NORTH CAROLINA GENERAL ASSEMBLY
1981 SESSION

CHAPTER 1398
HOUSE BILL 1669

AN ACT TO ESTABLISH A PROGRAM OF HOSPITAL AND MEDICAL CARE BENEFITS FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-32, G.S. 135-33, G.S. 135-33.1, G.S. 135-35, and G.S. 135-36 are repealed effective October 1, 1982, but such repeal does not affect any existing contract.

Sec. 2. Section 13.16 of Chapter 859, Session Laws of 1981 is repealed, and G.S. 135-34 is reenacted as it appears in the 1981 Replacement Volume of Volume 3B of the General Statutes.

Sec. 3. G.S. 135-37 is amended in line 2 by adding after the word "Article" the words ", or received from the Plan Administrator contracted with by the Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan."

Sec. 4. G.S. 135-37 is further amended after the words "Attorney General" the words ", or to the persons designated under G.S. 135-39.3" and by deleting the word "his" and inserting in lieu thereof the word "their".

Sec. 5. G.S. 135-38(c) is rewritten to read:

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

Sec. 6. Article 3 of Chapter 135 of the General Statutes is amended by designating G.S. 135-32 through G.S. 135-38 as Part 1 and adding the following new Parts:

"PART 2. Administrative Structure.

"**§ 135-39. Board of Trustees established. —** (a) There is established within the office of State Budget and Management the Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan.

(al) The Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan shall consist of nine members.

(b) Three members shall be appointed by the Governor.

Of the initial members, one shall serve a term to expire June 30, 1983, and two shall serve terms to expire June 30, 1984. Subsequent terms shall be for two years. Vacancies shall be filled by the Governor.

(c) Three members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives in accordance with G.S. 120-121. Of the initial members, two shall serve terms expiring June 30, 1983, and one shall serve a term expiring June 30, 1984. Vacancies shall be filled in accordance with G.S. 120-122.

(d) Three members shall be appointed by the General Assembly upon the recommendation of the President of the Senate in accordance with G.S. 120-121. Of the initial members, two shall serve terms expiring June 30, 1983, and one shall serve a term expiring June 30, 1984. Vacancies shall be filled in accordance with G.S. 120-122.

(dl) In case the General Assembly fails to make appointments under subsections (c) or (d) of this section prior to sine die adjournment of the 1981 General Assembly, the Governor may fill the vacancy or vacancies in accordance with G.S. 120-122 as if the vacancy had occurred while the General Assembly was not in session, provided that the terms of those appointees shall expire on April 1, 1983.

(e) The Governor shall have the power to remove any member appointed by him under subsection (b). The General Assembly may remove any member appointed under subsections (c) or (d).

(f) The members of the Board of Trustees shall receive a salary of two hundred dollars ($200.00) per day when the Board of Trustees meets or when holding a hearing under G.S. 135-39.7, and travel allowances under G.S. 138-6 when traveling to and from meetings of the Board of Trustees or hearings under G.S. 135-39.7, but shall not receive any subsistence allowance or per diem under G.S. 138-5.

(g) No State employee, member of the General Assembly, State officer, or anyone who is receiving benefits under the Plan or who is eligible to receive benefits under the Plan or who provides services, equipment or supplies under the Plan shall be eligible for membership on the Board of Trustees.

(h) No member of the Commission may serve more than three consecutive two-year terms.

"**§ 135-39.1. Auditing of the Plan. —** The State Auditor shall annually audit the Plan Administrator and the Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan, including the two special funds established under G.S. 135-39.6.

"**§ 135-39.2. Officers, quorum, meetings. —** (a) The Board of Trustees shall elect from its own membership for a one-year term a chairman and vice-chairman, and shall elect a secretary.

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

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

"**§ 135-39.3. Oversight team. —** (a) The Legislative Services Officer shall designate two employees of the Fiscal Research Division, and the Director of the Budget shall designate two employees of the Office of State Budget and Management as an oversight team, to monitor the Board of Trustees, the Plan Administrator, and the Comprehensive Major Medical Plan.

(b) The oversight team shall, jointly or individually, have access to all records of the Board of Trustees, the Plan Administrator, and the Comprehensive Major Medical Plan. They shall, jointly or individually, be entitled to attend all meetings of the Board of Trustees.

(c) The oversight team shall report to the Committee on Employee Hospital and Medical Benefits when requested by the Committee.

"**§ 135-39.4. Selection of Plan Administrator. —** (a) The General Assembly requests, authorizes and directs the State Budget Officer to select the lowest responsible bidder on a per transaction basis from the proposals submitted April 8, 1982, to the Division of Purchase and Contract, North Carolina Department of Administration and opened April 14, 1982, in response to Request for Proposals #2-V04-01, as the Plan Administrator to administer the Comprehensive Major Medical Plan described in Part 3 of this Article for the period October 1, 1982, through September 30, 1986, on an Administrative Services only basis. Upon ratification of this act, the State Budget Officer may authorize the Plan Administrator selected pursuant to this paragraph to begin preparatory work.

(b) The Board of Trustees shall contract with the Plan Administrator under the Terms and Conditions of the Request for Proposals dated February 15, 1982, by the Department of Administration, Division of Purchase and Contract, as amended or clarified by Addendum Number 1 of March 2, 1982; Addendum Number 2 of March 4, 1982; and Addendum Number 3 of March 15, 1982, as long as the Plan Administrator contracts as proposed in the offer in response to the request for proposal.

(c) Modifications from the request for proposal and the offer made in response may be made by the Board of Trustees, but such modification may not change any of the provisions of the Comprehensive Major Medical Plan provided in Part 3 of this Article except to correct a typographical error, or except as provided in subsection (e). No modification may be made without prior consultation with the Committee on Employee Hospital and Medical Benefits.

(d) Notwithstanding the provisions of Part 3 of this Article, the Board of Trustees shall negotiate cost-containment measures with the Plan Administrator, which, in case of conflict with Part 3, shall prevail.

