to a 12-month waiting period for preexisting health conditions, except for employees who elect to change their coverage in accordance with rules established by the Executive Administrator and Board of Trustees for optional prepaid hospital and medical benefit plans. Children born to covered employees having coverage type (2), or (3), as outlined in G.S. 135-40.3(d) shall be automatically covered at the time of birth without any waiting period for preexisting health conditions. Children born to covered employees having coverage type (1) shall be automatically covered at birth without any waiting period for preexisting health conditions so long as the Claims Processor receives notification within 30 days of the date of birth that the employee desires to change from coverage (1) to coverage type (2), or (3), provided that the employee pays any additional premium required by the coverage type selected retroactive to the first day of the month in which the child was born.

Newly acquired dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not be subject to the 12-month waiting period for preexisting conditions. A dependent can become qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a dependent child or the death of the spouse of a dependent child, and at the beginning of each legislative session (applies only to enrolled legislators). Effective date for newly acquired dependents if application was made within the 30 days can be the first day of the following month. Effective date for an adopted child can be date of adoption, or date of placement in the adoptive parent's home, or the first of the month following the date of adoption or placement."

Section 17. G.S. 135-40.2(a) is amended by adding new subdivisions to read:

"(7) Any member enrolled pursuant to subdivision (1) or (1a) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

(8) Employees on approved Family and Medical Leave."

Section 18. G.S. 135-40.1(8) reads as rewritten:

"(8) Health Benefits Representative. – The employee designated by the employing unit to administer the Comprehensive Major Medical Plan for the unit and its employees. The HBR is responsible for enrolling new employees, reporting changes, explaining benefits, reconciling group statements and remitting group fees. The State Retirement System is the Health Benefits Representative for retired members."

Section 19. G.S. 135-40.2(b)(2a) reads as rewritten:

"(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. To be eligible for coverage as a former member of the General Assembly, application must be made within 30 days of the end of the term of office. Only members of the General Assembly covered by the Plan at the end of the term of office are eligible. If application is not made within the specified time period, the member forfeits eligibility."

Section 20. G.S. 135-40.2(b)(5) reads as rewritten:

"(5) The spouses and eligible dependent children of enrolled teachers, State employees, retirees, former members of the General Assembly, former employees covered by the provisions of G.S. 135-40.2(a)(6), Disability Income Plan beneficiaries, enrolled continuation members, and members of the General Assembly. Spouses of surviving dependents are not eligible, nor are dependent children if they were not covered at the time of the member's death. Surviving spouses may cover their dependent children provided the children were enrolled at the time of the member's death or enroll within 30 days of the member's death."

Section 21. G.S. 135-40.2(b)(6) reads as rewritten:

"(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.

Spouses, dependent children, surviving spouses, and surviving dependent children of such members are not eligible for coverage."

Section 22. G.S. 135-40.2(b)(4a) is repealed.

Section 23. 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,~~ Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, provided the child was covered at the time of death of the retiree, teacher, State employee, ~~or~~ member of the General ~~Assembly~~ Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, (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.~~ An eligible surviving dependent child can remain covered until age 19, or age 26 if a full-time student, or indefinitely if certified as incapacitated under G.S. 135-40.1(3)b."

Section 24. G.S. 135-40.2(c) reads as rewritten:

"(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.~~ a dependent if eligible as an employee or retired employee, except when a spouse is eligible on a fully contributory basis. In addition, no person shall be eligible for coverage as a dependent of more than one employee or retired employee at the same time."

Section 25. G.S. 135-40.2(d) reads as rewritten:

"(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, shall be eligible for the benefit provisions of this Plan, as set forth in this Part, on ~~the same basis as a retired employee.~~ a noncontributory basis. 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."

Section 26. G.S. 135-40.2 is amended by adding a new subsection to read:

"(i) Any employee receiving benefits pursuant to Article 6 of this Chapter when the employee has less than five years of retirement membership service, or an employee on leave without pay due to illness or injury for up to 12 months, is entitled to continued coverage under the Plan for the employee and any eligible dependents by paying one hundred percent (100%) of the cost."

Section 27. G.S. 135-40.2(g) reads as rewritten:

"(g) An eligible surviving spouse and any eligible surviving dependent child of a deceased retiree, teacher, State employee, ~~or~~ member of the General ~~Assembly~~ Assembly, former member of the General Assembly, or Disability Income Plan beneficiary 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. Coverage may be elected at a later time, but will be subject to the 12-month waiting period for preexisting conditions and will be effective the first day of the month following receipt of the application."

Section 28. G.S. 135-40.3(b)(4) reads as rewritten:

"(4) Employees and dependents ~~reenrolled~~ enrolling or reenrolling within 12 months after a termination of ~~enrollment,~~ enrollment or employment, that were not enrolled at the time of this previous termination, 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."

