

Article 3.

General Regulations for Insurance.

§ 58-3-1. State law governs insurance contracts.

All contracts of insurance on property, lives, or interests in this State shall be deemed to be made therein, and all contracts of insurance the applications for which are taken within the State shall be deemed to have been made within this State and are subject to the laws thereof. (1899, c. 54, s. 2; 1901, c. 705, s. 1; Rev., s. 4806; C.S., s. 6287.)

§ 58-3-5. No insurance contracts except under Articles 1 through 64 of this Chapter.

Except as provided in G.S. 58-3-6, it is unlawful for any company to make any contract of insurance upon or concerning any property or interest or lives in this State, or with any resident thereof, or for any person as an insurance producer to make, negotiate, solicit, or in any manner aid in the transaction of such insurance, unless and except as authorized under the provisions of Articles 1 through 64 of this Chapter. (1899, c. 54, s. 2; Rev., s. 4807; C.S., s. 6288; 1998-211, s. 1(a); 2022-46, s. 14(f).)

§ 58-3-6. Charitable gift annuities.

(a) A charitable organization as described in section 501(c)(3) or section 170(c) of the Internal Revenue Code or an educational institution may receive a transfer of property from a donor in exchange for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the property transferred and the difference in value constitutes a charitable deduction for federal tax purposes. The issuance of the annuity by a charitable organization does not constitute engaging in the business of insurance if the organization, when the annuity agreement is issued:

- (1) Has a minimum of \$100,000 in unrestricted cash, cash equivalents, or publicly-traded securities, exclusive of the assets contributed by the donor in return for the annuity agreement;
- (2) Has been in active, continuous operation for at least three years or is a successor to or affiliate of a charitable organization that has been in active operation for at least three years; and
- (3) Includes the following disclosure clause in each annuity agreement issued on or after November 1, 1998: "This annuity is not issued by an insurance company, is not subject to regulation by the State of North Carolina, and is not protected or otherwise guaranteed by any government agency or insurance guaranty fund."

Subdivisions (1) and (2) of this subsection do not apply to an educational institution that was issuing annuity agreements prior to October 30, 1998 nor to an organization formed solely to support an educational institution in active operation at least three years prior to October 30, 1998.

(b) A charitable organization or educational institution that issues a charitable annuity shall notify the Department by January 1, 1999, or within 90 days of issuing its first annuity, whichever is later. The notice shall be signed by an officer or director of the organization or educational institution, identify the organization or institution, and certify that the organization or institution is a charitable organization or educational institution and that its annuities are issued in compliance with the applicable provisions of subsection (a) of this section.

(c) A charitable organization that issues charitable annuities must make available to the Commissioner, upon request, a copy of its Internal Revenue Service Form 990 or Form 990-EZ for the most recent fiscal year for which the due date has passed. If the organization was not required

to file either form with the Internal Revenue Service for the preceding fiscal year, or was allowed to submit the form in abbreviated format, it shall make available to the Commissioner, upon request, the same information that would have been required to have been filed under the Form 990, in a similar format as specified by the Commissioner. A copy of the Form 990, or corresponding substitute information as authorized by the Commissioner, shall be made available to the prospective annuitant at the time of the initial solicitation of the contribution, and updated information shall be made available at the time of execution of the annuity agreement.

(d) The Department may enforce performance of the requirements of this section by notifying the organization or institution and demanding that it comply with the requirements of this section. The Department may fine an organization or educational institution, up to \$1,000 per annuity agreement, for failure to comply after notice and demand from the Commissioner.

(e) A charitable gift annuity issued by a charitable organization or educational institution prior to October 30, 1998 does not constitute engaging in the business of insurance.

(f) For purposes of this section, an "educational institution" means a public or private college, university, or community college that maintains a faculty to provide instruction to students. (1998-211, s. 1(b).)

§ 58-3-7. Certain accountable care organizations not subject to this Chapter.

This Chapter shall not apply to any accountable care organization approved by the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare programs established under 42 U.S.C. § 1315a or 42 U.S.C. § 1395jjj. This exemption is limited to the activities performed by the accountable care organization pursuant to its agreement with CMS for participation in Medicare programs established under 42 U.S.C. § 1315a or 42 U.S.C. § 1395jjj. (2016-78, s. 5.)

§ 58-3-8. Medical direct primary care agreements not subject to this Chapter.

(a) Definitions. – The following definitions apply in this section:

- (1) Medical direct primary care agreement. – A contract between a primary care provider and an individual patient, a family, or an individual patient's legal representative in which the primary care provider agrees to provide primary care services to the individual patient or family for a specified fee and a specified period of time. Under a medical direct primary care agreement, a direct primary care provider charges a specified periodic fee for health care services and does not bill any third parties on a fee-for-service basis.
- (2) Primary care provider. – An individual or other legal entity that is licensed, registered, or otherwise authorized to provide primary health care services in this State under Chapter 90 of the General Statutes. This includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.
- (3) Primary care service. – Includes, but is not limited to, the screening, assessment, diagnosis, and treatment of a patient for the promotion of health or the detection and management of disease or injury within the scope of practice of the primary care provider.