(e) If the Board of Trustees determines that the annualized cost of the plan will exceed the amount budgeted, it may, after consultation with the Committee on Employee Hospital and Medical Benefits and after receiving the advice of the Committee, modify the benefits under Part 3 of this Article to reduce the costs to that level.

"**§ 135-39.5. Powers and duties of the Board of Trustees. —** The Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan shall have the following powers and duties:

(1) Supervising and monitoring of the Plan Administrator.
(2) Providing for enrollment of employees in the Plan.
(3) Communicating with employees enrolled under the Plan.
(4) Communicating with health care providers providing services under the Plan.
(5) Making payments at appropriate intervals to the Plan Administrator for benefit costs and administrative costs.
(6) Conducting administrative reviews under G.S. 135-39.7.
(7) Annually assessing the performance of the Plan Administrator.
(8) Preparing and submitting to the Governor and the General Assembly cost estimates for the health benefits plan.
(9) Recommending to the Governor and the General Assembly changes or additions to the health benefits program and health care cost containment programs.
(10) Working with State employee groups to improve health benefit programs.
(11) Employing such clerical, professional staff, and other such assistance as may be necessary to assist the Board of Trustees in carrying out its duties and responsibilities under this Article provided that all such action under this subdivision must have the approval of the State Budget Officer after consultation with the Committee on Employee Hospital and Medical Benefits.
(12) Determining basis of payments to health care providers.
(13) Requiring bonding of the Plan Administrator in the handling of State funds.
(14) Establishing advisory councils of beneficiaries and providers.
(15) In case of termination of the contract under G.S. 135-39.5A, or failure to contract under G.S. 135-39.4(b), to select a new Plan Administrator, after competitive bidding procedures approved by the Department of Administration.

"**§ 135-39.5A. Termination. —** The Board of Trustees may terminate the contract with the Plan Administrator as provided in the request for proposal.

"**§ 135-39.5B. Pre-Paid Plan**. — The Board of Trustees may, after consultation with the Committee on Employee Hospital and Medical Benefits, provide for an optional pre-paid hospital and medical benefits plan, but the amount of State funds shall be the same as for each person eligible on a noncontributory basis, with the person paying any excess, if necessary.

"**§ 135-39.6. Special funds created. —** (a) There are hereby established two special funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund.

All premiums, fees, charges, rebates, refunds or any other receipts including, but not limited to, earnings on investments, occurring or arising in connection with health benefits programs established by this Article, shall be deposited into the Public Employee Health Benefit Fund. Disbursements from the Fund shall include any and all amounts required to pay the benefits and the administrative costs of such programs and the administrative costs of the investment programs established herewith in accordance with G.S. 147-69.2 and 69.3.

Any unencumbered balance in excess of prepaid premiums or charges in the Public Employee Health Benefit Fund at the end of each fiscal year shall be used first, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented claims, second, to reduce the premiums required in providing the benefits of the health benefits programs, and third to improve the Plan, as may be provided by the General Assembly. The balance in the Health Benefits Reserve Fund may be transferred from time to time to the Public Employee Health Benefit Fund to provide for any deficiency occurring therein.

The Public Employee Health Benefit Fund and the Health Benefit Reserve Fund shall be deposited with the State Treasurer and invested as provided in G.S. 147-69.2 and 69.3.

(b) Disbursements from the Public Employee Health Benefit Fund may be made by warrant drawn on the State Treasurer by the Commission, or the Commission may by contract authorize the Plan Administrator to draw the warrant.

"**§ 135-39.6A. Premiums set. —** The Board of Trustees shall, from time to time, establish Premium Rates for the Comprehensive Major Medical Plan, and establish regulations for payment of the premiums.

"**§ 135-39.7. Administrative review. —** If, after exhaustion of internal appeal handling as outlined in the contract with the Plan Administrator any person is aggrieved, the Plan Administrator shall bring the matter to the attention of the Board of Trustees, which may make a binding decision on the matter in accordance with procedures established by the Board of Trustees.

"**§ 135-39.8. Rules and regulations. —** The Board of Trustees may issue rules and regulations to implement Parts 2 and 3 of this Article.

"**§ 135-39.9. Reports to the General Assembly. —** (a) The Board of Trustees shall report to the General Assembly at such times and in such forms as shall be provided by the Committee on Employee Hospital and Medical Benefits.

(b) The Board of Trustees shall report to the Committee on Employee Hospital and Medical Benefits no later than April 1, 1983 on the status of the Plan as of February 28, 1983.

(c) The Board of Trustees shall continually monitor expenditures under the Plan, and at any time it estimates that expenditures on an annualized basis will exceed one hundred twenty million dollars ($120,000,000) it shall report that fact to the Committee on Employee Hospital and Medical Benefits.

"PART 3. Comprehensive Major Medical Plan.

"**§ 135-40. Undertaking. —** (a) The State of North Carolina undertakes to make available a Comprehensive Major Medical Plan (hereinafter called the 'Plan') to employees, retired employees and certain of their dependents which will pay benefits in accordance with the terms hereof.

(b) The Plan benefits will be provided under contracts between the State and the Plan Administrator selected by the State. Plan Administrator refers to the administrator, third party administrator or other party contracting with the State to administer the Plan benefits. Such

contracts shall include the substance of G.S. 135-40.1 through G.S. 135-40.13 and Parts I through K of the description of Plan in the request for proposal, and shall be administered by the respective Plan Administrator of the State which will determine benefits and other questions arising thereunder. The contracts necessarily will conform to applicable State laws. If any of the provisions of G.S. 135-40.1 through G.S. 135-40.13 and Parts I through K must be modified for inclusion in the contract because of State laws, such modification will be made.

(c) Payroll deduction shall be available for coverage under this Part of amounts not paid by the State.

"**§ 135-40.1. General definitions. —** As used in Parts 2 and 3 of this Article, the following terms have the meanings specified as follows:

(1) 'Employee' – Any permanent full-time or permanent part-time regular employee (designated as half-time or more) of an employing unit.

