Article 3B.

State Health Plan for Teachers and State Employees.

Part 1. General Provisions.

§ 135-48.1. General definitions.

As used in this Article unless the context clearly requires otherwise, the following definitions apply:

(1) Authorized representatives who are assisting the State Health Plan Division staff. – Staff of the Department of the State Treasurer, staff of the Department of Justice, or persons providing internal auditing assistance required under G.S. 143-746(b).

(1a) Benefit period. – The period of time during which charges for covered services provided to a Plan member must be incurred in order to be eligible for payment by the Plan.

(2) Chemical dependency. – The pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(2a) Recodified as subdivision (2c) of this section by Session Laws 2025-25, s. 17(b), effective June 26, 2025.

(2b) Claim Payment Data. – Data fields within a Claims Data Feed that reflect the provider and the amount the provider billed for services provided to a Plan member, the allowed amount applied to the claim by the Claims Processor, and the amount paid by the Plan on the claim. The term "Claim Payment Data" includes any document, material, or other work, whether tangible or electronic, that is derived from, is based on, or reflects any of the foregoing data fields or information contained therein. If the Claims Processor designates Claim Payment Data as a trade secret, the Claim Payment Data shall be treated as a trade secret as defined in G.S. 66-152(3).

(2c) Claims Data Feed. – An electronic file provided by a Claims Processor that contains all claims processing data elements for every claim processed by the Claims Processor for the Plan, including Claim Payment Data for each claim.

(3) Claims Processor. – One or more administrators, third-party administrators, or other parties contracting with the Plan to administer Plan benefits.

(4) Comprehensive group health benefit plan. – A comprehensive health benefit plan offered to an individual because of an employment, organizational, or other group affiliation.

(5) Comprehensive health benefit plan. – Health care coverage that consists of inpatient and outpatient hospital and medical benefits, as well as other outpatient medical services, prescription drugs, medical supplies, and equipment that are generally available in the health insurance market.

(6) Covered service; benefit; allowable expense. – Any medically necessary, reasonable, and customary items of service, including prescription drugs, and medical supplies included in the Plan.

(7) Deductible. – The dollar amount that must be incurred for certain covered services in a benefit period before benefits are payable by the Plan.

(8) Dependent. – An eligible Plan member other than the subscriber.

(9) Dependent child. – Subject to the eligibility requirements of subsections (a) and (b) of G.S. 135-48.41, any of the following up to the first month following the dependent child's 26th birthday:
   a. A natural or legally adopted child or children of the employee, whether or not the child is living with the employee.
   b. A foster child or children of the employee, whether or not the child is living with the employee.
   c. A child for which an employee is a court-appointed guardian.
   d. A stepchild of a member who is married to the stepchild's natural parent.
   e. Repealed by Session Laws 2011-96, s. 3(a), effective July 1, 2011.

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

(11) Employing Unit. – A North Carolina School System; Community College; State Department, Agency, or Institution; the University of North Carolina Health Care System; Administrative Office of the Courts; or Association or Examining Board whose employees are eligible for membership in a State-Supported Retirement System. An employing unit also shall mean (i) a charter school in accordance with Article 14A of Chapter 115C of the General Statutes that becomes a participating employer in the Plan under G.S. 135-48.54 or (ii) a local government unit that participates in the Plan under G.S. 135-48.47 or under any other law. Bona fide fire departments, rescue or emergency medical service squads, and National Guard units are deemed to be employing units for the purpose of providing benefits under this Article.

(12) Firefighter. – A member of the group "eligible firefighter" as defined in G.S. 58-86-2.

(13) Health Benefits Representative or HBR. – The employee designated by the employing unit to administer the Plan for the unit and its employees. The HBR is responsible for enrolling new employees and dependents in accordance with the eligibility requirements under this Article, reporting changes, explaining benefits, reconciling group statements, and remitting group fees. The State Retirement System is the Health Benefits Representative for retired State employees.

(14) Plan or State Health Plan. – The North Carolina State Health Plan for Teachers and State Employees. Depending on the context, the term may refer to the entity created in G.S. 135-48.2 or to the health benefit plans offered by the entity, in which case "Plan" includes all comprehensive health benefit plans offered under the Plan.

(15) Plan member. – A subscriber or dependent who is eligible and currently enrolled in the Plan and for whom a premium is paid.

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

(17) Rescue squad worker. – An "eligible rescue squad worker" as defined in G.S. 58-86-30.

(18) Retired employee (retiree). – Retired teachers, State employees, and members of the General Assembly who (i) are receiving monthly retirement benefits from the Teachers' and State Employees' Retirement System, the Consolidated Judicial Retirement System, the Legislative Retirement System, or the Optional Retirement Programs established under G.S. 135-5.1 and G.S. 135-5.4 and (ii) earned contributory retirement service in one of these retirement systems prior to January 1, 2021, and did not withdraw that service, so long as the retiree is enrolled.

(19) Subscriber. – A Plan member who is not a dependent. (2008-168, s. 3(e); 2009-16, s. 3(a); 2009-281, s. 1; 2010-120, s. 1; 2011-85, ss. 1.7(a), 1.10(c), 2.6(b), 2.10; 2011-96, s. 3(a); 2011-183, s. 102; 2011-326, s. 19.3; 2012-173, s. 1; 2014-75, s. 1; 2014-97, s. 5(a); 2014-101, s. 7; 2016-104, s. 1; 2017-57, s. 35.21(c); 2017-135, s. 5; 2021-125, s. 5; 2023-134, s. 4.10(q); 2024-42, s. 2(b); 2024-57, s. 2G.1; 2025-25, s. 17(b).)

§ 135-48.2. Undertaking.

(a) The State of North Carolina undertakes to make available a State Health Plan (hereinafter called the "Plan") exclusively for the benefit of eligible employees, eligible retired employees, and certain of their eligible dependents, which will pay benefits in accordance with the terms of this Article. The Plan shall have all the powers and privileges of a corporation and shall be known as the State Health Plan for Teachers and State Employees. The State Treasurer, Executive Administrator, and Board of Trustees shall carry out their duties and responsibilities as fiduciaries for the Plan. The Plan shall administer one or more group health plans that are comprehensive in coverage. The State Treasurer may operate group plans as a preferred provider option, or health maintenance, point-of-service, or other organizational arrangement.

(b) Payroll deduction shall be available for coverage under the Plan for subscribers able to meet the Plan's requirements for payroll deduction. (2008-168, s. 3(c); 2009-16, ss. 2(f), 5(h); 2009-281, s. 1; 2009-313, s. 2; 2010-194, s. 18(b); 2011-85, ss. 2.6(a), 2.10.)

§ 135-48.3. Right to amend.

The General Assembly reserves the right to alter, amend, or repeal this Article. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1985, c. 732, s. 62; 2008-168, ss. 3(a), (u); 2011-85, s. 2.6(k); 2012-173, s. 5.)

§ 135-48.4. Conflict with federal law.

If any provision of this Article is in conflict with applicable federal law, federal law shall control to the extent of the conflict. (2018-84, s. 7.)

§ 135-48.5. Health benefit trust funds created.

(a) There are hereby established two health benefit trust funds, to be known as the Public Employee Health Benefit Fund and the Health Benefit Reserve Fund for the payment of hospital and medical benefits. As used in this section, the term "health benefit trust funds" refers to the fund type described under G.S. 143C-1-3(a)(10).

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 administrative costs of such programs as may be determined by the Executive Administrator and Board of Trustees.

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 in the following order:

(1) First, to provide an actuarially determined Health Benefit Reserve Fund for incurred but unpresented claims.

(2) Second, an amount determined by the State Treasurer, subject to approval by the Board of Trustees, that does not exceed twenty-five percent (25%) of any unencumbered balance remaining after providing for incurred but unpresented claims may be transferred to the Retiree Health Benefit Fund, established under G.S. 135-7(f). Upon the direction and approval of, and in the amount specified by, the State Treasurer, the Office of State Budget Management shall transfer the amount in accordance with this subdivision.

(3) Third, to reduce the premiums required in providing the benefits of the health benefits programs.

(4) Fourth, to improve the plan, as may be provided by the State Treasurer, subject to approval by the Board of Trustees.

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 G.S. 147-69.3.

(b) Disbursement from the Public Employee Health Benefit Fund may be made by warrant drawn on the State Treasurer by the Executive Administrator, or the Executive Administrator and Board of Trustees may by contract authorize the Claims Processors to draw the warrant.

(c) Repealed by Session Laws 2012-173, s. 3(b), effective January 1, 2013. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1985, c. 732, ss. 43, 63; 1985 (Reg. Sess., 1986), c. 1020, s. 20; 1997-468, s. 3; 1998-1, s. 4(d); 2008-107, s. 10.13(a); 2008-168, ss. 1(a), 2(a), (l); 2011-85, s. 2.5(e); 2012-173, s. 3(b); 2020-48, s. 2.2(b).)

§ 135-48.6: Reserved for future codification purposes.

§ 135-48.8. Statements of public interest.

(a) The State of North Carolina deems it to be in the public interest for individual North Carolina firefighters, rescue squad workers, and members of the National Guard, and certain of their dependents, who are not eligible for any other type of comprehensive health insurance or other comprehensive health benefits, and who have been without any form of health insurance or other comprehensive health benefit coverage for at least six consecutive months, to be given the opportunity to participate in the benefits provided by the State Health Plan for Teachers and State Employees. Coverage under the Plan shall be voluntary for eligible firefighters, rescue squad workers, and members of the National Guard who elect participation in the Plan for themselves and their eligible dependents.

(b) The State of North Carolina deems it to be in the public interest for local government units to be allowed to join the State Health Plan for Teachers and State Employees and to participate in the Plan. (2008-168, s. 3(c); 2009-16, ss. 2(f), 5(h); 2009-281, s. 1; 2009-313, s. 2; 2010-194, s. 18(b); 2011-85, s. 2.6(a); 2014-75, s. 2; 2015-112, s. 1; 2020-48, s. 1.5(a).)

§ 135-48.9: Reserved for future codification purposes.

§ 135-48.10. Confidentiality of information and medical records; provider contracts.

(a) Any information described in this section that is in the possession of the State Health Plan for Teachers and State Employees or its Claims Processor under the Plan or the Predecessor Plan shall be confidential and shall be exempt from the provisions of Chapter 132 of the General Statutes or any other provision requiring information and records held by State agencies to be made public or accessible to the public. This section shall apply to all information concerning individuals, including the fact of coverage or noncoverage, whether or not a claim has been filed, medical information, whether or not a claim has been paid, and any other information or materials concerning a plan participant, including Claim Payment Data and any documents or other materials derived from the Claim Payment Data. This information may, however, be released to the State Auditor or to the Attorney General in furtherance of their statutory duties and responsibilities, or to such persons or organizations as may be designated and approved by the State Treasurer. Any information so released shall remain confidential as stated above and any party obtaining such information shall assume the same level of responsibility for maintaining such confidentiality as that of the State Health Plan for Teachers and State Employees.

(b) The terms of a contract between the Plan and its third party administrator or between the Plan and its pharmacy benefit manager are a public record under Chapter 132 of the General Statutes. No provision of law, however, shall be construed to prevent or restrict the release of any information in a Plan contract to the State Treasurer, the State Auditor, the Attorney General, the Director of the State Budget, the Plan's Board of Trustees, and the Plan's Executive Administrator solely and exclusively for their use in the furtherance of their duties and responsibilities. (1981, c. 355; 1981 (Reg. Sess., 1982), c. 1398, ss. 3, 4; 1983, c. 922, s. 21.10; 1985, c. 732, s. 38; 1985 (Reg. Sess., 1986), c. 1020, s. 20; 1998-1, s. 4(h); 2007-323, s. 28.22A(c); 2008-107, s. 10.13(m); 2008-168, s. 1(a), (c), (d); 2009-16, s. 5(f); 2009-83, s. 1; 2010-194, s. 18(a); 2011-85, ss. 1.9(a), 2.4(a), 2.10; 2011-326, s. 15(r); 2016-104, s. 2; 2024-9, s. 4(e).)

