§ 108A-70.21. (Contingently repealed – see note) Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans.

(a) Eligibility. – The Department may enroll eligible children based on availability of funds. Following are eligibility and other requirements for participation in the Program:

(1) Children must:

a. Be between the ages of 6 through 18;

b. Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;

c. Be uninsured;

d. Be in a family whose family income is above one hundred thirty-three percent (133%) and less than or equal to two hundred eleven percent (211%) of the federal poverty level;

e. Be a resident of this State and eligible under federal law; and

f. Have paid the Program enrollment fee required under this Part.

(2) Proof of family income and residency and declaration of uninsured status shall be provided by the applicant at the time of application for Program coverage. The family member who is legally responsible for the children enrolled in the Program has a duty to report any change in the enrollee's status within 60 days of the change of status.

(3) If a responsible parent is under a court order to provide or maintain health insurance for a child and has failed to comply with the court order, then the child is deemed uninsured for purposes of determining eligibility for Program benefits if at the time of application the custodial parent shows proof of agreement to notify and cooperate with the child support enforcement agency in enforcing the order.

If health insurance other than under the Program is provided to the child after enrollment and prior to the expiration of the eligibility period for which the child is enrolled in the Program, then the child is deemed to be insured and ineligible for continued coverage under the Program. The custodial parent has a duty to notify the Department within 10 days of receipt of the other health insurance, and the Department, upon receipt of notice, shall disenroll the child from the Program. As used in this paragraph, the term "responsible parent" means a person who is under a court order to pay child support.

(4) Except as otherwise provided in this section, enrollment shall be continuous for one year. At the end of each year, applicants may reapply for Program benefits.

(b) Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under [the] North Carolina Medicaid Program except for the following:

(1) No services for long-term care.

(2) No nonemergency medical transportation.

(3) No EPSDT.

(4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.

In addition to the benefits provided under the North Carolina Medicaid Program, the following services and supplies are covered under the Health Insurance Program for Children established under this Part:

(1), (1a) Repealed by Session Laws 2011-145, s. 10.41(b), effective July 1, 2011.

(2) Vision: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every 24 months, and optical supplies and solutions when needed. NCHC recipients must obtain optical services, supplies, and solutions from NCHC enrolled, licensed or certified ophthalmologists, optometrists, or opticians. In accordance with G.S. 148-134, NCHC providers must order complete eyeglasses, eyeglass lenses, and ophthalmic frames through Nash Optical Plant. Eyeglass lenses are limited to NCHC-approved single vision, bifocal, trifocal, or other complex lenses necessary for a Plan enrollee's visual welfare. Coverage for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses, and laminated lenses is limited to the coverage for single vision, bifocal, trifocal, or other complex lenses provided by this subsection. Eyeglass frames are limited to NCHC-approved frames made of zylonite, metal, or a combination of zylonite and metal. All visual aids covered by this subsection require prior approval. Requests for medically necessary complete eyeglasses, eyeglass lenses, and ophthalmic frames outside of the NCHC-approved selection require prior approval. Requests for medically necessary fabrication of complete eyeglasses or eyeglass lenses outside of Nash Optical Plant require prior approval. Upon prior approval refractions may be covered more often than once every 12 months.

(3) Under the North Carolina Health Choice Program for Children, the co-payment for nonemergency visits to the emergency room for children whose family income is less than or equal to one hundred fifty-nine percent (159%) of the federal poverty level is ten dollars ($10.00). The co-payment for children whose family income is above one hundred fifty-nine percent (159%) and less than or equal to two hundred eleven percent (211%) of the federal poverty level is twenty-five dollars ($25.00).

(4) Over the counter medications: Selected over the counter medications provided the medication is covered under the State Medical Assistance Plan. Coverage shall be subject to the same policies and approvals as required under the Medicaid program.

(5) Routine diagnostic examinations and tests: annual routine diagnostic examinations and tests, including x-rays, blood and blood pressure checks, urine tests, tuberculosis tests, and general health check-ups that are medically necessary for the maintenance and improvement of individual health are covered.

No benefits are to be provided for services and materials under this subsection that do not meet the standards accepted by the American Dental Association.

The Department shall provide services to children enrolled in the NC Health Choice Program through Community Care of North Carolina (CCNC) and shall pay Community Care of North Carolina providers the per member, per month fees as allowed under Medicaid.