(2) 'Retired Employee' – Retired teachers and State employees who are receiving monthly retirement benefits from any retirement system supported in whole or in part by contribution of the State of North Carolina, so long as the retiree is enrolled.

(3) 'Dependent Child' – A natural, legally adopted, or foster child of the employee and/or spouse, unmarried, up to the first of the month following his or her 19th birthday, whether or not the child is living with the employee, as long as the employee is legally responsible for such child's maintenance and support.

A foster child is covered (1) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (2) if at the time of enrollment, or at the time a foster child relationship is established, whichever occurs first, the employee applies for coverage for such child and submits evidence of a bona fide foster child relationship, identifying the foster child by name and setting forth all relevant aspects of the relationship, (3) if the Plan Administrator accepts the foster child as a participant through a separate written document identifying the foster child by name and specifically recognizing the foster child relationship, and (4) if at the time a claim is incurred, the foster child relationship, as identified by the employee, continues to exist. Children placed in a home by a welfare agency which obtains control of, and provides for maintenance of, the child(ren), are not eligible participants.

Coverage may be extended beyond the 19th birthday under the following conditions:

a. If the dependent is a full-time student who is pursuing a course of study that represents at least the normal workload of a full-time student at a school or college accredited by the state of jurisdiction.

b. The dependent is physically or mentally incapacitated to the extent that he or she is incapable of earning a living.

(4) 'Hospital' – An institution which meets fully all the following criteria:

a. A general medical and surgical hospital, including eye, ear, nose and throat, maternity, pediatric, tuberculosis, or mental hospital, licensed as such by the applicable State agency.

b. It is primarily engaged in providing—for compensation from its patients and on an inpatient basis—diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians;

c. It continuously provides 24-hour-a-day nursing service by registered graduate nurses; and

d. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, a hotel, or the like. Hospitals classified and accredited as psychiatric hospitals by the Joint Commission on Accreditation of Hospitals will be deemed to be hospitals for the purpose of this Plan.

(5) 'Doctor' – A doctor of medicine, a doctor of osteopathy licensed to practice medicine or surgery by the Board of Medical Examiners of the state in which he or she practices, a doctor of dentistry, a doctor of podiatry or surgical chiropody, a doctor of optometry, a doctor of chiropractic, or a doctor of psychology who is licensed or certified in the State and has a doctorate practice degree in psychology and at least two years' clinical experience in a recognized health setting or has met the standards of the National Register of Health Services provided in psychology, each of whom is licensed to practice by the state in which he or she performs any service covered by this Plan, and who regularly charges and collects fees in his or her own right.

(6) 'Pregnancy' – Shall include resulting childbirth, miscarriage or abortion.

(7) 'Usual, Customary and Reasonable' – The meaning of the term 'UCR' shall be developed from criteria used for determining reasonable charges for services, including usual preoperative examination and customary postoperative care and care of usual complications, and shall be based on the usual charge made by an individual doctor for his or her private patients for a particular service, or the customary charge within the range of usual fees charged by most doctors of similar skill and training in North Carolina for a comparable service, whichever is the lower. A fee is reasonable if it meets the above two criteria. In cases of unusual complexity and cases involving supplemental skills of two or more doctors, reasonable charges will be determined by the Plan Administrator upon advice of its medical advisors.

(8) 'Employing Unit' – A North Carolina School System; Technical Institute; Community College; State Department, Agency or Institution; Administrative Office of the Courts; or Association or Examining Board whose employees are eligible for membership in the Teachers' and State Employees' Retirement System.

(9) '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.

(10) 'Skilled Nursing Facility' – An institution licensed under applicable State laws and primarily engaged in providing to inpatients, under the supervision of a doctor and a registered professional nurse, skilled nursing care and related services on a 24-hour basis, and rehabilitative services.

(11) 'Covered Services' – Any 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 shall be synonymous with allowable expenses.

(12) 'Deductible' – Deductible shall mean an amount of covered expenses during a calendar year which must be incurred after which benefits (subject to the

deductible) become payable. The deductible for an employee, retired employee and/or his or her dependents shall be one hundred dollars ($100.00) for each calendar year.

Covered expenses incurred during the last three months of a calendar year and used toward satisfying the deductible in that calendar year may be reused toward satisfying the deductible for the next calendar year.

The deductible applies separately to each covered individual in each calendar year, except that a maximum of three such deductibles shall apply to each family (employee or retiree and his or her covered dependents) in any calendar year.

If two or more family members are injured in the same accident only one deductible is required for charges related to that accident during the benefit period.

(13) 'Medicare' – The Health Insurance For The Aged and Disabled Program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97), as such program is currently constituted and as it may be later amended.

(14) 'Preexisting condition' – A condition, disease, illness or injury which existed or had its beginning to any degree, whether diagnosed or not, prior to the effective date of coverage.

(15) 'Predecessor Plan' – The Hospital and Medical Benefits for the Teachers' and State Employees' Retirement System of the State of North Carolina.

(16) 'Enrollment' – New employees enroll themselves and their dependents when first eligible. 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.

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

(18) 'Home Health Care Agency' – An agency which is constituted, licensed and operated in accordance with the laws pertaining to agencies providing home health care.

(19) 'Home Health Aide' – An individual who provides medical or therapeutic care and who reports to and is under the direct supervision of a Home Health Care Agency.

"**§ 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.

(2) Retired teachers and State employees.

(3) Surviving spouses of deceased retirees and surviving spouses (of deceased teachers and State employees), receiving a survivor's alternate benefit under G.S. 135-5(m).

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

(1) Members of the General Assembly.

(2) Former members of the General Assembly.

(3) Surviving spouses of deceased former members of the General Assembly.

(4) All permanent part-time employees (designated as half-time or more) of an employing unit who meet the conditions outlined in subdivision (a)(l)a. above.