§ 135-48.11: Reserved for future codification purposes.

§ 135-48.12. Committee on Actuarial Valuation of Retired Employees' Health Benefits.

(a) There is established the Committee on Actuarial Valuation of Retired Employees' Health Benefits. The Committee shall be responsible for collecting data and reviewing assumptions for the sole purpose of conducting required actuarial valuations of State supported retired employees' health benefits under other post-employment benefit accounting standards set forth by the Governmental Accounting Standards Board of the Financial Accounting Foundation.

(b) The Committee on Actuarial Valuation of Retired Employees' Health Benefits shall consist of five members serving ex officio, as follows:

(1) The State Budget Officer, who shall serve as the Chair;
(2) Repealed by Session Laws 2013-373, s. 1, effective October 1, 2013.
(3) The State Controller;
(4) The State Treasurer; and
(5) The Executive Administrator for the State Health Plan for Teachers and State Employees.

(c) A majority of the members of the Committee then serving shall constitute a quorum.

(d) Each member shall be entitled to one vote on the Committee. Three affirmative votes shall be necessary for a decision by the members at any meeting of the Committee.

(e) The Committee shall keep in convenient form such data as is necessary for actuarial valuation of retired employees' health benefits under accounting standards set forth by the Governmental Accounting Standards Board of the Financial Accounting Foundation. The Department of State Treasurer, Retirement Systems Division, the State Health Plan for Teachers and State Employees, and any other State agency, department, or university institution, local public school agency, or local community college institution shall provide any necessary data upon request of the Committee for the purpose of conducting its responsibilities.

(f) The Committee shall designate either the actuary under contract with the Department of State Treasurer, Retirement Systems Division, or the actuary under contract with the State Health Plan for Teachers and State Employees as the technical adviser to the Committee on matters regarding the actuarial valuation of retired employees' health benefits created by the provisions of this Chapter. The technical advisor shall perform such actuarial valuation and other duties as are required under this Chapter.

(g) The Committee shall secure an annual calendar-year actuarial valuation of retired employees' health benefits under accounting standards set forth by the Governmental Accounting Standards Board of the Financial Accounting Foundation.

(h) The Committee shall keep a record of all of its proceedings which shall be open to public inspection.

(i) The Committee shall adopt a funding policy and shall include information about the State's contribution policy, including the basis for determining contributions in the annual actuarial valuation. (2007-467, s. 1; 2007-323, s. 28.22A(o); 2008-168, ss. 1(a), (c), (f); 2011-85, ss. 2.4(b), 2.10; 2013-373, s. 1; 2017-125, s. 3.)

§ 135-48.13: Reserved for future codification purposes.

§ 135-48.14: Reserved for future codification purposes.

§ 135-48.15. Whistle-blower protections related to the State Health Plan.

(a) Statement of Public Policy. – It is the policy of this State that persons shall be encouraged to report verbally or in writing to the State Health Plan, Attorney General, or other appropriate authority evidence of activity related to the State Health Plan and involving the following:

(1) A violation of State or federal law, rule, or regulation.
(2) Fraud.
(3) Misappropriation of State resources.
(4) Gross mismanagement, a gross waste of monies, or gross abuse of authority.

Further, it is the policy of this State that persons shall be free of intimidation or harassment when reporting matters of public concern related to the State Health Plan, including offering testimony to or testifying before appropriate legislative panels.

(a1) Rules to Further Public Policy. – In accordance with G.S. 135-48.25, the State Treasurer may adopt rules to assist in the identification and investigation of activities described under subsection (a) of this section undertaken by a health care provider that provides services to Plan members. If the Plan adopts a program to encourage its members to report these activities, then the Plan is authorized to expend State funds in furtherance of the policy objectives of this

section and may adopt rules to offer an incentive to Plan members. The incentive offered shall be five hundred dollars ($500.00), or a maximum of twenty percent (20%) of any net recovery made by the Plan resulting from the member report, whichever amount is less.

(b) Protection From Retaliation. – No employer shall sue, discharge, threaten, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because the employee, or a person acting on behalf of the employee, reports or is about to report, verbally or in writing, any activity described in subsection (a) of this section, unless the employee knows or has reason to believe that the report is inaccurate. No other employee of an employer shall retaliate against another employee because the employee, or a person acting on behalf of the employee, reports or is about to report, verbally or in writing, any activity described in subsection (a) of this section. No person shall sue, terminate a contract, threaten, or otherwise discriminate against a reporting person regarding the reporting person's compensation or terms of contract because the reporting person, or a person acting on behalf of the reporting person, reports or is about to report, verbally or in writing, any activity described in subsection (a) of this section, unless the reporting person knows or has reason to believe that the report is inaccurate.

(c) Relief for Violation. – Any person injured by a violation of subsection (b) of this section may maintain an action in superior court for damages, an injunction, or other remedies provided in this section against the person who committed the violation within one year after the occurrence of the alleged violation of this Article.

(d) Remedies. – A court, in rendering a judgment in an action brought pursuant to this section, may order an injunction, damages, reinstatement of the employee, the payment of back wages or payments owed under a contract, full reinstatement of fringe benefits and seniority rights, costs, reasonable attorneys' fees, or any combination of these. If an application for a permanent injunction is granted, the person maintaining the action shall be awarded costs and reasonable attorneys' fees. If in an action for damages the court finds that the person maintaining the action was injured by a willful violation of subsection (b) of this section, the court shall award as damages three times the amount of actual damages plus costs and reasonable attorneys' fees against the individual or individuals found to be in violation of subsection (b) of this section.

(e) Unrelated Unfavorable Action. – It shall not be a violation of this Article for a person to discharge or take any other unfavorable action with respect to an employee who has engaged in protected activity as set forth under this Article if the person proves by the greater weight of the evidence that it would have taken the same unfavorable action in the absence of the protected activity of the employee. (2012-192, s. 3; 2021-157, s. 1.)

§ 135-48.16. Fraud detection and audit programs.

(a) Access to Persons and Records. – In the course of conducting an investigation or an audit under G.S. 135-48.30(a)(9), the Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall have ready access to the following:

(1) Persons, books, records, reports, vouchers, correspondence, files, personnel files, investments, and any other documentation of any employing unit. The Plan shall have the authority to examine and make copies of the information described in this subdivision only insofar as it directly relates to a specific investigation or audit. The review of State tax returns shall be limited to matters of official business, and the Plan's report shall not violate the confidentiality

provisions of the tax laws. A confidentiality agreement may be put in place with an agency providing documentation to the Plan.

(2) Persons, records, papers, reports, vouchers, correspondence, books, and any other documentation that is in the possession of any individual, private corporation, institution, association, board, or other organization that pertain to any benefits received, disbursed, or otherwise handled pursuant to a grant or contract from the federal government that is administered by the State Health Plan, the State, or its political subdivisions. Providers of social and medical services to a beneficiary shall make copies of records they maintain for services provided to the beneficiary.

Authorized representatives who are assisting the State Health Plan Division staff must have a HIPAA business associate agreement with the State Health Plan and enter into a HIPAA data sharing agreement with any vendor whose records they are copying.

(b) Records of Providers of Social and Medical Services. – Providers of social and medical services who provide ready access to the Plan under subdivision (2) of subsection (a) of this section shall make copies of records they maintain for services provided to a beneficiary available to the Plan or to the authorized representatives who are assisting the State Health Plan Division staff. The Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall request records in writing by providing the name of each beneficiary from whom records are sought, the purpose of the request, the authority for the request, and a reasonable period of time for the production of record copies by the provider. A provider may charge and the Plan, or authorized representatives who are assisting the State Health Plan Division staff, shall, in accordance with G.S. 90-411, pay a reasonable fee to the provider for copies of the records provided.

(c) Fraud Detection and Audit Reports and Work Papers. – The Plan shall maintain for 10 years a complete file of all compliance investigative reports, fraud investigative reports, and reports of other examinations, investigations, surveys, and reviews issued under the Plan's authority under G.S. 135-48.30(a)(9). Fraud or compliance investigation work papers and other evidence or related supportive material directly pertaining to the work of the State Health Plan Division of the Department of State Treasurer shall be retained according to an agreement between the Plan and State Archives. To promote intergovernmental cooperation and avoid unnecessary duplication of fraud investigative effort, and notwithstanding local unit personnel policies to the contrary, pertinent work papers and other supportive material relating to issued fraud or compliance investigation reports may be, at the discretion of the Executive Administrator of the Plan, and unless otherwise prohibited by law, made available for inspection by duly authorized representatives of the State and federal government who desire access to, and inspection of, such records in connection with some matter officially before them, including criminal investigations. Except as provided in this section, or upon an order issued in Wake County Superior Court upon 10 days' notice and hearing finding that access is necessary to a proper administration of justice, fraud investigation work papers and related supportive material shall be kept confidential, including any information developed as a part of the investigation. (2017-135, s. 6.)

§ 135-48.17: Reserved for future codification purposes.

§ 135-48.18: Reserved for future codification purposes.

§ 135-48.19: Reserved for future codification purposes.

Part 2. Administrative Structure.

§ 135-48.20. Board of Trustees established.

(a) There is established the Board of Trustees of the State Health Plan for Teachers and State Employees.

(b) The Board of Trustees of the State Health Plan for Teachers and State Employees shall consist of 10 members.

(c) The State Treasurer shall be an ex officio member of the Board and shall serve as its Chair, but shall only vote in order to break a tie vote.

(d) The Director of the Office of State Budget and Management shall be an ex officio nonvoting member of the Board.

(e) Two members shall be appointed by the Governor. Terms shall be for two years. Vacancies shall be filled by the Governor.

(f) Two members shall be appointed by the State Treasurer. Terms shall be for two years. Vacancies shall be filled by the State Treasurer.

(g) Two 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. Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

(h) Two members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate in accordance with G.S. 120-121. Terms shall be for two years. Vacancies shall be filled in accordance with G.S. 120-122.

(i) In making appointments, the appointing authorities shall ensure that one of the appointees under subsection (e) of this section, one of the appointees under subsection (f) of this section, and one of the appointees under subsection (g) of this section, and one of the appointees under subsection (h) of this section are one of the following:

(1) An employee of a State department, agency, or institution;

(2) A teacher employed by a North Carolina public school system;

(3) A retired employee of a State department, agency, or institution; or

(4) A retired teacher from a North Carolina public school system.

In making appointments to the Board under this section, each appointing authority shall consult with all other appointing authorities prior to making its own appointments to ensure that the Board includes members of each of the groups listed in subdivisions (1) through (4) of this subsection.

(j) In making appointments, the appointing authorities shall appoint individuals from the following categories:

(1) Individuals with expertise in actuarial science or health economics.

(2) Repealed by Session Laws 2018-84, s. 9, effective June 25, 2018.

(3) Individuals with expertise in health benefits and administration.

(4) Individuals with expertise in health law and policy.

(5) Physicians who are licensed to practice medicine in this State.

In making appointments to the Board under this section, each appointing authority shall consult with all other appointing authorities prior to making its own appointments to ensure that each of the areas of expertise listed in subdivisions (1) through (5) of this subsection is represented by at least one member of the Board.

(k) Each appointing authority may remove any member appointed by that appointing authority.