Section 29. G.S. 135-40.3(c)(3) reads as rewritten:

"(3) Employees and retired employees may change from individual or parent/child(ren) coverage to parent/child(ren) or family coverage or add dependents to existing family or parent/child(ren) coverage upon acquiring a dependent without a waiting period for preexisting conditions, and such dependents will be covered under the Plan the first of the month or the first of the second month following the dependent's eligibility for coverage, provided ~~upon~~ written application ~~at any time after acquiring a dependent, and such dependent will be covered under the Plan beginning the first of the next calendar month following receipt of such application by the Claims Processor.~~ is submitted to the Health Benefits Representative within 30 days of becoming eligible."

Section 30. G.S. 135-40.3(c)(4) reads as rewritten:

"(4) Employees or retired employees who wish to change from family coverage to parent/child(ren) or individual or from parent/child(ren) to individual coverage shall give written notice to ~~the Claims Processor within 31~~ their Health Benefits Representative within 30 days after any change in the status of dependents, (resulting from death, divorce, etc.) ~~which~~ that requires a change ~~from family coverage to individual coverage.~~ in contract type. The effective date will be the first of the month following the dependent's ineligibility event. If notification was not made within the 30 days following the dependent's ineligibility event, the dependent will be retroactively

removed the first of the month following the dependent's ineligibility event, and the coverage type change will be the first of the month following written notification, except in cases of death, in which case the coverage type change will be made retroactive to the first of the month following the death."

Section 31. G.S. 135-40.3(c) is amended by adding two new subdivisions to read:

"(6) Employees or retired employees who wish to change from family to parent/child(ren) or individual coverage or from parent/child(ren) to individual coverage, even though their dependents continue to be eligible, shall give written notification to their Health Benefits Representative. Effective date of this type change will be the first of the month following written notification or any first of the month thereafter as desired by the employee.

(7) The effective date for newborns or adopted children will be date of birth, date of adoption, or placement with adoptive parent provided member is currently covered under a family or parent/child(ren) coverage. If the member wishes to add a newborn or adopted child and is currently enrolled on individual coverage, the member must submit application for coverage and a coverage type change within 30 days of the child's birth or date of adoption or placement. Effective date for the coverage type change is the first of the month in which the child is born, adopted, or placed. Adopted children may also be covered the first of the month following placement or adoption."

Section 32. G.S. 135-40.11(a)(7) reads as rewritten:

"(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. Such members are eligible to apply for conversion coverage."

Section 33. G.S. 135-40.11(b) is amended by adding a new subsection to read:

"(b1) Coverage under the Plan as a surviving dependent child whether covered as a dependent of a surviving spouse, or as an individual member (no living parent), ceases when the child ceases to be a dependent child as defined by G.S. 135-40.1(3) except coverage may continue under the Plan on a fully contributory basis for a period of not more than 36 months after loss of dependent status."

Section 34. 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 months following termination of employment on a fully contributory basis. Employees who were covered under the Plan at termination of employment may be continued for a period of not more than 18 months or 29 months if determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI."

Section 35. G.S. 135-40.11(h) reads as rewritten:

"(h) Continuation coverage under this Plan shall not be continued past the occurrence of any one of the following events:

(1) The termination of the Plan.

(2) Failure of a Plan member to pay monthly in advance any required premiums.

(3) A ~~member~~ person becomes a covered employee or a dependent of a covered employee under any group health plan ~~or, in the case of a surviving spouse, when the surviving spouse remarries and becomes covered under a group health plan.~~ and that group health plan has no restrictions or limitations on benefits.

(4) A ~~member~~ person becomes eligible for Medicare ~~benefits.~~ benefits on or after the effective date of the continuation coverage.

(5) The person was determined to be no longer disabled, provided the 18-month coverage was extended to 29 months due to having been determined to be disabled under the Social Security Act, Title II, OASDI or Title XVI, SSI.

(6) The person reaches the maximum applicable continuation period of 18, 29, or 36 months."

Section 36. G.S. 135-40.6(8)i. reads as rewritten:

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

Section 37. G.S. 135-40.6(8)r. reads as rewritten:

"r. Occupational Therapy: Recognized forms of occupational therapy provided by a doctor, hospital, ~~or by a~~ licensed professional occupational therapist, or certified occupational therapy assistant to restore fine motor skills for the resumption of bodily functions."

Section 38. (a) G.S. 135-40.6(8)o. reads as rewritten:

"o. Foot Surgery: ~~All foot~~ 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.~~ joints."

(b) G.S. 135-40.6A(a)(7) is repealed.

Section 39. G.S. 135-40.6A(b)(5) and G.S. 135-40.6A(b)(6) are repealed.

Section 40. G.S. 135-40.3(b)(5) reads as rewritten:

"(5) To administer the 12-month waiting period for preexisting conditions under this Article, the Plan must give credit against the 12-month period for the time that a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than ~~60~~ 63 days before the effective date of coverage. As used in this subdivision, a 'previous plan' means any policy, certificate, contract, or any other arrangement provided by any accident and health insurer, any hospital or medical service corporation, any health maintenance organization, any preferred provider organization, any multiple employer welfare arrangement, any self-insured health benefit arrangement, any governmental health benefit or health care plan or program, or any other health benefit arrangement."

Section 41. This act becomes effective July 1, 1997.