(5) The spouses and eligible dependents of enrolled employees, retirees and enrolled members and enrolled surviving spouses, as outlined in subdivisions (a)(1) through (a)(3) above.

(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 (1) employee or retired employee at the same time.

(d) Former employees who are receiving Disability Retirement Benefits 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.

(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.

"**§ 135-40.3. Effective dates of coverage. —** (a) Employees and Retired Employees.

(1) Employees and retired employees covered under the Predecessor Plan will continue to be covered, subject to the terms hereof.

(2) New employees may apply for coverage to be effective on the first day of the month following employment, or on a like date the following month if the employee has enrolled.

(3) Late entrants, employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month but will be subject to a 12-month waiting period for preexisting health conditions.

(b) Waiting Periods and Preexisting Conditions. New employees and dependents enrolling when first eligible:

(1) Comprehensive Medical Coverage – no waiting periods for preexisting conditions.

(2) Employees not enrolling or not adding dependents when first eligible may enroll later on the first of any following month, but will be subject to the following:

(3) Comprehensive Medical Coverage – 12-month waiting period for preexisting conditions.

(c) Dependents of Employees and Retired Employees.

(1) Dependents of employees and retired employees who have family coverage under the Predecessor Plan will continue to be covered subject to the terms hereof.

(2) Employees who have dependents may apply for family coverage at the time they enroll as provided in subdivisions (a)(2) and (a)(3) and such dependents will be covered under the Plan beginning the same date as such employees.

(3) Employees and retired employees may change from individual to family coverage 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 Plan Administrator.

(4) Employees who wish to change from family coverage to individual coverage shall give written notice to the Plan Administrator within 31 days after any change in the status of dependents, (resulting from death, divorce, etc.) which requires a change from family coverage to individual coverage.

(5) Employees not adding dependents when first eligible may enroll later on the first of any following month, but dependents will be subject to a 12-month waiting period for preexisting health conditions.

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

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

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

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

(4) Split Coverage-Wife – Covers female State employee whose husband is also employed by the State, and who enrolls in (5). Maternity benefits provided.

(5) Split Coverage-Husband – Covers male State employee whose wife is also employed by the State, and who enrolls in (4). (Also covers dependent children).

"**§ 135-40.4. Benefits in general. —** In the event a covered person, as a result of accidental bodily injury, disease or pregnancy, incurs covered expenses, the Plan will pay benefits up to the amounts described in G.S. 135-40.5 through G.S. 135-40.9.

The Plan is divided into two parts. The first part includes certain benefits which are not subject to a deductible or coinsurance. The second part is a comprehensive Plan and includes those benefits which are subject to both a one hundred dollar ($100.00) deductible for each covered individual to a maximum of three deductibles per family and coinsurance of 95% / 5%. There is a limit on out-of-pocket expenses under the second part.

"**§ 135-40.5. Benefits not subject to deductible or coinsurance. —** (a) Accidental Injury. The Plan pays one hundred percent (100%) of services rendered in outpatient department of a hospital, in a doctor's office, in an ambulatory surgical facility or elsewhere and one hundred percent (100%) of reasonable and customary charges for doctor's services rendered in any of the above when such services are rendered within 30 days of the actual occurrence of injury and provided treatment is initiated within five days of injury occurrence. Dental services are excluded except as specifically included in G.S. 135-40.6(e)(3). This benefit is subject to a three hundred dollar ($300.00) annual maximum per covered individual. Benefits in excess of three hundred dollars ($300.00) are covered under the comprehensive part of the Plan.

(b) Ambulatory (Outpatient) Surgery. The Plan will pay one hundred percent (100%) of reasonable and customary charges for facility and surgeon's charges for surgery performed in an ambulatory surgical facility. Medical supplies, drugs, laboratory and other ancillary services and physicians' services will be covered under the comprehensive section of the Plan.

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

(d) Second Surgical Opinions. The Plan will pay one hundred percent (100%) of reasonable and customary charges for one presurgical consultation by a second surgeon 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.

"**§ 135-40.6. Benefits subject to deductible and coinsurance (comprehensive benefits). —** The following benefits are subject to a deductible of one hundred dollars ($100.00) per covered individual to a maximum of three per family and are payable on the basis of ninety-five percent (95%) by the Plan and five percent (5%) by the covered individual up to a maximum of one hundred dollars ($100.00) out-of-pocket per calendar year:

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

Successive admissions: While the covered individual is continuously covered under this Plan, shall be considered a single confinement for this purpose, if discharge and readmission to the same or any other hospital or skilled nursing facility shall occur within 90 days, whether or not benefits are paid for such admissions.

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

(1) Intensive and cardiac nursing care.
(2) All recognized drugs and medicines for use in the hospital.
(3) Radiation services, including diagnostic x-rays, x-ray therapy, radiation therapy and treatment.
(4) Clinical and pathological laboratory examinations.
(5) Electrocardiograms and electroencephalograms.
(6) Physical therapy.
(7) Intravenous solutions.
(8) Oxygen and oxygen therapy, plus the use of equipment.
(9) Dressings, ordinary splints, plaster casts and sterile supplies.
(10) Use of operating, delivery, recovery and treatment rooms and equipment.
(11) Routine nursery charges, if the mother is eligible to receive maternity benefits.
(12) Anesthetics and the administration thereof by the hospital's employee anesthesiologist.
(13) Devices or appliances surgically inserted within the body.
(14) Processing and administering of blood and blood plasma, but not including the supplying of blood or plasma.
(15) Children who are born under the coverage type (2), (3), or (5), as outlined in G.S. 135-40.3(d), and who remain continuously covered are entitled to benefits for treatment of illnesses or congenital defect, incubation or isolette care, and treatment of prematurity or postmaturity.
If the mother is a covered individual, benefits are provided for the newborn's circumcision and routine nursery care.
(16) 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.
(17) 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.
(18) Thirty days per calendar year are provided for inpatient treatment of mental illness, alcoholism and drug addiction, or any combination thereof. Readmission for any of these conditions within 365 days of last discharge shall be considered a single confinement. When furnished to a patient in a skilled nursing facility, 30 days less the days of care already provided for the same illness in a hospital are provided.