(*l*) The members of the Board of Trustees shall receive one hundred dollars ($100.00) per day, except employees eligible to enroll in the Plan, whenever the full Board of Trustees holds a public session, and travel allowances under G.S. 138-6 when traveling to and from meetings of the Board of Trustees or hearings under G.S. 135-48.24, but shall not receive any subsistence allowance or per diem under G.S. 138-5, except when holding a meeting or hearing where this section does not provide for payment of one hundred dollars ($100.00) per day.

(m) No member of the Board of Trustees may serve more than three consecutive two-year terms.

(n) Immunity. – Except to the extent provided under Article 31A of Chapter 143 of the General Statutes and to the extent of insurance coverage purchased pursuant to G.S. 58-32-15, a person serving on the Board of Trustees shall be immune individually from civil liability for monetary damages for any act, or failure to act, arising out of that service, except where any of the following apply:

(1) The person was not acting within the scope of that person's official duties.
(2) The person was not acting in good faith.
(3) The person committed gross negligence or willful or wanton misconduct that resulted in damages or injury.
(4) The person derived an improper personal financial benefit, either directly or indirectly, from the transaction.
(5) The person incurred the liability from the operation of a motor vehicle. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1983, c. 922, s. 1; 1985, c. 732, ss. 2-5, 8, 11, 42, 59, 60; 1985 (Reg. Sess., 1986), c. 1020, s. 1; 1987, c. 857, s. 2; 1995, c. 490, s. 56; 2002-126, s. 28.16(a); 2007-323, s. 28.22A(b); 2008-168, ss. 1(a), 2(a), (e); 2011-85, ss. 2.5(a), 2.10; 2011-96, s. 6(a); 2017-135, s. 4; 2018-84, s. 9.)

§ 135-48.21. Board officers, quorum, meetings.

(a) Besides the Chair, the Board of Trustees shall elect from its own membership such officers as it sees fit.

(b) A majority of the voting 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 Article.

(c) The Board shall meet at least quarterly. Meetings may also be called by the Chair, or at the written request of three members. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1987, c. 857, s. 3; 2008-168, ss. 1(a), 2(a), (f); 2009-16, s. 5(c); 2011-85, ss. 2.5(b), 2.10.)

§ 135-48.22. Board powers and duties.

The Board of Trustees shall have the following powers and duties:

(1) Approve benefit programs, as provided in G.S. 135-48.30(a)(2).
(2) Approve premium rates, co-pays, deductibles, and coinsurance percentages and maximums for the Plan, as provided in G.S. 135-48.30(a)(2).
(2a) Approve the benefit program, premium rates, co-pays, deductibles, and coinsurance percentages and maximums for the coverage offered under G.S. 135-48.40(e).
(3) Repealed by Session Laws 2021-125, s. 3(b), effective August 30, 2021.
(4) Approve large contracts, as provided in G.S. 135-48.33(a).

(5) Consult with and advise the State Treasurer as required by this Article and as requested by the State Treasurer.

(6) Develop and maintain a strategic plan for the Plan. (2011-85, s. 2.10; 2012-173, s. 4(a); 2014-100, s. 35.16(b); 2021-125, s. 3(b).)

§ 135-48.23. Executive Administrator.

(a) The Plan shall have an Executive Administrator. The Executive Administrator position is exempt from the provisions of Chapter 126 of the General Statutes as provided in G.S. 126-5(c1).

(b) The Executive Administrator shall be appointed by the State Treasurer. The term of employment and salary of the Executive Administrator shall be set by the State Treasurer.
The Executive Administrator may be removed from office by the State Treasurer, and any vacancy in the office of Executive Administrator may be filled by the State Treasurer.

(c) Repealed by Session Laws 2018-84, s. 8(a), effective June 25, 2018.

(c1) The State Treasurer may employ such clerical and professional staff, and such other assistance as may be necessary to assist the Executive Administrator, the Board of Trustees, and the State Treasurer in carrying out their duties and responsibilities under this Article. The State Treasurer may designate any managerial, professional, or policy-making positions as exempt from the North Carolina Human Resources Act. All exempt employees shall serve at the pleasure of the State Treasurer, and any vacancies in these positions may be filled by the State Treasurer. Salaries of exempt employees shall be set by the State Treasurer.

(c2) The Executive Administrator may also negotiate, renegotiate and execute contracts with third parties in the performance of the Executive Administrator's duties and responsibilities under this Article; provided any contract negotiations, renegotiations and execution with a Claims Processor, with an optional alternative comprehensive health benefit plan, or program thereunder, authorized under G.S. 135-48.2, with a preferred provider of institutional or professional hospital and medical care, or with a pharmacy benefit manager shall be done only with the consent of the State Treasurer.

(d) Repealed by Session Laws 2018-85, s. 6, effective June 25, 2018. (1985, c. 732, s. 10; 1985 (Reg. Sess., 1986), c. 1020, s. 20; 1987, c. 857, s. 5; 1991, c. 427, s. 2; 2000-141, s. 2; 2001-446, s. 6; 2004-124, s. 31.27(a); 2005-276, ss. 29.33(c), 29.34(a); 2007-323, s. 28.22A(l); 2008-168, ss. 1(a), 2(a), (h), 2.2; 2011-85, ss. 2.1(a), 2.5(c), 2.10; 2013-382, s. 9.1(c); 2017-57, s. 35.22; 2018-84, s. 8(a); 2018-85, s. 6.)

§ 135-48.24. Administrative review.

(a) If, after exhaustion of internal appeal handling outlined in the contract with the Claims Processor, any person is aggrieved, then the Claims Processor shall bring the matter to the attention of the Executive Administrator. The Executive Administrator shall promptly decide whether the subject matter of the internal appeal is a determination subject to external review under Part 4 of Article 50 of Chapter 58 of the General Statutes. The following shall apply to decisions made under this subsection:

(1) The Executive Administrator shall inform the aggrieved person and the aggrieved person's provider of the decision and shall provide the aggrieved person notice of the aggrieved person's right to appeal that decision as provided in this subsection.

(2) If the Executive Administrator decides that the subject matter raised on internal appeal is not a determination subject to external review, then the Executive Administrator shall have the authority to make a binding decision on the matter.

(3) If the Executive Administrator decides that the subject matter raised on internal appeal is a determination subject to external review, as provided for under subsection (b) of this section, then that decision may be contested by the aggrieved person under Chapter 150B of the General Statutes. The person contesting the decision may proceed with external review pending a decision in the contested case under Chapter 150B of the General Statutes.

(b) The State Treasurer, in consultation with the Board of Trustees, shall adopt and implement utilization review and internal grievance procedures that are substantially equivalent to those required under G.S. 58-50-61 and G.S. 58-50-62. External review of determinations shall be conducted in accordance with Part 4 of Article 50 of Chapter 58 of the General Statutes. As used in this section, "determination" is a decision by the State Treasurer, or the Plan's designated utilization review organization administrated by or under contract with the Plan that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon information provided, does not meet the Plan's benefit offerings, or requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service is therefore denied, reduced, or terminated.

(c) Repealed by Session Laws 2011-398, s. 49, effective January 1, 2012, and applicable to contested cases commenced on or after that date. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1985, c. 732, s. 53; 1985 (Reg. Sess., 1986), c. 1020, s. 20; 1991, c. 427, s. 6; 2001-446, s. 5(e); 2008-168, ss. 1(a), 2(a), (n); 2011-85, ss. 2.5(g), 2.10; 2011-398, s. 49; 2021-125, s. 3(a).)

§ 135-48.25. Rules.

The State Treasurer, in consultation with the Board of Trustees, may adopt rules to implement this Article. The State Treasurer shall provide to all employing units, all health benefit representatives, all relevant health care providers affected by a rule, and to any other persons requesting a written description and approved by the State Treasurer written notice and an opportunity to comment not later than 30 days prior to adopting, amending, or rescinding a rule, unless immediate adoption of the rule without notice is necessary in order to fully effectuate the purpose of the rule. Rules of the Board of Trustees shall remain in effect until amended or repealed by the State Treasurer. The State Treasurer shall provide a written description of the rules adopted under this section to all employing units, all health benefit representatives, all relevant health care providers affected by a rule, and to any other persons requesting a written description and approved by the State Treasurer on a timely basis. Rules adopted by the State Treasurer to implement this Article are not subject to Article 2A of Chapter 150B of the General Statutes. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1985, c. 732, s. 54; 1991, c. 427, s. 7; 1997-278, s. 3; 1997-468, s. 5; 1998-1, s. 4(f); 2001-253, s. 1(r); 2008-168, ss. 1(a), 2(a), (o); 2011-85, ss. 2.5(h), 2.10.)

§ 135-48.26: Reserved for future codification purposes.

§ 135-48.27. Reports to the General Assembly; General Assembly access to information.

The State Treasurer, the Executive Administrator, and Board of Trustees shall report to the General Assembly as requested, and in the manner designated, by the President Pro Tempore of the Senate and the Speaker of the House of Representatives. Employees of the Legislative Services

Commission designated by the Legislative Services Officer (i) shall have access to all records related to the Plan of the State Treasurer, the Board of Trustees, the Executive Administrator, the Claims Processor, and the Plan and (ii) shall be entitled to attend all meetings, including executive sessions, of the Board of Trustees. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1985, c. 732, ss. 55, 55.1; 1985 (Reg. Sess., 1986), c. 1020, s. 7; 2008-168, ss. 1(a), (c), 2(c); 2011-85, ss. 2.4(d), 2.10; 2012-194, s. 30; 2021-125, s. 4.)

§ 135-48.28. Auditing of the Plan.

The State Health Plan for Teachers and State Employees and the Claims Processor shall be subject to the oversight of the State Auditor pursuant to Article 5A of Chapter 147 of the General Statutes. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1983, c. 913, s. 24; 1985, c. 732, s. 46; 1985 (Reg. Sess., 1986), c. 1020, p. 20; 2007-323, s. 28.22A(o); 2007-345, s. 12; 2008-168, ss. 1(a), (c), 2(g); 2011-85, ss. 2.4(c), 2.10.)

Part 3. Plan Operation.

§ 135-48.30. Powers and duties of the State Treasurer.

(a) The State Treasurer shall have the following powers and duties:

(1) Administer and operate the State Health Plan for Teachers and State Employees in accordance with G.S. 135-48.2 and the provisions of this Article.

(2) Set benefits, premium rates, co-pays, deductibles, and coinsurance percentages and maximums, subject to approval by the Board of Trustees. In setting premium rates, the State Treasurer may set a partially contributory rate of zero dollars, subject to approval by the Board of Trustees.

(3) Set the allowable charges for medical and prescription drug benefits, as necessary.

(4) Design and implement coordination of benefits policies.

(5) May offer wellness incentives.

(6) Set administrative and medical policies that are not in direct conflict with this Article.

(7) Adopt and implement, in consultation with the Board of Trustees, utilization review and internal grievance procedures that are substantially equivalent to those required under G.S. 58-50-61 and G.S. 58-50-62. External review of determinations shall be conducted in accordance with Part 4 of Article 50 of Chapter 58 of the General Statutes.

(8) Implement and administer pharmacy and medical utilization management programs and programs to detect and address utilization abuse of benefits.

(9) Establish and operate fraud detection and audit programs.

(10) Expend funds for any independent audit.

(11) Establish procedures to require prior medical approval and implement the procedures after consultation with the Board of Trustees.

(12) Prepare and submit to the Governor and the General Assembly cost estimates for the Plan, including those required by Article 15 of Chapter 120 of the General Statutes.

(13) Disclose to the Governor and the General Assembly changes or additions to the health benefits programs and health care cost containment programs offered

under the Plan, together with statements of financial and actuarial effects as required by Article 15 of Chapter 120 of the General Statutes.

