GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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HOUSE BILL 1838
Committee Substitute Favorable 6/27/00

Short Title: State Health Plan Amend's. (Public)

Sponsors:

Referred to:

May 30, 2000

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN SHALL COVER THE COST OF ONE ANNUAL PAP SMEAR FOR ANY COVERED FEMALE UNDER THE PLAN'S WELLNESS BENEFIT AND TO ALLOW INDIVIDUALS EXCLUDED FROM MEMBERSHIP IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN FOR FILING FRAUDULENT CLAIMS TO BE CONSIDERED FOR REINSTATEMENT IN THE PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.5(e) reads as rewritten:

"(e) Routine Diagnostic Examinations. – The Plan will pay one hundred percent (100%) of allowable charges for routine diagnostic examinations and tests, including ~~Pap smears,~~ breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 50 years, and once a year for covered individuals age 50 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility.

Routine diagnostic examinations and tests covered under this subsection also include one Pap smear per year for any covered female. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities, or to comply with governmental licensing requirements. The maximum amount payable under this subsection for a covered individual is one hundred fifty dollars ($150.00) per fiscal year."

Section 2. G.S. 135-40.2(h) reads as rewritten:

"(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. The Executive Administrator and Board of Trustees may make an exception to the provisions of this subsection when persons subject to this subsection have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subsection shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subsection."

Section 3. G.S. 135-40.11(a)(6) reads as rewritten:

"(6) The last day of the month in which a covered individual is found to have 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. The Executive Administrator and Board of Trustees may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subdivision."

Section 4. This act becomes effective July 1, 2000.