(b) Limitations and exclusions to in-hospital benefits.
(1) The services of physicians, surgeons and technicians not employed by or under contract to the hospital are not covered.

(2) Any admission for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis, if no hospitalization would have been required except for such diagnostic services is not covered. However, benefits are provided at ninety-five percent (95%) of Plan benefits for diagnostic tests and procedures consistent with the symptoms or diagnosis for which admitted.

(3) The Plan will not cover any admission to a hospital prior to the effective date of coverage or beginning prior to the expiration of any waiting period so long as the individual remains continuously in a hospital.

(4) Hospitalization for custodial, domiciliary or sanitarium care, or rest cures, is not covered.

(5) Hospitalization for dental care and treatment is not covered, except when a hospital setting is medically necessary.

(c) Skilled nursing facility benefits. The Plan will pay benefits in a skilled nursing facility which qualifies for delivery of benefits under Title XVIII 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 (a) of this section, less the days of care already provided for the same illness in a hospital.

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:

(1) The services are medically required to be given on an inpatient basis because of the covered individual's need for skilled nursing care on a continuing basis for any of the conditions for which he or she was receiving inpatient hospital services prior to transfer from a hospital to the skilled nursing facility or for a condition requiring such services which arose after such transfer and while he or she was still in the facility for treatment of the condition or conditions for which he or she was receiving inpatient hospital services, and

(2) Only on prior referral by and so long as, the patient remains under the active care of an attending doctor.

(d) Outpatient hospital benefits. The Plan pays for services rendered in the outpatient department of a hospital, in a doctor's office, in an ambulatory surgical facility, or elsewhere, as follows:

(1) Accidental injury: When services are furnished within 30 days of the actual occurrence of injury and provided treatment is initiated within five days of injury occurrence. Dental services are excluded except for oral surgery specifically listed in subsection (e)(3) of this section. The first three hundred dollars ($300.00) of these charges are covered under the first dollar part of the Plan.

(2) All hospital services for nonaccident operative procedures.

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

(4) All hospital services in connection with pathological examinations of tissue removed by resection or biopsy. Routine Pap smears are not covered.

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

No benefits are provided for screening examinations and routine physical examinations to assess general health status in the absence of specific symptoms of active illness, routine office visits or for doctor's services for diagnostic procedures covered under Surgical Benefits.

(e) Surgical Benefits. The Plan pays the usual, customary and reasonable charges for covered surgical services as follows:

(1) Surgery: Cutting procedures, treatment of fractures, transfusions, operative preparation for diagnostic x-ray examinations, surgical implantation of radiation sources, major endoscopic examinations, biopsies, surgical sterilization, other standard services and operations.

(2) Anesthesia: Administration of general, spinal block or local anesthesia. Covered services include pre- and postoperative visits, the administration of the anesthetic, fluids and/or blood provided by the anesthesiologist and incidental to the anesthesia, and necessary drugs and materials provided by the anesthesiologist. No benefits are provided for administration of local anesthesia or for anesthesia administered by the operating surgeon or surgical assistant(s).

(3) Oral Surgery: Services which are within the scope of practice of both a doctor of medicine and a dentist, such as excision of tumors and lesions of the mouth, treatment of jaw fractures and surgery to correct injuries of the mouth structure other than teeth and their supporting structure.

(4) Maternity Care: Independent operative procedures in connection with pregnancy, such as: manipulative obstetrical delivery, delivery by Caesarean section, removal of ectopic pregnancy, dilation and curettage. Benefits for manipulative obstetrical delivery include use of forceps and or episiotomy. No benefits are provided for antepartum or postpartum care, except for direct surgical procedures of delivery and surgical treatment.

(5) Surgical Assistants: Services of an assistant surgeon when medical judgment requires the services of an assistant surgeon and no hospital- employed doctor in training is available.

(6) Multiple Procedures: When multiple or bilateral surgical procedures are performed by the same doctor through separate incisions or approaches during the same session, the surgical benefits will be the greater UCR allowance, plus fifty percent (50%) of the lesser UCR allowance. Anesthesia benefits will be the greater UCR allowance.

When multiple surgical procedures are performed by the same doctor through the same incision or operative approach, the surgical benefits are limited to the procedure which has the highest UCR allowance.

When a surgical procedure is performed in two or more stages, the surgical benefit for the entire procedure is the same as it would be were the procedure performed in one stage (except where otherwise provided in the benefit schedule). This limitation does not apply to anesthesia benefits.

(f) Limitations and Exclusions to Surgical Benefits.

(1) No benefits are provided for dental prostheses such as crowns, or dentures; orthodontic care; operative restoration of teeth (fillings); dental extractions (whether impacted or not impacted); apicoectomies; treatment of dental caries, gingivitis, or periodontal diseases by gingivectomies or other

periodontal surgery; vestibuloplasties, alveoplasties, removal of exostosis and tori preparatory to fitting of dentures; correction of malocclusion by orthognathic surgery or other procedures by repositioning of bone tissue; removal of cysts incidental to apicoectomies or extraction of teeth.

(2) Cosmetic surgery or surgery solely for beautifying purposes is not covered, except for procedures related to injury sustained while the individual is continously covered under the Plan.

(3) If a covered individual receives both medical and surgical treatment for the same condition, by the same doctor, either medical or surgical care may be paid, whichever is greater, but not both.

(4) When a covered individual is admitted for medical treatment and during the hospital admission is subsequently referred to another doctor for surgery, medical benefits are provided for hospital days prior to the date of referral.

(5) If during hospital admission for necessary medical treatment, surgery is provided for a wholly distinct and unrelated condition, both medical and surgical benefits are payable, however, the same doctor may not be paid both medical and surgical benefits provided on the same day.