(14) Secure and maintain tax qualification of the Plan under any applicable provisions of the Internal Revenue Code.

(15), (16) Repealed by Session Laws 2012-173, s. 3(c), effective January 1, 2013.

(17) Optionally offer Medicare-related options under G.S. 135-48.38.

(18) In accordance with G.S. 135-48.39 and subject to approval by the Board of Trustees, issue an order declaring an option of deferring premium or debt payments when there is a state of disaster or emergency.

(19) Optionally offer to pay premiums to purchase alternative coverage in lieu of coverage under the Plan under G.S. 135-48.39A.

(20) If delegated by the Board of Trustees under G.S. 135-48.54(b)(2), carry out the powers and duties provided to the Board of Trustees under G.S. 135-48.54(b)(2).

(b) The State Treasurer may delegate his or her powers and duties under this section to the Executive Administrator, the Board of Trustees, and employees of the Plan. In delegating powers or duties, however, the State Treasurer maintains the responsibility for the performance of those powers or duties. (2011-85, s. 2.10; 2012-173, s. 3(c), 4(b); 2020-3, s. 4.21(a); 2023-134, s. 39.29(a); 2025-19, s. 7.8.)

§ 135-48.31: Reserved for future codification purposes.

§ 135-48.32. Contracts to provide benefits.

(a) The Plan benefits shall be provided under contracts between the Plan and the claims processors selected by the Plan. The contracts necessarily will conform to applicable State law.

(b) Unless otherwise directed by the Plan, each Claims Processor shall provide the Plan with a Claims Data Feed, which includes all Claim Payment Data, at a frequency agreed to by the Plan and the Claims Processor. The frequency shall be no less than monthly. The Claims Processor is not required to disclose Claim Payment Data that reflects rates negotiated with or agreed to by a noncontracted third party but, upon request, shall provide to the Plan sufficient documentation to support the payment of claims for which Claim Payment Data is withheld on such basis.

(c) Any provision of any contract between a Claims Processor and a health care provider, subcontractor, or third party that would prevent or prohibit the Claims Processor from disclosing Claim Payment Data to the Plan, in accordance with this section, shall be void and unenforceable, but only to the extent the provision prevents and prohibits disclosure to the Plan.

(d) The Plan may use and disclose Claim Payment Data solely for the purpose of administering and operating the State Health Plan for Teachers and State Employees in accordance with G.S. 135-48.2 and the provisions of this Article. The Plan shall not make any use or disclosure of Claim Payment Data that would compromise the proprietary nature of the data or, as applicable, its status as a trade secret, or otherwise misappropriate the data.

(e) The Plan may not use a provider's Claim Payment Data to negotiate rates, fee schedules, or other master charges with that provider or any other provider.

(f) The Plan may disclose Claim Payment Data to a third party to use on the Plan's behalf as agreed upon between the Plan and the Claims Processor. The Plan must obtain the agreement of the Claims Processor for each third party to whom the Plan seeks to disclose Claim Payment Data and for each use the third party will make of the data. The Plan may not disclose Claim Payment

Data to any third party without first entering into a contract with the third party that contains restrictions on the use and disclosure of the Claim Payment Data by the third party that are at least as restrictive as the provisions of this section.

(g) A Claims Processor who discloses Claim Payment Data in accordance with this section shall not incur any civil liability and shall not be subject to equitable relief in connection for the disclosure. (2008-168, s. 3(c); 2009-16, ss. 2(f), 5(h); 2009-281, s. 1; 2009-313, s. 2; 2010-194, s. 18(b); 2011-85, ss. 2.6(a), 2.10; 2016-104, s. 3.)

§ 135-48.33. Contracting provisions; large contract review by Board of Trustees and Attorney General, auditing, no cost plus contracts.

(a) The Board of Trustees must approve all Plan contracts in excess of three million dollars ($3,000,000), including contracts with an initial cost of less than three million dollars ($3,000,000), but that may exceed three million dollars ($3,000,000) during the term of the contract.

(b) The Plan shall: (i) submit all proposed contracts for supplies, materials, printing, equipment, and contractual services that exceed one million dollars ($1,000,000) authorized by this Article to the Attorney General or the Attorney General's designee for review as provided in G.S. 114-8.3; and (ii) include in all proposed contracts to be awarded by the Plan under this section a standard clause which provides that the State Auditor and internal auditors of the Plan may audit the records of the contractor during and after the term of the contract to verify accounts and data affecting fees and performance. The Plan shall not award a cost plus percentage of cost agreement or contract for any purpose. (2008-168, s. 3(c); 2009-16, ss. 2(f), 5(h); 2009-281, s. 1; 2009-313, s. 2; 2010-194, s. 18(b); 2011-85, ss. 2.6(a), 2.10; 2011-326, s. 15(s); 2021-125, s. 1.)

§ 135-48.34. Contracts not subject to Article 3 of Chapter 143 of the General Statutes.

The design, adoption, and implementation of the preferred provider contracts, networks, and optional alternative comprehensive health benefit plans, and programs available under the optional alternative plans, as authorized under G.S. 135-48.2, are not subject to the requirements of Article 3 of Chapter 143 of the General Statutes, but are subject to the requirements of G.S. 135-48.33. (2011-85, s. 2.10.)

§ 135-48.35. Contract disputes not contested case under the Administrative Procedure Act, Chapter 150B of the General Statutes.

A dispute involving the performance, terms, or conditions of a contract between the Plan and an entity under contract with the Plan is not a contested case under Article 3 of Chapter 150B of the General Statutes. (2001-192, s. 2; 2008-168, ss. 1(a), (c), 2(d); 2011-85, s. 2.4(e).)

§ 135-48.36. Pharmacy benefits manager contracts.

The Executive Administrator shall consider incorporating the following items into a request for proposal for a pharmacy benefits manager for the Plan:

(1) Allowing the Plan's pharmacy benefits managers to provide a monetary advantage to pharmacies in North Carolina neighborhoods, communities, and counties that are underserved by pharmacies.

(2) Requiring the Plan's pharmacy benefits managers to annually report all of the information required in G.S. 58-56A-22 to the State Treasurer, Commissioner

of Insurance, and Joint Legislative Oversight Committee on Health and Human Services no later than May 1 of each year.

(3) Preventing the Plan's pharmacy benefits managers from contractually requiring independent pharmacies to accept reimbursement for a drug, device, or pharmacy service in an amount that is less than the acquisition cost of the drug, device, or pharmacy service.

(4) Requiring the Plan and the Plan's pharmacy benefits managers to adhere to the coverage requirements of G.S. 58-56A-55.

(5) Requiring the Plan's pharmacy benefits managers to act as a fiduciary in accordance with G.S. 58-56A-21.

(6) Requiring the Plan and the Plan's pharmacy benefits managers to adhere to the pharmacy of choice provisions of G.S. 58-51-37.

(7) Requiring the Plan's pharmacy benefits managers to meet or exceed the Medicare Part D program standards for convenient access to network pharmacies under 42 C.F.R. § 423.120.

(8) Requiring the Plan's pharmacy benefits managers to reimburse affiliated and non-affiliated pharmacies on the same terms.

(9) Adhering to the cost-sharing consumer protection provisions of G.S. 58-3-182. (2025-69, s. 10(a).)

§ 135-48.37. Liability of third person; right of subrogation; right of first recovery.

(a) The Plan shall have the right of subrogation upon all of the Plan member's right to recover from a liable third party for payment made under the Plan, for all medical expenses, including provider, hospital, surgical, or prescription drug expenses, to the extent those payments are related to an injury caused by a liable third party. The Plan member shall do nothing to prejudice these rights. The Plan has the right to first recovery on any amounts so recovered, whether by the Plan or the Plan member, and whether recovered by litigation, arbitration, mediation, settlement, or otherwise. Notwithstanding any other provision of law to the contrary, the recovery limitation set forth in G.S. 28A-18-2 shall not apply to the Plan's right of subrogation of Plan members.

(b) If the Plan is precluded from exercising its right of subrogation, it may exercise its rights of recovery against any third party who was overpaid. If the Plan recovers damages from a liable third party in excess of the claims paid, any excess will be paid to the member, less a proportionate share of the costs of collection.

(c) In the event a Plan member recovers any amounts from a liable third party to which the Plan is entitled under this section, the Plan may recover the amounts directly from the Plan member. If, prior to the Plan exercising its rights under this section, a Plan member utilizes or otherwise disposes of any amounts that were recovered from a liable third party to which the Plan is entitled under this section, then the Plan may pursue alternative judicial remedies against the Plan member to recover the amount to which the Plan is entitled, including the pursuit of a judgment and lien against real property.

(c1) The Plan has a lien, for not more than the value of claims paid related to the liability of the third party, on any damages subsequently recovered by a Plan member against any liable third party. If the Plan member fails to pursue the remedy against a liable third party, the Plan is subrogated to the rights of the Plan member and is entitled to enforce liability in the Plan's own name or in the name of the Plan member for the amount paid by the Plan.

(d) In no event shall the Plan's lien exceed fifty percent (50%) of the total damages recovered by the Plan member, exclusive of the Plan member's reasonable costs of collection as determined by the Plan in the Plan's sole discretion. The decision by the Plan as to the reasonable cost of collection is conclusive and is not a "final agency decision" for purposes of a contested case under Chapter 150B of the General Statutes. Notice of the Plan's lien or right to recovery shall be presumed when a Plan member is represented by an attorney, and the attorney shall disburse proceeds pursuant to this section.

(e) The priority of any lien held by the State Health Plan for Teachers and State Employees shall be superior to all nongovernmental liens and rights, whether such liens and rights are prior or subsequent to the lien. (2004-124, s. 31.25; 2006-264, s. 66(a); 2008-168, ss. 1(a), 3(a), (t); 2011-85, ss. 2.6(j), 2.10; 2018-52, ss. 3, 5(a).)

§ 135-48.37A. Employing unit cooperation in collection of amounts owed to Plan.

(a) Any payment of benefits or other amount to, or premiums or claims paid on behalf of, any Plan member that is later determined to be an overpayment, an erroneous payment, or a benefit or amount for which the Plan member was ineligible shall be repaid by the Plan member to the Plan. If the Plan member is an employee of an employing unit, then any amounts to be recouped under this subsection shall be offset against the net wages of the Plan member.

(b) If a Plan member owes an amount to the Plan under this section, has been notified of this amount owed by the Plan member in writing, and has not entered into a payment plan acceptable to the Plan within 30 days after the written notice, then the Plan shall notify the Plan member's employer of the amount owed. Upon receipt of this notice from the Plan, an employing unit shall offset the amount owed against not less than ten percent (10%) of the net wages of the Plan member until the Plan notifies the employing unit that the amount owed has been paid in full. The Plan's notice to the employing unit shall be prima facie evidence that the amount owed is valid and, notwithstanding any other provision of law to the contrary, the employing unit has no obligation to verify the amount owed. The employing unit shall provide no more than 30 days' but not less than 14 days' written notice to the Plan member prior to beginning the offset. The employing unit shall remit all amounts offset under this subsection to the Plan in intervals corresponding with the employing unit's regular pay periods.

(c) If an employing unit fails to adhere to the provisions of this section, the Plan shall, after notice to the employing unit of its failure to cooperate, be entitled to seek recovery of any amounts due directly from the employing unit.

(d) No amount due under this section may be forgiven by the Board, the Plan, the Executive Administrator, the State Treasurer, or an employing unit. The Plan and the employing unit shall have a duty to pursue the repayment in full of these funds by all lawful means available, including the filing of a civil action in the General Court of Justice.

(e) Nothing in this section shall be construed to limit the Plan's ability to pursue alternative judicial remedies against a Plan member or a former Plan member, including the pursuit of a judgment and lien against real property. (2018-52, s. 2(a).)