(b1) Payments. – Prescription drug providers shall accept as payment in full, for outpatient prescriptions filled, amounts allowable for prescription drugs under Medicaid. For all other providers, services provided to children enrolled in the Program shall be provided at rates equivalent to one hundred percent (100%) of Medicaid rates, less any co-payments assessed to enrollees under this Part.

(c) Annual Enrollment Fee. – There shall be no enrollment fee for Program coverage for enrollees whose family income is less than or equal to one hundred fifty-nine percent (159%) of

the federal poverty level. The enrollment fee for Program coverage for enrollees whose family income is above one hundred fifty-nine percent (159%) and less than or equal to two hundred eleven percent (211%) of the federal poverty level shall be fifty dollars ($50.00) per year per child with a maximum annual enrollment fee of one hundred dollars ($100.00) for two or more children. The enrollment fee shall be collected by the county department of social services and retained to cover the cost of determining eligibility for services under the Program. County departments of social services shall establish procedures for the collection of enrollment fees.

(d) Cost-Sharing. – There shall be no deductibles, copayments, or other cost-sharing charges for families covered under the Program whose family income is less than or equal to one hundred fifty-nine percent (159%) of the federal poverty level, except that fees for outpatient prescription drugs are applicable and shall be one dollar ($1.00) for each outpatient generic prescription drug, for each outpatient brand-name prescription drug for which there is no generic substitution available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is three dollars ($3.00). Families covered under the Program whose family income is above one hundred fifty-nine percent (159%) of the federal poverty level shall be responsible for copayments to providers as follows:

(1) Five dollars ($5.00) per child for each visit to a provider, except that there shall be no copayment required for well-baby, well-child, or age-appropriate immunization services;
(2) Five dollars ($5.00) per child for each outpatient hospital visit;
(3) A one dollar ($1.00) fee for each outpatient generic prescription drug, for each outpatient brand-name prescription drug for which there is no generic substitution available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is ten dollars ($10.00).
(4) Twenty dollars ($20.00) for each emergency room visit unless:
    a. The child is admitted to the hospital, or
    b. No other reasonable care was available as determined by the Department.

Copayments required under this subsection for prescription drugs apply only to prescription drugs prescribed on an outpatient basis.

(e) Cost-Sharing Limitations. – The Department shall establish maximum annual cost-sharing limits per individual or family, provided that the total annual aggregate cost-sharing, including enrollment fees, with respect to all children in a family receiving benefits under this section shall not exceed five percent (5%) of the family's income for the year involved.

(f) Coverage From Private Plans. – The Department shall, from funds available for the Program, pay the cost for dependent coverage provided under a private insurance plan for persons eligible for coverage under the Program if all of the following conditions are met:

(1) The person eligible for Program coverage requests to obtain dependent coverage from a private insurer in lieu of coverage under the Program and shows proof that coverage under the private plan selected meets the requirements of this subsection;
(2) The dependent coverage under the private plan is actuarially equivalent to the coverage provided under the Program and the private plan does not engage in the exclusive enrollment of children with favorable health care risks;
(3) The cost of dependent coverage under the private plan is the same as or less than the cost of coverage under the Program; and

(4) The total annual aggregate cost-sharing, including fees, paid by the enrollee under the private plan for all dependents covered by the plan, do not exceed five percent (5%) of the enrollee's family income for the year involved.

The Department may reimburse an enrollee for private coverage under this subsection upon a showing of proof that the dependent coverage is in effect for the period for which the enrollee is eligible for the Program.

(g), (h) Repealed by Session Laws 2015-241, s. 12H.14(a), effective September 18, 2015.

(i) Benefits provided to an enrollee in the Program may be subject to lifetime maximum limits set forth in Medicaid and NC Health Choice medical coverage policies adopted pursuant to G.S. 108A-54.2. (1998-1, s. 1; 1999-237, s. 11.9; 2002-126, s. 10.20(a); 2003-284, s. 10.29(a); 2005-276, ss. 10.22(b), 10.22(c), 10.22(d); 2007-323, s. 28.22A(o); 2007-345, s. 12; 2008-107, ss. 10.12(b), (c), 10.13(f), (k); 2008-118, s. 1.6(b), (c); 2009-16, s. 4(d); 2009-451, s. 10.35(a); 2011-145, s. 10.41(b); 2013-360, s. 12H.10(g); 2015-96, s. 4; 2015-241, ss. 12H.2(f), 12H.14(a), (b), 12H.25(b), 12H.26(b); 2015-245, s. 22; 2017-102, s. 16; repealed by 2022-74, s. 9D.15(b).)