(6) If during hospital admission for necessary medical treatment, a covered individual receives related surgical procedures such as paracentesis, biopsy, endoscopy, operative preparation for x-ray examination, or other diagnostic procedures for which benefits are applicable under the surgical benefits section of the Plan, both medical and surgical benefits are payable.

(7) No benefits are provided for concurrent co-attending medical and surgical care by two or more doctors for the same condition other than as provided above.

(8) No benefits will be payable for any surgical procedure specifically listed by the American Medical Association or the North Carolina Medical Association as having no medical value.

(g) Medical Benefits.

(1) Services of Doctors. The Plan pays the usual, reasonable and customary charges for covered inpatient medical (nonsurgical) services. Services are covered if the individual is hospital confined and is eligible for hospitalization benefits as described in this section. Benefits are provided for exactly the same number of days as the individual is entitled to under this section, except that medical benefits are provided on both the day of admission and the day of discharge.

In the event a covered individual is treated by two or more co-attending doctors during the same hospital confinement for a medical (nonsurgical) condition, benefits are limited to payment for services provided by the primary attending doctor, except where need is established for supplementary skills for treatment of separate and distinct diagnoses or conditions.

Home, office, and skilled nursing facility visits including (i) charges for injected medications, (ii) inpatient care by attending medical doctors, radiologists, pathologists, and consultants during such time as hospital benefits are paid under any section of this Plan, (iii) care in the outpatient department of a hospital, and (iv) administration of shock therapy (drug or electric) including the services of anesthesiologists provided on an office or hospital outpatient basis for treatment of acute psychotic reaction or severe depression.

(2) Consultations. Consultation services are provided when requested by the attending doctor and the consultation is necessary in conjunction with and directly related to care and treatment of the condition for which admitted. No benefits are provided for staff consultation required by hospital rules and regulations. When a covered individual is admitted for oral surgery, a single consultation allowance will be provided for medical examination and pre-anesthesia evaluation.

(3) Newborn Care. When a child is eligible at birth, benefits are provided for treatment of illness, injury, prematurity, or congenital condition as a registered inpatient. When delivery is by Caesarean section, a single consultation allowance will be provided for standby, resuscitation, and infant care in the operating room provided by a doctor other than the operating surgeon.

When a mother receives maternity benefits under the Plan for a child's delivery, benefits are provided for examination and supervision of a normal newborn infant.

(4) Outpatient Psychiatric Care. The Plan will pay eighty percent (80%) UCR for outpatient psychiatric care, not to exceed 50 visits and two thousand two hundred dollars ($2,200) per calendar year. This benefit is subject to the one hundred dollar ($100.00) deductible. Payments made for this benefit are not eligible towards the maximum out-of-pocket expenditure.

(h) Other Covered Charges.

(1) Prescription Drugs: Prescription legend drugs for use outside of a hospital or skilled nursing facility. A prescription legend drug is defined as an article the label of which, under the Federal Food, Drug, and Cosmetic Act, is required to bear the legend: 'Caution: Federal Law Prohibits Dispensing Without Prescription.' Such articles may not be sold to or purchased by the public without a prescription order. Benefits are provided for insulin even though prescription is not required.

(2) Private Duty Nursing: Services of licensed nurses (not immediate relatives or members of the participant's household or private duty nursing used in lieu of or as a substitute for hospital staff nurses) ordered by the attending doctor for a condition requiring skilled nursing services.

(3) Visiting Nurse Association or Home Health Agency Services: Services provided in a covered individual's home by an association, agency, or other organization.

(4) Licensed Ambulance Service. Local ambulance transportation:

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

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

From a hospital to a skilled nursing facility.

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

(5) Prosthetic and Orthopedic Appliances and Durable Medical Equipment: Appliances and equipment including corrective and supportive devices such as artificial limbs and eyes, wheelchairs, traction equipment, inhalation therapy and suction machines, hospital beds, braces, orthopedic corsets and trusses, and other prosthetic appliances or ambulatory apparatus which are provided solely for the use of the participant. Eligible charges include repair and replacement when medically necessary. Benefits will be provided on a

rental or purchase basis at the sole discretion of the Administrator and agreements to rent or purchase shall be between the Administrator and the supplier of the appliance.

(6) Dental Services: Dental surgery and appliances for mouth, jaw, and tooth restoration necessitated because of external violent and accidental means, such as the impact of moving body, vehicle collision, or fall occurring while an individual is covered under G.S. 135-40.3. No benefits are provided in connection with injury incurred in the act of chewing, nor for damage or breakage of an appliance such as bridge or denture being cleaned or otherwise not in normal mouth usage at the time of accident.

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

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

(8) Blood: Transfusions including cost of blood, plasma, or blood plasma expanders.

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

(10) Inhalation Therapy: When provided by a doctor, hospital, or other organization.

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

(i) Limitations and exclusions to other covered charges. No benefits are available under this section of the Plan until full utilization is made of similar benefits available under other sections of this Plan.

No benefits will be payable for:

(1) Private duty nursing provided by an immediate relative or member of the covered individual's household; or private duty nursing used in lieu of or as a substitute for hospital staff nurses;

(2) Dental care except as covered under subsection (b)(6) and other dental services covered by the Surgical Benefits section of this Plan, subsection (e)(3) of this section;

(3) Foot care except in connection with services covered by the Surgical or Inpatient Medical Benefits section of this Plan, subsections (a) and (e) of this section;

(4) Immunizations for prevention of contagious diseases;

(5) Expenses incurred in the event a covered individual is a bed patient in a hospital, or skilled nursing facility on the effective date of coverage, so long as the covered individual remains so confined;

(6) Eyeglasses (corrective lenses), hearing aids, braces for teeth, dental plates or bridges or other dental prostheses, air-conditioners, vaporizers, humidifiers, nebulizers, mattresses (other than as supplied with a hospital bed) and specially built shoes (other than attached to artificial limbs or orthopedic braces);

(7) The difference between charges made by doctors and the UCR allowance for covered benefits, and the coinsurance expenses required under this Plan;
(8) Habit forming drugs to support drug dependency;
(9) Any other services not specifically outlined in this Plan.