§ 135-48.38. Persons eligible for Medicare; optional participation in other Medicare products.

(a) Benefits payable for covered expenses under this Plan will be reduced by any benefits payable for the same covered expenses under Medicare, so that Medicare will be the primary carrier except where compliance with federal law specifies otherwise.

(b) For those participants eligible for Medicare, the Plan will be administered on a "carve out" basis. The provisions of the 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 Plan just as if the charges not paid by Medicare were the total bill.

(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.

(d) Notwithstanding the foregoing provisions of this section or any other provisions of the Plan, the State Treasurer may enter into negotiations with the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, in order to secure a more favorable coordination of the Plan's benefits with those provided by Medicare, including but not limited to, measures by which the Plan would provide Medicare benefits for all of its Medicare-eligible members in return for adequate payments from the federal government in providing such benefits. Should such negotiations result in an agreement favorable to the Plan and its Medicare-eligible members, the State Treasurer may, after consultation with the Board of Trustees, implement such an agreement which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members.

(e) Notwithstanding subsections (a), (b), and (c) of this section, the State Treasurer may contract for coverage in lieu of current Plan medical and prescription drug benefits for Medicare retirees or to supplement Medicare benefits and may, after consultation with the Board of Trustees, implement such an agreement, which shall supersede all other provisions of the Plan to the contrary related to its payment of claims for Medicare-eligible members. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1985 (Reg. Sess., 1986), c. 1020, s. 18; 1987, c. 857, s. 21; 1989, c. 752, s. 22(o); 2008-168, ss. 1(a), 3(a), (o); 2011-85, ss. 2.6(g), 2.10.)

§ 135-48.39. Operations during state of disaster or emergency.

(a) For the purposes of this section, the term "state of disaster" shall mean that one of the following has occurred:

(1) The Governor or legislature has declared a state of emergency under G.S. 166A-19.20.

(2) The Governor has issued a disaster declaration under G.S. 116A-19.21.

(3) The President of the United States has issued a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121, et seq., as amended, for this State, for an area within this State, or for an area in which a member or an employing unit is located.

(4) The Governor, legislature, or other governing body has declared a state of emergency or disaster, or the equivalent, for an area in which a member or employing unit is located.

(b) Subject to approval by the Board of Trustees, when there is a state of disaster, the State Treasurer may order that members, employing units, or both adversely affected by the state of disaster shall have the option of deferring premium or debt payments that are due during the time period in which there is a state of disaster. The State Treasurer may order the expiration of the option to defer premium or debt payments prior to the end of the time period in which there is a state of disaster but may not extend the option beyond that period.

(c) Any option to defer premium or debt payments offered under this section shall be made for a period of 30 days from the last day the premium or debt payment may have been made under

the terms of the Plan, policy, contract, or agreement. This 30-day deferral period may also be applied to any statute, rule, or other policy or contract provision that imposes a time limit on the Plan or a member to perform any act related to the Plan during the time period in which there is a state of disaster. This 30-day deferral period may be extended by the State Treasurer in 30-day increments, subject to approval by the Board of Trustees. A deferral period shall not last beyond 90 days from the last day of the time period in which there is a state of disaster.

(d) An option to defer premium or debt payments offered under this section may be limited to a specific category of members or employing units, as the state of disaster necessitates and as determined by the State Treasurer.

(e) Nothing in this section shall be construed as to authorize the nonpayment of premiums or debt. All premium payments in arrears shall be paid to the Plan. If premiums in arrears are not paid, coverage shall lapse as of the last day of the month for which premiums were paid in full. The member shall be responsible for all medical expenses incurred since the effective date of the lapse in coverage. (2020-3, s. 4.21(b).)

§ 135-48.39A. Premiums to purchase alternative coverage for retirees in lieu of coverage under the Plan.

(a) The State Treasurer may offer to pay or reimburse premiums for alternative health benefit plan coverage in lieu of coverage under the State Health Plan. If the State Treasurer elects to offer premium payments in lieu of coverage, then the State Treasurer shall adopt rules for and limitations on doing so.

(b) Premium payments in lieu of coverage shall be limited to persons eligible for coverage under the following, and the State Treasurer may vary the amounts of premium payments depending on the category of eligibility:

(1) G.S. 135-48.40(a)(1).
(2) G.S. 135-48.40(a)(2).
(3) G.S. 135-48.40(b)(3).
(4) G.S. 135-48.40(b)(4).
(5) G.S. 135-48.40(c)(2).

(c) Notwithstanding the eligibility for coverage provided in Part 4 of this Article, coverage outside of the Plan shall be in lieu of coverage under the Plan during the period for which the Plan member chooses premium payments in lieu of coverage. (2023-134, s. 39.29(b).)

Part 4. Eligibility and Enrollment.

§ 135-48.40. Categories of eligibility.

(a) Noncontributory Coverage. – The following persons are eligible for coverage under the Plan, on a noncontributory basis, subject to the provisions of G.S. 135-48.43:

(1) Retired employees, as defined in G.S. 135-48.1(18), and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1,

2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more years of retirement service credit in order to be covered by the provisions of this subdivision.

(2) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986.

(b) Partially Contributory Coverage. – The following persons are eligible for coverage under the Plan, on a partially contributory basis, subject to the provisions of G.S. 135-48.43:

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

a. The employee is paid from general or special State funds.

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

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

This subdivision shall not apply to employees eligible to be enrolled in a comprehensive health benefit plan offered by East Carolina University pursuant to G.S. 116-360.15 or the University of North Carolina Health Care System pursuant to G.S. 116-350.30.

(1a) All retirees who (i) are employed by an employing unit that elects to be covered by this subdivision, (ii) do not qualify for coverage under subdivision (1) of this subsection, and (iii) are determined to be "full-time" by their employing unit in accordance with section 4980H of the Internal Revenue Code and the applicable regulations, as amended. The employing unit shall pay the employer premiums for retirees who enroll under this subdivision.

(2) Repealed by Session Laws 2013-324, s. 2, effective July 23, 2013.

(3) Retired employees, as defined in G.S. 135-48.1(18), and retired State law enforcement officers who retired under the Law Enforcement Officers' Retirement System prior to January 1, 1985. Except as otherwise provided in this subdivision, on and after January 1, 1988, a retiring employee or retiree must have completed at least five years of contributory retirement service with an employing unit prior to retirement from any State-supported retirement system in order to be eligible for group benefits under this Part as a retired employee or retiree. For employees first hired on and after October 1, 2006, and members of the General Assembly first taking office on and after February 1, 2007, future coverage as retired employees and retired members of the General Assembly is subject to a requirement that the future retiree have 20 or more

years of retirement service credit in order to be covered by the provisions of this subdivision.

(4) Surviving spouses of:

a. Deceased retired employees, provided the death of the former plan member occurred prior to October 1, 1986; and

b. Deceased teachers, State employees, and members of the General Assembly who are receiving a survivor's alternate benefit under any of the State-supported retirement programs, provided the death of the former plan member occurred prior to October 1, 1986.

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

(6) Members of the General Assembly.

(7) Notwithstanding the provisions of subsection (e) of this section, employees on official leave of absence while completing a full-time program in school administration in an approved program as a Principal Fellow in accordance with Article 5C of Chapter 116 of the General Statutes.

(8) Notwithstanding the provisions of G.S. 135-48.44, employees formerly covered by the provisions of this section, other than retired employees eligible for coverage on a noncontributory basis, who have been employed for 12 or more months by an employing unit, or who have completed a contract term of employment of 10 or 11 months and whose employing unit is a local school administrative unit, and whose jobs are eliminated because of a reduction, in total or in part, in the funds used to support the job or its responsibilities, provided the employees were covered by the Plan at the time of separation from service resulting from a job elimination. Employees covered by this subsection shall be covered for a period of up to 12 months following a separation from service because of a job elimination. An employee formerly covered by the provisions of this section shall not be eligible for coverage under this subdivision if the employee is provided health benefit coverage on a non-contributory basis by a subsequent employer.

(9) Any member enrolled pursuant to subdivision (1) or (2) of this subsection who is on approved leave of absence with pay or receiving workers' compensation.

(10) Employees on approved Family and Medical Leave.

(c) One-Half Contributory Coverage. – The following persons are eligible for coverage under the Plan, on a one-half contributory basis, subject to the provisions of G.S. 135-48.43:

(1) A school employee in a job-sharing position as described in G.S. 115C-326.5. If these employees elect to participate in the Plan, the employing unit shall pay fifty percent (50%) of the Plan's total employer premiums. Individual employees shall pay the balance of the total premiums not paid by the employing unit.

(2) Retired employees, as defined in G.S. 135-48.1(18), with 10 but less than 20 years of retirement service credit provided the employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007. For such future retirees, the State shall pay fifty percent (50%) of the

Plan's total employer premiums. Individual retirees shall pay the balance of the total premiums not paid by the State.

(d) Fully Contributory Coverage. – The following persons shall be eligible for coverage under the Plan, on a fully contributory basis, subject to the provisions of G.S. 135-48.43:

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

(2) 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.

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

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

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

(6) All permanent part-time employees (designated as half-time or more) of an employing unit who meet the conditions outlined in sub-subdivision (b)(1)a. of this section and who are not covered by the provisions of subdivision (b)(1) of this section.

(7) 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 subdivision (b)(8) of this section, 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 90 days of the member's death.

(8) Blind persons licensed by the State to operate vending facilities under contract with the Department of Health and Human Services, 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.

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

(10) Any eligible dependent child of the deceased retiree, teacher, State employee, member of the General 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, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary, was in posse at the time and is covered at birth under this Part, or was covered under the Plan on September 30, 1986. An eligible surviving dependent child can remain covered until age 26 or indefinitely if certified as incapacitated under G.S. 135-48.41(b).

(11) Retired employees, as defined in G.S. 135-48.1(18), with less than 10 years of retirement service credit, provided the teachers and State employees were first hired on or after October 1, 2006, and the members first took office on or after February 1, 2007.

(12) Notwithstanding the provisions of G.S. 135-48.44, former employees covered by the provisions of this section and their spouses and eligible dependent children who were covered by the Plan at the time of the former employees' separation from service pursuant to this section, following expiration of the former employees' coverage provided by this section. Election of coverage under this subdivision shall be made within 90 days after the termination of coverage provided under this section.

(13) The following persons, their eligible spouses, and eligible dependent children, provided that the person seeking coverage as a subscriber (i) is not eligible for another comprehensive health benefit plan and (ii) has been without coverage under a comprehensive health benefit plan for at least six consecutive months:

a. Firefighters.
b. Rescue squad workers.
c. Persons receiving a pension from the North Carolina Firefighters' and Rescue Squad Workers' Pension Fund.
d. Members of the North Carolina National Guard.
e. Retirees of the North Carolina National Guard with 20 years of service.

For the purposes of this subdivision, Medicare benefits, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits, and other Uniformed Services benefits shall be considered comprehensive health benefit plans. The Plan may require certification of persons seeking coverage under this subdivision. Nothing in this section shall be construed to either (i) permit a person to enroll or (ii) require the Plan to enroll a person in the Plan when that enrollment may jeopardize the Plan's preferential tax exempt status as a governmental plan under the Internal Revenue Code.