(b) A medical direct primary care agreement is not insurance and is not subject to the provisions of this Chapter. Entering into a medical direct primary care agreement is not the business of insurance and is not subject to the provisions of this Chapter.

(c) Primary care providers and their agents shall not be required to be licensed or certified under this Chapter to market, sell, or offer to sell direct primary care agreements.

(d) A medical direct primary care agreement under this section must do all of the following:

- (1) Be in writing.
- (2) Be signed by the primary care provider, or the provider's agent, and the individual patient, an adult member of the family, or the individual patient's legal representative.
- (3) Allow either party to terminate the agreement with written notice to the other party.
- (4) Specify the periodic fee for the agreement.
- (5) Specify the primary care services that are included in the agreement and covered by the specified periodic fee.
- (6) Specify the duration of the agreement and any automatic renewal periods.
- (7) Prominently state in writing that the agreement is not health insurance. (2020-85, s. 1.)

§ 58-3-10. Statements in application not warranties.

All statements or descriptions in any application for a policy of insurance, or in the policy itself, shall be deemed representations and not warranties, and a representation, unless material or fraudulent, will not prevent a recovery on the policy. (1901, c. 705, s. 2; Rev., s. 4808; C.S., s. 6289.)

§ 58-3-15. Additional or coinsurance clause.

No insurance company or insurance producer licensed to do business in this State may issue any policy or contract of insurance covering property in this State that contains any clause or provision requiring the insured to take or maintain a larger amount of insurance than that expressed in the policy, nor in any way provide that the insured shall be liable as a coinsurer with the company issuing the policy for any part of the loss or damage to the property described in the policy, and any such clause or provision shall be null and void, and of no effect: Provided, the coinsurance clause or provision may be written in or attached to a policy or policies issued when there is printed or stamped on the declarations page of the policy or on the form containing the clause the words "coinsurance contract," and the Commissioner may, in the Commissioner's discretion, determine the location of the words "coinsurance contract" and the size of the type to be used. If there is a difference in the rate for the insurance with and without the coinsurance clause, the rates for each shall be furnished the insured upon request. (1915, c. 109, s. 5; C.S., s. 6441; 1925, c. 70, s. 4; 1945, c. 377; 1947, c. 721; 1999-132, s. 7.1; 2022-46, s. 14(g).)

§ 58-3-20. Group plans other than life, annuity or accident and health.

No policy of insurance other than life, annuity or accident and health may be written in North Carolina on a group plan which insures a group of individuals under a master policy at rates lower than those charged for individual policies covering similar risks. The master policy and certificates, if any, shall be first approved by the Commissioner and the rate, premiums or other essential information shall be shown on the certificate. (1945, c. 377.)

§ 58-3-25. Discriminatory practices prohibited.

(a) No insurer shall after September 1, 1975, base any standard or rating plan for private passenger automobiles or motorcycles, in whole or in part, directly or indirectly, upon the age or sex of the persons insured.

(b) No insurer shall refuse to insure or refuse to continue to insure an individual, limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for the same coverage, solely because of blindness or partial blindness or deafness or partial deafness. With respect to all other physical conditions, including the underlying cause of the blindness or partial blindness or deafness or partial deafness, individuals who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted individuals or individuals whose hearing is not impaired. Refusal to insure or refusal to continue to insure includes denial by an insurer providing disability insurance on the grounds that the policy defines disability as being presumed in the event that the insured loses his eyesight or hearing: Provided that an insurer providing disability insurance may except disability coverage for blindness, partial blindness, deafness, or partial deafness when those conditions existed at the time the application was made for the disability insurance policy. The provisions of this subsection shall be construed to supplement the provisions of G.S. 58-63-15(7) and G.S. 168-10. This subsection shall apply only to the underwriting of life insurance, accident, health, or accident and health insurance under Articles 1 through 66 of this Chapter, and annuities.

(c) No insurer shall refuse to insure or refuse to continue to insure an individual; limit the amount, extent, or kind of coverage available to an individual; or charge an individual a different rate for the same coverage, because of the race, color, or national or ethnic origin of that individual. This subsection supplements the provisions of G.S. 58-3-120, 58-33-80, 58-58-35, and 58-63-15(7). (1975, c. 666, s. 1; 1985, c. 267, s. 1; 1989, c. 485, s. 22; 1991, c. 720, s. 67.)

§ 58-3-30. Meaning of terms "accident", "accidental injury", and "accidental means".

(a) This section applies to the provisions of all group life, group accident, group health, and group accident and health insurance policies and group annuities under Articles 1 through 64 of this Chapter that are issued on or after October 1, 1989, and preferred provider arrangements under Articles 1 through 64 of this Chapter that are entered into on or after October 1, 1989.