"**§ 135-40.7. General limitations and exclusions. —** The following shall in no event be considered covered expenses nor will benefits described in G.S. 135-40.5 through G.S. 135-40.11 be payable for:

(1) Charges for any services rendered to a person prior to the date coverage under this Plan becomes effective with respect to such person.
(2) Charges for care in a nursing home, home for the aged, or convalescent home for custodial or domiciliary care or for rest cures.
(3) Charges to the extent paid, or which the individual is entitled to have paid, or to obtain without cost, in accordance with any government laws or regulations except Medicare. If a charge is made to any such person which he or she is legally required to pay, any benefits under this Plan will be computed in accordance with its provisions, taking into account only such charge. 'Any government' includes the federal, State, provincial or local government, or any political subdivision thereof, of the United States, Canada or any other country.
(4) Charges for services rendered in connection with any occupational injury or disease arising out of and in the course of employment with any employer, if (1) the employer furnishes, pays for or provides reimbursement for such charges, or (2) the employer makes a settlement payment for such charges, or (3) the person incurring such charges waives or fails to assert his or her rights respecting such charges.
(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 necessary treatment of the injury or disease.
(6) Charges for any services rendered as a result of injury or sickness due to an act of war, declared or undeclared, which act shall have occurred after the effective date of a person's coverage under the Plan.
(7) Charges for personal services such as barber services, guest meals, radio and TV rentals, etc.
(8) Charges for any services with respect to which there is no legal obligation to pay. For the purposes of this item, any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by any person for anything which is normally or customarily furnished by such person without payment from the recipient or user thereof shall also be treated as a charge for which there is no legal obligation to pay.
(9) Charges during a continuous hospital confinement which commenced prior to the effective date of the person's coverage under this Plan.
(10) Charges in excess of either the usual, customary and reasonable charge for or the fair and reasonable value of the services or supply which gives rise to the expense; provided that in each instance the extent that a particular charge is usual, customary and reasonable or fair and reasonable shall be measured and determined by comparing the charge with charges made for similar things to individuals of similar age, sex, income and medical condition in the locality concerned, and the result of such determination shall constitute the maximum allowable as Covered Medical Expenses unless the Plan

Administrator finds that considerations of fairness and equity in a particular set of circumstances require that greater or lesser charges be considered as Covered Medical Expenses in that set of circumstances.

(11) Charges for or in connection with any dental work or dental treatment except to the extent that such work or treatment is specifically provided for under the Plan. Excluded is payment for surgical benefits for tooth replacement, such as crowns, bridges or dentures; orthodontic care; filling of teeth; extraction of teeth (whether or not impacted); root canal therapy; removal of root tips from teeth; treatment for tooth decay, inflammation of gingiva, or surgical procedures on diseased gingiva or other periodontal surgery; repositioning soft tissue, reshaping bone, and removal of bony projections from the ridges preparatory to fitting of dentures; removal of cysts incidental to removal of root tips from teeth and extraction of teeth; or other dental procedures involving teeth and their bones or tissue supporting structure. This exclusion also applies to any orthognathic procedures.

(12) Charges incurred for any medical observations or diagnostic study when no disease or injury is revealed, unless proof satisfactory to the Plan Administrator is furnished that (i) the claim is in order in all other respects, (ii) the covered individual had a definite symptomatic condition of 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.

(13) Charges for eyeglasses and hearing aids or examinations for the prescription or fitting thereof.

(14) Charges for cosmetic surgery or treatment except that charges for cosmetic surgery or treatment required for correction of damage caused by accidental injury sustained by the covered individual while this insurance or its Predecessor Plan is in force on his or her account or to correct congenital deformities or anomalies shall not be excluded if they otherwise qualify as covered medical expenses.

(15) Admissions for diagnostic tests or procedures which could be, and generally are, performed on an outpatient basis and inpatient services or supplies which are not consistent with the diagnosis, for which admitted.

(16) Costs denied by the Plan Administrator as part of its overall program of claim review and cost containment.

"**§ 135-40.8. Out-of-pocket expenditures. —** For the balance of any calendar year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays ninety-five percent (95%) of the eligible expenses outlined in G.S. 135-40.6. The covered individual is then responsible for the remaining five percent (5%) until one hundred dollars ($100.00), in excess of the deductible, has been paid out-of-pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses.

"**§ 135-40.9. Maximum benefits. —** The maximum lifetime benefit for each covered individual will be five hundred thousand dollars ($500,000).

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

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

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

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

"**§ 135-40.11. Cessation of coverage. —** (a) Coverage under this Plan of an employee and his or her dependents or of a retired employee and his or her dependents shall cease on the earliest of the following dates:

(1) The day after the employee or retired employee dies. Any surviving dependents may then elect to continue the same coverage under the Plan by submitting written application within 30 days after the death of the employee or retired employee, to the Plan Administrator and by paying the cost for such coverage when due at the applicable fees. Such coverage shall cease on the last day of the month in which such surviving dependent dies.

(2) The last day of the month in which an employee's employment with the State is terminated as provided in subsection (c) of this section.

(3) The day a divorce becomes final.

(4) The last day of the month in which an employee or retired employee requests cancellation of coverage.

(5) The last day of the month in which a covered individual enters active military service.

(b) Coverage under this Plan as a dependent child shall cease as of the last day of the month in which such person marries, attains age 19 and is not a full- time student, ceases to be physically or mentally incapacitated after he or she was certified to be covered beyond age 19, or ceases to be a full-time student.

(c) Termination of employment shall mean termination for any reason, including layoff and leave of absence, except as provided in (a)(1) and (2) of this section, but shall not, for purposes of this Plan, include retirement upon which the employee is granted an immediate service or disability pension under and pursuant to the Teachers' and State Employees' Retirement System of North Carolina.