(e) Other Contributory Coverage. – Any employee of an employing unit is eligible for coverage under this section on a contributory basis, subject to the provisions of G.S. 135-48.43 and of this section, if (i) the employee's employing unit determines that the employee is a full-time employee and (ii) the employee does not qualify for coverage under subdivision (1), (1a), (5), (6), (7), (8), (9), or (10) of G.S. 135-48.40(b). For the purposes of this subsection, the full-time status of an employee shall be determined by the employing unit, in its sole discretion, in accordance with Section 4980H of the Internal Revenue Code and the applicable regulations, as amended. The coverage offered and the contribution required for coverage under this section shall be determined by the Treasurer and approved by the Board of Trustees. Such coverage shall do all of the following:

(1) Be designed to meet the requirements of minimum essential coverage under the Patient Protection and Affordable Care Act, P.L. 111-148, and the applicable regulations, as amended (Affordable Care Act).

(2) Provide no greater coverage than a bronze-level plan, as defined under the Affordable Care Act.

(3) Minimize the required employer contribution in an administratively feasible manner. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1983, c. 499; c. 761, ss. 252-255; c. 867, s. 4; c. 922, s. 5; 1985, c. 400, ss. 5, 6; 1985 (Reg. Sess., 1986), c. 1020, s. 29(a)-(l); 1987, c. 738, ss. 29(n), 36(a), 36(b); c. 809, ss. 3, 4; c. 857, ss. 11(a), 11.1, 11.2, 12; 1989, c. 752, s. 22(e), (f); 1989 (Reg. Sess., 1990), c. 1074, s. 22(a); 1993, c. 321, s. 85(b); 1995, c. 278, s. 1; c. 507, ss. 7.21(a)-(c), 7.28(a)-(c); 1997-443, s. 11A.118(a); 1997-512, ss. 17, 19-27; 1999-237, s. 28.29(f); 2000-141, ss. 6(a), (b); 2000-184, ss. 1(a),(b), 3; 2001-487, s. 86(a); 2002-174, s. 4; 2003-358, s. 4; 2004-124, s. 31.21(b); 2004-199, s. 34(b); 2005-276, s. 29.31(e); 2006-174, ss. 1, 2, 3; 2007-323, s. 28.22A(g1), (o); 2007-345, s. 12; 2008-168, ss. 1(a), 3(a), (f); 2008-194, s. 6(b); 2009-16, s. 3(b); 2009-281, s. 1; 2009-570, s. 43.2; 2009-571, s. 3(a), (d); 2010-72, s. 3(a); 2010-136, ss. 1, 2; 2011-85, ss. 1.6(b), 2.6(c), 2.10; 2011-96, s. 2(a); 2013-324, ss. 1, 2; 2014-100, s. 35.16(a), (c); 2015-100, ss. 3, 4(a); 2015-241, s. 30.25(a); 2016-56, s. 8; 2017-57, s. 35.21(d); 2017-135, s. 2; 2019-110, s. 4; 2020-48, s. 1.5(b); 2023-134, s. 4.10(r); 2024-1, s. 1.7(j); 2025-19, s. 7.5.)

§ 135-48.41. Additional eligibility provisions.

(a) A foster child is covered as a dependent child (i) if living in a regular parent-child relationship with the expectation that the employee will continue to rear the child into adulthood, (ii) 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, (iii) if the claims processor 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 (iv) 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, are not eligible participants.

(b) Notwithstanding the age requirement under G.S. 135-48.1(9), coverage of a dependent child may be continued beyond the dependent child's 26th birthday if the dependent child is disabled and if the dependent was covered by the Plan on the dependent child's 26th birthday.

Verification of the dependent child's disability shall be provided to the Plan no later than 60 days after the dependent child's 26th birthday.

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

(d) Former employees who are receiving disability retirement benefits or disability income benefits pursuant to Article 6 of Chapter 135 of the General Statutes or who are approved for those benefits but not in receipt of the benefits due to lump-sum payouts of vacation, bonus, and sick leave, provided the former employee has at least five years of contributory retirement service with an employing unit of a State-supported retirement system, shall be eligible for the benefit provisions of this Plan, as set forth in this Part, on a noncontributory or partially contributory 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.

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

(f) For the support of the benefits made available to any member vested at the time of retirement, their spouses or surviving spouses, and the surviving spouses of employees who are receiving a survivor's alternate benefit under G.S. 135-5(m) of those associations listed in G.S. 135-27(a), licensing and examining boards under G.S. 135-1.1, the North Carolina State Art Society, Inc., and the North Carolina Symphony Society, Inc., each association, organization or board shall pay to the Plan the full cost of providing these benefits under this section as determined by the State Health Plan for Teachers and State Employees. In addition, each association, organization or board shall pay to the Plan an amount equal to the cost of the benefits provided under this section to presently retired members of each association, organization or board since such benefits became available at no cost to the retired member. This subsection applies only to those individuals employed prior to July 1, 1983, as provided in G.S. 135-27(d).

(g) An eligible surviving spouse and any eligible surviving dependent child of a deceased retiree, teacher, State employee, member of the General Assembly, former member of the General Assembly, or Disability Income Plan beneficiary shall be eligible for group benefits under this section provided coverage is elected within 90 days after the death of the former plan member. Coverage may be elected at a later time during an annual enrollment period.

(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 State Treasurer 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 or in any representation or attestation to the Plan.

The State Treasurer 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 State Treasurer to make an exception as allowed for under this subsection.

(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.

(j) If a retiree has been hired by an employing unit and is eligible for coverage under subdivision (1), (1a), (5), (6), (7), (8), (9), or (10) of G.S. 135-48.40(b) or under G.S. 135-48.40(e), then the hired retiree shall not, during the time of employment, be eligible for retiree coverage under G.S. 135-48.40(a)(1), G.S. 135-48.40(b)(3), G.S. 135-48.40(c)(2), or G.S. 135-48.40(d)(11).

(k) If a retiree is a prisoner serving an active sentence in the State prison system and covered under G.S. 148-19, then the incarcerated retiree shall not, during the time of incarceration, be eligible for retiree coverage under G.S. 135-48.40(a)(1), 135-48.40(b)(3), 135-48.40(c)(2), or 135-48.40(d)(11). (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1983, c. 499; c. 761, ss. 252-255; c. 867, s. 4; c. 922, s. 5; 1985, c. 400, ss. 5, 6; 1985 (Reg. Sess., 1986), c. 1020, s. 29(a)-(l); 1987, c. 738, ss. 29(n), 36(a), 36(b); c. 809, ss. 3, 4; c. 857, ss. 11(a), 11.1, 11.2, 12; 1989, c. 752, s. 22(e), (f); 1989 (Reg. Sess., 1990), c. 1074, s. 22(a); 1993, c. 321, s. 85(b); 1995, c. 278, s. 1; c. 507, ss. 7.21(a)-(c), 7.28(a)-(c); 1997-443, s. 11A.118(a); 1997-512, ss. 17, 19-27; 1999-237, s. 28.29(f); 2000-141, ss. 6(a), (b); 2000-184, ss. 1(a),(b), 3; 2001-487, s. 86(a); 2002-174, s. 4; 2003-358, s. 4; 2004-124, s. 31.21(b); 2004-199, s. 34(b); 2005-276, s. 29.31(e); 2006-174, ss. 1, 2, 3; 2007-323, s. 28.22A(g1), (o); 2007-345, s. 12; 2008-168, ss. 1(a), 3(a), (f); 2008-194, s. 6(b); 2009-16, s. 3(b); 2009-281, s. 1; 2009-570, s. 43.2; 2009-571, s. 3(a), (d); 2010-72, s. 3(a); 2010-136, ss. 1, 2; 2011-85, ss. 1.7(b), 2.6(c), 2.10; 2011-96, s. 3(b); 2011-294, s. 1; 2012-173, s. 2(a); 2014-100, s. 35.16A(a); 2015-100, s. 4(b); 2015-241, s. 30.25(b); 2017-135, s. 8; 2021-125, s. 2.)

§ 135-48.42. Enrollment.

(a) Except as otherwise required by applicable federal law, new employees must be given the opportunity to enroll or decline enrollment for themselves and their dependents within 30 days from the date of employment or from first becoming eligible on a partially contributory or other contributory 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 age 19 and older not enrolling themselves and their dependents age 19 and older within 30 days, or not adding dependents when first eligible as provided herein may enroll during annual enrollment, but may 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 State Treasurer for optional or alternative plans available under the Plan. Children born to covered employees shall be covered at the time of birth so long as the Plan receives notification within 30 days of the date of birth and 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.

(b) Except as otherwise required by applicable federal law, newly acquired dependents (spouse/child) age 19 and older 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 first eligible due to marriage, adoption, legal guardianship, entering a foster child relationship, 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 parents' home, or the first of the month following the date of adoption or placement. Firefighters, rescue squad workers, and members of the National Guard, and their eligible

dependents, are subject to the same terms and conditions as are new employees and their dependents covered by this subdivision. Enrollments in these circumstances must occur within 30 days of eligibility to enroll.

(c) Eligible employees younger than age 19 and dependents younger than age 19 may be enrolled during annual enrollment and shall not be subject to any waiting period for a preexisting condition.

(d) When an eligible or enrolled member applies to enroll the member's eligible dependent child or spouse, the member shall provide the documentation required by the Plan to verify the dependent's eligibility for coverage.

(e) Eligible employees and retirees may only change their elections, including adding or removing dependents, during the Plan year due to a qualifying event as defined under federal law. Notwithstanding the preceding sentence, retirees and surviving spouses may disenroll from the Plan during the Plan year without a qualifying event. Retirees and surviving spouses may also disenroll their dependents from the Plan during the Plan year without a qualifying event. (2008-168, s. 3(g); 2009-16, s. 3(c), (g); 2009-281, s. 1; 2011-85, ss. 1.7(c), 2.6(d), 2.10; 2011-96, ss. 2(d)(1), 3(c); 2012-173, s. 2(b); 2013-324, s. 3; 2015-100, ss. 1, 5; 2017-135, s. 3(a).)

§ 135-48.43. Effective dates of coverage.

(a) Eligible Employees and Retired Employees. – Employees and retirees who otherwise satisfy the eligibility requirements set forth in G.S. 135-48.40 will be offered coverage with the following effective dates:

(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, except that the effective date of coverage for employees who become eligible in accordance with G.S. 135-48.40(e) will be determined by the employing unit in a manner that is consistent with section 4980H of the Internal Revenue Code and the applicable regulations, as amended.

(3) Employees not enrolling or adding dependents when first eligible in accordance with G.S. 135-48.42 may enroll later during annual enrollment, except employees who elect to change their coverage in accordance with rules adopted by the State Treasurer for optional alternative plans offered under the Plan.

(4) Members of the General Assembly, beginning with the 1985 Session, shall become first eligible with the convening of each Session of the General Assembly, regardless of a Member's service during previous Sessions. Members and their dependents enrolled when first eligible after the convening of each Session of the General Assembly will not be subject to any waiting periods for preexisting health conditions. Members of the 1983 Session of the General Assembly, not already enrolled, shall be eligible to enroll themselves and their dependents on or before October 1, 1983, without being subject to any waiting periods for preexisting health conditions.

(b) Waiting Periods and Preexisting Conditions. –

(1) New employees and dependents age 19 and older enrolling when first eligible are subject to no waiting period for preexisting conditions under the Plan.

(2) Employees age 19 and older not enrolling or not adding dependents age 19 and older when first eligible may enroll later during annual enrollment, but enrollees age 19 or older may be subject to a twelve-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section. The waiting period under this subdivision is subject to applicable federal law.

(3) Retiring employees and dependents enrolled when first eligible after an employee's retirement are subject to no waiting period for preexisting conditions under the Plan. Retiring employees not enrolled or not adding dependents age 19 and older when first eligible after an employee's retirement may enroll at a later time during annual enrollment, but may be subject to a 12-month waiting period for preexisting conditions except as provided in subdivision (a)(3) of this section.