(1) In the event of termination for any reason, coverage under this Plan for an employee and his or her dependents may be continued for a period of not more than three months. The employee must have been covered under this Plan for at least three months in order to be eligible for this extension. Also, the employee must pay in advance to the employer the total cost of the Plan for the length of the extension.

This provision will be preempted when the individual becomes eligible for any other group coverage.

(2) In the event of layoff, coverage under this Plan for an employee and his or her dependents may be continued for a period of not more than 12 months by the employee's paying one hundred percent (100%) of the cost.

(3) In the event of approval leave of absence without pay, other than for active duty in the armed forces of the United States, coverage under this Plan for an employee and his or her dependents may be continued during the period of such leave of absence by the employee's paying one hundred percent (100%) of the cost.

(4) If employment is terminated in the second half of a calendar month and the covered individual has made the required contribution for any coverage in the following month, that coverage will be continued to the end of the calendar month following the month in which employment was terminated.

(5) Employees paid for less than 12 months in a year, who are terminated at the end of the work year and who have made contributions for the non-work months, will continue to be covered to the end of the period for which they have made contributions, with the understanding that if they are not employed by another State-covered employer under this Plan at the beginning of the next work year, the employee will refund to the ex-employer the amount of the employer's cost paid for them during the non-paycheck months.

(d) No benefits will be paid by this Plan for any expenses incurred or treatment received after cessation of coverage as provided in subsections (a) or (b) of this section, except that in the event of hospital confinement at that time, hospitalization benefits as described in G.S. 135-40.6 will continue to the extent provided therein.

"**§ 135-40.12. Conversion. —** (a) Upon cessation of coverage due to termination of employment, an employee or dependent will be entitled to convert to nongroup coverage without the necessity of a physical examination, and on a fully contributory basis. Such coverage will include hospitalization, surgical and medical benefits similar in scope to those provided under the Plan. The Board of Trustees, after consultation with the Committee on Employee Hospital and Medical Benefits shall approve the conversion plan, which shall be administered by the Plan Administrator through an insurance contract arranged by the Plan Administrator, or administered as otherwise directed by the Board of Trustees. The eligible individual must apply for coverage within 30 days after termination of group eligibility.

(b) The Board of Trustees shall provide for the continuation of conversion privilege exercised under the predecessor plan, on a fully contributory basis. The Board of Trustees shall consult with the Committee on Employee Hospital and Medical Benefits before taking action under this subsection.

"**§ 135-40.13. Coordination of benefits. —** (a) Benefits subject to this provision. All of the benefits provided under this Comprehensive Major Medical Plan.

(b) Definitions.

(1) 'Plan' means any Plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (i) group, blanket or franchise insured or uninsured coverage, (ii) hospital services prepayment Plan on a group basis, medical service prepayment Plan on a group basis, group practice, or other prepayment coverage on a group basis, (iii) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs except Medicare, or any coverage required or provided by any statute, which coverage is not otherwise excluded from the calculation of benefits under this Plan, but the term 'Plan' shall not include any individual policies.

The term 'Plan' shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

(2) 'Covered Services' means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. To the extent legally possible, it shall be synonymous with allowable expenses. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

(3) 'Claim Determination Period' means any period of time during which a person covered by this Plan is eligible to receive benefits.

(c) Effect on Benefits.

(1) This provision shall apply in determining the benefits as to a person covered under this Plan for any claim determination period if, for the Covered Services incurred as to such a person during such claim determination period, the sum of:

a. the benefits that would be payable under this Plan in the absence of this provision, and

b. the benefits that would be payable under all other plans in the absence therein of provisions of similar purpose of this provision would exceed the usual and customary charges for such covered services.

(2) As to any claim determination period with respect to which this provision is applicable, the benefits that would be payable under this Plan in the absence of this provision for the covered services incurred as to such person during such claim determination period shall be reduced to the extent necessary so that the sum of such reduced benefit and all the benefits payable for such covered services under all other plans, except as provided in Item (3) immediately below, shall not exceed the total of such covered services. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor. In the case of another Plan which does not contain a provision coordinating its benefits, the benefits of such other Plan shall be determined before the benefits of this Plan. A Plan without a coordination of benefits provision shall be deemed to be the primary carrier within the meaning of this Plan.

(3) If:

a. another Plan which is involved in Item (2) immediately above and which contains provisions coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

b. the rules set forth in Item (4) immediately below would require this Plan to determine its benefits before such other Plan, then the benefits of such other plan will be ignored for the purposes of determining the benefits under this Plan.

(4) For the purposes of Item (3) immediately above, the rules establishing the order of benefit determination are:

a. the benefits of a plan which covers the person on whose covered services claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a dependent;

b. the benefits of a plan which covers the person on whose covered services claim is based as a dependent of a male person shall be determined before the benefits of a plan which covers such person as a dependent of a female person;

c. when roles a. and b. immediately above do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose covered services claim is based for the longer period of time shall be determined before the benefits of a Plan which had covered such person for the shorter period of time.

(5) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

(d) Medicare Participants' Eligibility. For participants eligible for Medicare, Medicare benefits will be paid in coordination with benefits hereunder so that Medicare benefits will be primary.

(e) Right to Receive and Release Necessary Information. For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement the provision.

(f) Facility of Payment. Whenever payments which should have been made under this Plan, in accordance with this provision, have been made under any other plans, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts to be paid shall be deemed to be benefits paid under this Plan, and, to the extent of such payments, the Plan Administrator shall be fully discharged from liability under the Plan.

(g) Right of Recovery. Whenever payments have been made by the Plan Administrator with respect to covered services in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Plan Administrator shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations.

"**§ 135-40.14. Right to amend. —** The General Assembly reserves the right to alter, amend, or repeal this Part."

Sec. 2. This act is effective upon ratification except that Part 3 of Article 3 of Chapter 135 of the General Statutes is effective October 1, 1982, and Section 1 of this act shall become effective October 1, 1982.

In the General Assembly read three times and ratified, this the 23rd day of June, 1982.