(4) Employees and dependents enrolling or reenrolling within 12 months after a termination of 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 alternative plans available under the Plan; 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 subdivision (3) of this subsection; 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 adopted by the State Treasurer 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.

(5) To administer the 12-month waiting period for preexisting conditions for employees age 19 and older and dependents age 19 and older under this Article, the Plan must give credit against the 12-month period for the time a person was covered under a previous plan if the previous plan's coverage was continuous to a date not more than 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. Waiting

periods for preexisting conditions administered under this Article are subject to applicable federal law.

(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) of this section and such dependents will be covered under the Plan beginning the same date as such employees.

(3) Employees and retired employees may change from one category of coverage to a different category of coverage without a waiting period for preexisting conditions, and, as applicable, 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 written application is submitted to the Health Benefits Representative within 30 days of becoming eligible.

(4) Employees or retired employees who wish to change to employee only coverage shall give written notice to their Health Benefits Representative within 30 days after any change in the status of dependents, (resulting from death, divorce, etc.) that requires a change in contract category. 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 category change will be the first of the month following written notification, except in cases of death, in which case the coverage category change will be made retroactive to the first of the month following the death.

(5) Employees not adding dependents age 19 and older when first eligible may enroll later during annual enrollment, but dependents may be subject to a 12-month waiting period for preexisting health conditions except as provided in subdivision (a)(3) of this section.

(6) Employees or retired employees who wish to change to employee only coverage even though their dependents continue to be eligible, shall give written notification to their Health Benefits Representative. Except as otherwise required by applicable federal law, the date of this category 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 employee and family or employee and child coverage. If the member wishes to add a newborn or adopted child and is currently enrolled in employee only 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 category 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.

(d) Categories of Coverage Available. – There are four categories 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. – 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) Employee and Spouse. – Covers employee and spouse only. Maternity benefits are provided to the employee or the employee's enrolled spouse.

(e) Firefighters, rescue squad workers, and members of the National Guard are subject to the same terms and conditions of this section as are employees. Eligible dependents of firefighters, rescue squad workers, and members of the National Guard are subject to the same terms and conditions of this section as are dependents of employees.

(f) If any provision of this section is in conflict with applicable federal law, federal law shall control to the extent of the conflict. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1983, c. 499; c. 761, ss. 252-255; c. 867, s. 4; c. 922, s. 5; 1985, c. 400, ss. 5, 6; 1985 (Reg. Sess., 1986), c. 1020, ss. 5(b), 20; 1987, c. 857, s. 13; 1991, c. 427, ss. 10-12; 1996, 2nd Ex. Sess., c. 18, s. 28.23(b); 1997-512, ss. 28-31, 40; 1999-237, s. 28.29(g); 2007-323, s. 28.22A(h); 2008-168, ss. 1(a), 3(a), (h); 2009-16, ss. 3(d), 5(a); 2009-281, s. 1; 2011-85, ss. 1.7(d), 2.6(e), 2.10; 2011-96, ss. 2(d)(2), 3(d); 2012-173, s. 2(c); 2013-324, s. 4; 2014-100, ss. 35.16(a), (d).)

§ 135-48.44. Cessation of coverage.

(a) Coverage under this Plan of an employee and his or her surviving spouse or eligible dependent children or of a retired employee and his or her surviving spouse or eligible dependent children shall cease on the earliest of the following dates:

(1) The last day of the month in which an employee or retired employee dies. Provided such surviving spouse or eligible dependent children were covered under the Plan at the time of death of the former employee or retired employee, or were covered on September 30, 1986, any such surviving spouse or eligible dependent children may then elect to continue coverage under the Plan by submitting written application to the Claims Processor 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 spouse or eligible dependent children die, except as provided by this Article.

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

(3) The last day of the month in which a divorce becomes final.

(4) The last day of the month, or as soon thereafter as administratively feasible, in which the Plan approves cancellation of coverage for an employee or retired employee.

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

(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 regarding eligibility or enrollment information or in a claim for reimbursement of medical services under the Plan. The State Treasurer 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 State Treasurer to make an exception as allowed for under this subdivision.

(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.

(8) The last day of the month in which a covered individual is found to be ineligible for coverage.

(9) The last day of the month for which a premium is paid in full.

(b) Coverage under this Plan as a dependent child ceases when the child ceases to be a dependent child as defined by G.S. 135-48.1 except, coverage may continue under this Plan for a period of not more than 36 months after loss of dependent status on a fully contributory basis provided the dependent child was covered under the Plan at the time of loss of dependent status.

(c) 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. 135-48.1, 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.

(d) Termination of employment shall mean termination for any reason, including layoff and leave of absence, except as provided in subdivisions (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 a State-supported Retirement System.

(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 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.

(2) In the event of approved 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.

(3) 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.

(4) 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.

(5) 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 of absence 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 the employee's paying one hundred percent (100%) of the cost.

(e) A legally divorced spouse and any eligible dependent children of a covered employee or retired employee may continue coverage under this Plan for a period of not more than 36 months following the first of the month after a divorce becomes final on a fully contributory basis, provided the former spouse and any eligible dependent children were covered under the Plan at the time a divorce became final.

(f) A legally separated spouse of a covered employee or retired employee may continue coverage under this Plan for a period not to exceed 36 months from the separation date on a fully contributory basis, provided the separated spouse was covered under the Plan at the time of separation and provided the covered employee's or retired employee's actions result in the loss of coverage for the separated spouse. Eligible dependent children may also continue coverage if covered under the Plan at time of separation, provided the employee's or retired employee's actions result in the loss of coverage for the dependent children.

(g) Whenever this section gives a right to continuation coverage, such coverage must be elected within the time allowed by applicable federal law.

(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 person becomes a covered employee or a dependent of a covered employee under any group health plan and that group health plan has no restrictions or limitations on benefits.

(4) A person becomes eligible for Medicare 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.

(i) Notice requirements concerning continuation coverage shall be developed by the Plan.

(j) The spouse and any eligible dependent children of a covered employee may continue coverage under the Plan on a fully contributory basis for a period not to exceed 36 months from the

date the employee becomes eligible for Medicare benefits which results in a loss of coverage under the Plan, provided that the spouse and eligible dependent children were covered under the Plan at the time the employee became eligible for Medicare benefits which results in a loss of coverage under the Plan. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1983, c. 922, ss. 17, 19-21; 1985, c. 732, ss. 13, 34; 1985 (Reg. Sess., 1986), c. 1020, ss. 19, 29(m)-(x); 1987, c. 738, s. 29(o); 1989, c. 752, s. 22(p); 1991, c. 427, s. 42; 1995, c. 278, s. 2; 1997-512, ss. 32-35; 2000-184, s. 4; 2008-168, ss. 1(a), 3(a), (q); 2008-187, s. 49.5; 2009-16, s. 3(f); 2011-85, ss. 2.6(h), 2.10; 2011-183, s. 103; 2012-194, s. 31; 2015-100, s. 2; 2017-135, s. 1.)

§ 135-48.45. Conversion.

(a) Upon a cessation of group coverage under the Plan and/or eligibility for group coverage under the Plan, an employee or dependent shall be entitled to a conversion to nongroup coverage without the necessity of a physical examination. Such conversion coverage shall include hospitalization, surgical, and medical benefits as contained in the major medical and alternative plan conversion provisions of Article 53 of Chapter 58 of the General Statutes. The State Treasurer in his or her sole discretion shall approve the conversion coverage, which shall be administered by the Claims Processor through an insurance contract arranged by the Claims Processor, or administered as otherwise directed by the State Treasurer. An eligible employee or dependent must apply for conversion coverage within 30 days after termination of group eligibility.

(b) The State Treasurer shall provide for the continuation of conversion privilege exercised under the predecessor plan, on a fully contributory basis. The State Treasurer shall consult with the Board of Trustees before taking action under this subsection. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1983, c. 922, s. 21.6; 1985, c. 732, ss. 30, 56; 1985 (Reg. Sess., 1986), c. 1020, s. 20; 2008-168, ss. 1(a), 3(a), (r); 2011-85, ss. 2.6(i), 2.10.)

§ 135-48.46. Settlement agreements by employing units.

(a) No employing unit may enter into any settlement agreement with an employee or former employee regarding health benefits covered under the Plan unless the employing unit has received written authorization from the Plan's Executive Administrator.

(b) No settlement agreement between an employing unit and an employee or former employee may reinstate health benefit coverage under the Plan more than one year prior to the date of the settlement agreement.

(c) Any settlement agreement provision in violation of this section shall be void ab initio. (2018-52, s. 8(a).)

§ 135-48.47. Participation in State Health Plan by local government employees and dependents.

(a) Eligibility. – The employees and dependents of employees of local government units are eligible to participate in the State Health Plan, as provided in this section. This section does not apply to employees of a charter school operated by a municipality.

Employees and dependents participating under this section are not guaranteed participation in the Plan, and participation is contingent on their respective local government units (i) electing to participate in the Plan and (ii) complying with the provisions of this section and this Article, as well as any policies adopted by the Plan.

(b) Participation Requirements. – A local government unit may elect to participate in the State Health Plan. Participation shall be governed by the following:

(1) In order to participate, a local government unit must do the following:
   a. Pass a valid resolution expressing the local government's desire to participate in the Plan.
   b. Enter into a memorandum of understanding with the Plan that acknowledges the conditions of this section and this Article.
   c. Provide at least 90 days' notice to the Plan prior to entry and complete the requirements of this subdivision at least 60 days prior to entry.

(2) In order to participate, a local government unit and its employees must meet the federal requirements to participate in a governmental plan. The Plan may refuse participation to persons who would jeopardize the Plan's qualification as a governmental plan under federal law.

(2a) The Plan shall admit any local government unit that meets the administrative and legal requirements of this section, regardless of the claims experience of the local government unit group or the financial impact on the Plan.

(3) A local government unit shall determine the eligibility of its employees and employees' dependents.

(3a) The premiums employees pay to the local government unit for their own coverage shall conform to the premiums in the structure set by the Plan. The premiums employees pay to the local government unit for coverage of their dependents may be determined by the local government unit but may not exceed the premiums set by the Plan.

(4) Premiums for coverage and Plan options shall be the same as those offered to State employees and dependents on a fully contributory basis.

(5) The local government unit shall pay all premiums for all covered individuals directly to the Plan or the Plan's designee.

(c) Enrollment Limitation. – Local governments may elect to participate until the number of employees and dependents of employees of local governments enrolled in the Plan reaches 16,000, after which time no additional local governments may join the Plan. Any local government electing to participate must have less than 1,000 employees and dependents enrolled in health coverage at the time the local government provides notice to the Plan of its desire to participate.

(d) Local governments participating in the Plan as of April 1, 2016, may elect to withdraw from participating in the Plan effective January 1, 2017. Notice of withdrawal must be given by the local government to the Plan no later than September 15, 2016.

(e) Except as permitted under subsection (d) of this section, a local government unit's election to participate in the Plan is irrevocable. (2014-75, s. 3; 2014-105, s. 1; 2015-112, s. 2; 2016-104, ss. 4, 5(a), 6; 2018-145, s. 20(d); 2020-48, s. 1.17.)

§ 135-48.48: Reserved for future codification purposes.

§ 135-48.49. IRC Sections 6055 and 6056 regulatory reporting.

The Plan shall be responsible for reporting coverage for retirees and coverage for direct bill members, except for individuals participating in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, as required by Section 6055 of the Internal Revenue Code. The Plan shall provide employing units with access to Plan data necessary for employing units to meet filing requirements under Sections 6055 and 6056 of the Internal Revenue Code. The Plan may facilitate the availability of a reporting solution; however, the employing unit is responsible for paying all

costs associated with the use of any reporting solution made available by the Plan. (2016-104, s. 7.)

Part 5. Coverage Mandates and Exclusions; Other Mandates.

§ 135-48.50. Coverage mandates.

The Plan shall provide coverage subject to the following coverage mandates:

(1) Abortion coverage. – The Plan shall not provide coverage for abortions for which State funds could not be used under G.S. 143C-6-5.5. The Plan shall, however, provide coverage for subsequent complications or related charges arising from an abortion not covered under this subdivision.

(2) Immunizations. – The Plan shall pay one hundred percent (100%) of allowable medical charges for immunizations for the prevention of contagious diseases as generally accepted medical practices would dictate when directed by a credentialed provider as determined by the claims processor.

(3) Insulin. – Prescription benefits shall be provided for insulin even though a prescription is not required.

(4) Mental health parity. – 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. Nothing in this subdivision, however, shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by a person undergoing necessary care and treatment for chemical dependency.

(5) [Reserved.]

(6) Permissive coverage extension. – If a covered service becomes excluded from coverage under the Plan, the Executive Administrator and Claims Processor may, in the event of exceptional situations creating undue hardships or adverse medical conditions, allow persons enrolled in the Plan to remain covered by the Plan's previous coverage for up to three months after the effective date of the change in coverage, provided the persons so enrolled had been undergoing a continuous plan of specific treatment initiated within three months prior to the effective date of the change in coverage.

(7) Reconstructive surgery. – Charges for cosmetic surgery or treatment required for correction of damage caused by accidental injury sustained by the covered individual while coverage under this 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. Reconstructive breast surgery following mastectomy, as those terms are defined in G.S. 58-51-62, shall be covered. (2011-85, s. 2.10; 2011-145, s. 29.23(c); 2012-194, s. 32.)

§ 135-48.51. Coverage and operational mandates related to Chapter 58 of the General Statutes.

The following provisions of Chapter 58 of the General Statutes apply to the State Health Plan:

(1) G.S. 58-3-191, Managed care reporting and disclosure requirements.

(2) G.S. 58-3-221, Access to nonformulary and restricted access prescription drugs.

(3) G.S. 58-3-223, Managed care access to specialist care.

(4) G.S. 58-3-225, Prompt claim payments under health benefit plans.
(5) G.S. 58-3-235, Selection of specialist as primary care provider.
(6) G.S. 58-3-240, Direct access to pediatrician for minors.
(7) G.S. 58-3-245, Provider directories.
(7a) G.S. 58-3-247, Insurance identification card.
(8) G.S. 58-3-250, Payment obligations for covered services.
(9) G.S. 58-3-265, Prohibition on managed care provider incentives.
(10) G.S. 58-3-280, Coverage for the diagnosis and treatment of lymphedema.
(11) G.S. 58-3-285, Coverage for hearing aids.
(12) G.S. 58-50-30, Right to choose services of certain providers.
(13) G.S. 58-67-88, Continuity of care. (2011-85, s. 2.10; 2012-129, s. 2; 2013-296, s. 3; 2013-324, s. 5; 2021-30, s. 1(b).)

§ 135-48.52. General limitations and exclusions.

The Plan shall not provide coverage for or pay any benefits for any of the following:

(1) 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.
(2) 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 (i) the employer furnishes, pays for or provides reimbursement for such charges, or (ii) the employer makes a settlement payment for such charges, or (iii) the person incurring such charges waives or fails to assert his or her rights respecting such charges.
(3) 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.
(4) 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.
(5) Charges during a continuous hospital confinement which commenced prior to the effective date of the person's coverage under this Plan.
(6) Charges for services unless a claim is filed within 18 months from the date of service.
(7) Charges for sexual dysfunction or hair growth drugs or for nonmedically necessary drugs used for cosmetic purposes. (2011-85, s. 2.10.)

§ 135-48.54. Optional participation for charter schools operated by private nonprofit corporations or municipalities.

(a) Repealed by Session Laws 2018-84, s. 11(a), effective June 25, 2018.

(b) The board of directors of a charter school operated by a private nonprofit corporation or a charter school operated by a municipality may elect to become a participating employer in the Plan. The following shall apply to that election:

(1) If the election is made no later than two years from the date that both parties have signed the written charter under G.S. 115C-218.15, then the charter school shall become a participating employing unit in the Plan. The board of directors shall provide written notification of this election and the resulting status of the charter school as a participating unit in the Plan to the Plan, the Charter Schools Review Board, and the State Board of Education. The written notification shall include the date that the charter school employees shall be enrolled in the Plan. For any charter school employee hired after the initial enrollment date, this election is effective as of the date of that employee's entry into eligible service.

(2) If the election is made at any time after two years from the date that both parties have signed the written charter under G.S. 115C-218.15, then the board of directors of that charter school shall file an application with the Board of Trustees for participation in the Plan on a form approved by the Board of Trustees. The application shall be subject to approval by the Board of Trustees and notification of approval or denial of the application shall be provided by the Board of Trustees to the board of directors within 180 days of receipt of the complete application. Upon approval of the application by the Board of Trustees, the charter school shall become a participating employing unit in the Plan. The board of directors shall provide written notification of the election, the submission of the application required under this subdivision, and the approval of that application by the Board of Trustees to the Charter Schools Review Board and the State Board of Education. This written notification shall include the date that the charter school employees shall be enrolled in the Plan. For any charter school employee hired after the initial enrollment date, this election is effective as of the date of that employee's entry into eligible service. The Board of Trustees may (i) delegate its powers and duties under this subdivision to the North Carolina State Treasurer and (ii) require the board of directors of charter schools applying for participation in the Plan to file their applications with the person or entity designated by the North Carolina State Treasurer.

(b1) A charter school making an election to become a participating employing unit in the Plan under this section shall provide notice of the intent to make that election six months prior to making the election. The Board of Trustees shall not prohibit a charter school from becoming a participating employing unit in the Plan solely because that charter school did not provide this notice.

(c) A board of director's election to become a participating employing unit in the Plan under this section is irrevocable and shall require all eligible employees of the charter school to participate.

(d) If a charter school's board of directors does not elect to become a participating employer in the Plan under this section, then that school's employees and the dependents of those

employees are not eligible for any benefits under the Plan on account of employment with a charter school.

(e) The board of directors of each charter school shall notify each of its employees as to whether the board elected to become a participating employer in the Plan under this section. This notification shall be in writing and shall be provided within 30 days of the board's election or at the time an initial offer for employment is made, whichever occurs last. If the board did not elect to become a participating employer in the Plan, the notice shall include a statement that the employee shall have no legal recourse against the board or the State for any possible benefit under the Plan. The employee shall provide written acknowledgment of the employee's receipt of the notification under this subsection. (1998-212, s. 9.14A(e); 2008-168, ss. 1(a), 3(a), (i); 2011-85, ss. 2.6(f), 2.10; 2014-101, s. 7; 2018-84, s. 11(a); 2018-145, s. 20(e); 2023-110, s. 1(t); 2024-42, s. 2(a); 2025-19, s. 7.7.)

§ 135-48.55. (Repealed) Interest charged to charter schools and local government units on late premiums. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1985, c. 732, s. 52; 1991, c. 427, s. 5; 1997-468, s. 4; 1998-1, s. 4(e); 1999-237, s. 28.29(h); 2003-69, s. 2; 2004-124, s. 31.21(c); 2005-276, s. 29.31(e); 2007-323, s. 28.22A(m), (m1), (o); 2007-345, ss. 11, 12; 2008-107, s. 10.13(a); 2008-168, ss. 1(a), 2(a), (m); 2009-281, s. 1; 2009-571, s. 3(c); 2011-85, s. 2.5(f); 2014-75, s. 4; repealed by 2022-53, s. 7, effective July 7, 2022.)

§ 135-48.56. Education of covered active and retired employees.

It is the intent of the General Assembly that active employees and retired employees covered under the Plan and its successor Plan shall have several opportunities in each fiscal year to attend presentations conducted by Plan management staff providing detailed information about benefits, limitations, premiums, co-payments, and other pertinent Plan matters. To this end, the Plan's management staff shall conduct multiple presentations each year to Plan members and association groups representing active and retired employees across all geographic regions of the State. Regional meetings shall be held in locations that afford reasonably convenient access to Plan members. The presentations shall be designed not only to present information about the Plan but also to hear and respond to Plan members' questions and concerns. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1983, c. 922, s. 2; 1985, c. 732, ss. 7, 9, 23, 24, 50, 51; 1985 (Reg. Sess., 1986), c. 1020, ss. 3, 20; 1987, c. 857, ss. 6, 7; 1987 (Reg. Sess., 1988), c. 1091, s. 5; 1989, c. 752, s. 22(a); 1991, c. 427, s. 3; 1993 (Reg. Sess., 1994), c. 679, s. 10.3; 1997-468, s. 2; 1997-519, s. 3.15; 1998-1, s. 4(c); 2000-141, s. 3; 2001-253, ss. 1(a), 1(q); 2001-487, s. 85.5; 2006-249, s. 4(b); 2007-323, s. 28.22(i); 2008-107, s. 10.13(a); 2008-168, ss. 1(a), 2(a), (k), (j); 2009-16, s. 5(b); 2011-85, s. 2.5(d); 2011-326, s. 27.)

§ 135-48.57. Payments for county or city ambulance service.

Allowable payments for services provided by a county or city ambulance service shall be paid directly or shall be co-payable to the county or city ambulance service provider. As used in this subsection, "county or city ambulance service" means ambulance services provided by a county or county-franchised ambulance service supplemented by county funds, or a municipally owned and operated ambulance service or by an ambulance service supplemented by municipal funds. (1981, c. 355; 1981 (Reg. Sess., 1982), c. 1398, ss. 3, 4; 1983, c. 922, s. 21.10; 1985, c. 732, s. 38; 1985

(Reg. Sess., 1986), c. 1020, s. 20; 1998-1, s. 4(h); 2007-323, s. 28.22A(c); 2008-107, s. 10.13(m); 2008-168, s. 1(a), (c), (d); 2009-16, s. 5(f); 2009-83, s. 1; 2010-194, s. 18(a); 2011-85, s. 2.4(a).)

§ 135-48.58. Premiums for firefighters, rescue squad workers, and members of National Guard.

In setting premiums for firefighters, rescue squad workers, and members of the National Guard, and their eligible dependents, the Plan shall establish rates separate from those affecting other members of the Plan. These separate premium rates shall include rate factors for incurred but unreported claim costs, for the effects of adverse selection from voluntary participation in the Plan, and for any other actuarially determined measures needed to protect the financial integrity of the Plan for the benefit of its served employees, retired employees, and their eligible dependents. (1981 (Reg. Sess., 1982), c. 1398, s. 6; 1985, c. 732, s. 52; 1991, c. 427, s. 5; 1997-468, s. 4; 1998-1, s. 4(e); 1999-237, s. 28.29(h); 2003-69, s. 2; 2004-124, s. 31.21(c); 2005-276, s. 29.31(e); 2007-323, s. 28.22A(m), (m1), (o); 2007-345, ss. 11, 12; 2008-107, s. 10.13(a); 2008-168, ss. 1(a), 2(a), (m); 2009-281, s. 1; 2009-571, s. 3(c); 2011-85, ss. 2.5(f), 2.10.)

§ 135-48.59: Reserved for future codification purposes.

Part 6. Long-Term Care Benefits.

§ 135-48.60: Repealed by Session Laws 2012-173, s. 3(d), effective January 1, 2013.

§ 135-48.61: Repealed by Session Laws 2012-173, s. 3(d), effective January 1, 2013.

§ 135-48.62: Repealed by Session Laws 2012-173, s. 3(d), effective January 1, 2013.

§ 135-49: Reserved for future codification purposes.