(b) "Accident", "accidental injury", and "accidental means" shall be defined to imply "result" language and shall not include words that establish an accidental means test. (1989, c. 485, s. 10.)

§ 58-3-33. Insurer conditionally required to provide information.

(a) A person who claims to have been physically injured or to have incurred property damage where such injury or damage is subject to a policy of nonfleet private passenger automobile insurance may request by certified mail directed to the insurance adjuster or to the insurance company (Attention Corporate Secretary) at its last known principal place of business that the insurance company provide information regarding the policy's limits of coverage under the applicable policy. Upon receipt of such a request, which shall include the policyholder's name, and, if available, policy number, the insurance company shall notify that person within 15 business days, on a form developed by the Department, that the insurer is required to provide this information prior to litigation only if the person seeking the information satisfies all of the following conditions:

(1) The person seeking the information submits to the insurer the person's written consent to all of the person's medical providers to release to the insurer the

person's medical records for the three years prior to the date on which the claim arose, as well as all medical records pertaining to the claimed injury.

- (2) The person seeking the information submits to the insurer the person's written consent to participate in mediation of the person's claim under G.S. 7A-38.3A.
- (3) The person seeking the information submits to the insurer a copy of the accident report required under G.S. 20-166.1 and a description of the events at issue with sufficient particularity to permit the insurer to make an initial determination of the potential liability of its insured.

(b) Within 30 days of receiving the person's written documents required under subsection (a) of this section, the insurer shall provide the policy limits.

(c) Disclosure of the policy limits under this section shall not constitute an admission that the alleged injury or damage is subject to the policy.

(d) This section does not apply to claims seeking recovery for medical malpractice or claims for which an insurer intends to deny coverage under any policy of insurance. (2003-307, s. 1; 2004-199, s. 21.)

§ 58-3-35. Stipulations as to jurisdiction and limitation of actions.

(a) No insurer, self-insurer, service corporation, HMO, MEWA, continuing care provider, viatical settlement provider, or professional employer organization licensed under this Chapter shall make any condition or stipulation in its contracts concerning the court or jurisdiction in which any suit or action on the contract may be brought.

(b) No insurer, self-insurer, service corporation, HMO, MEWA, continuing care provider, viatical settlement provider, or professional employer organization licensed under this Chapter shall limit the time within which any suit or action referred to in subsection (a) of this section may be commenced to less than the period prescribed by law.

(c) All conditions and stipulations forbidden by this section are void. (1899, c. 54, ss. 23, 106; 1901, c. 391, s. 8; Rev., s. 4809; C.S., s. 6290; 2001-334, s. 1; 2007-298, s. 7.1; 2007-484, s. 43.5.)

§ 58-3-40. Proof of loss forms required to be furnished.

When any company under any insurance policy requires a written proof of loss after notice of such loss has been given by the insured or beneficiary, the company or its representative shall furnish a blank to be used for that purpose. If such forms are not so furnished within 15 days after the receipt of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss, upon submitting within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made. (1945, c. 377.)

§ 58-3-45. Insurance as security for a loan by the company.

Where an insurance company, as a condition for a loan by such company, of money upon mortgage or other security, requires that the borrower insure either his life or that of another, or his property, or the title to his property, with the company, and assign or cause to be assigned to it a policy of insurance as security for the loan, and agree to pay premiums thereon during the continuance of the loan, whether the premium is paid annually, semiannually, quarterly, or monthly, such premiums shall not be considered as interest on such loans, nor will any loan be rendered usurious by reason of any such requirements, where the rate of interest charged for the

loan does not exceed the legal rate and where the premiums charged for the insurance do not exceed the premiums charged to other persons for similar policies who do not obtain loans. (1915, c. 8; 1917, c. 61; C.S., s. 6291.)

§ 58-3-50. Companies must do business in own name; emblems, insignias, etc.

Every insurance company or group of companies must conduct its business in the State in, and the policies and contracts of insurance issued by it shall be headed or entitled only by, its proper or corporate name or names. There shall not appear on the policy anything that would indicate that it is the obligation of any other than the company or companies responsible for the payment of losses under the policy, though it will be permissible to stamp or print on the policy, the name or names of the department or general agency issuing the same, and the group of companies with which the company is financially affiliated. The use of any emblem, insignia, or anything other than the true and proper corporate name of the company or group of companies shall be permitted only with the approval of the Commissioner; provided that, with the exception of policies subject to the provisions of Article 36 of this Chapter, a coverage within a policy may be issued by more than one company, so long as the policy clearly identifies the company responsible for each coverage. (1899, c. 54, s. 18; Rev., s. 4811; C.S., s. 6292; 1945, c. 377; 1951, c. 781, s. 10; 1995, c. 193, s. 9; 2015-281, s. 10.)

§ 58-3-55. Must not pay death benefits in services.

No insurance company now doing business in this State or that may hereafter be authorized to do business in this State issuing contracts providing benefits in the event of death shall issue any contract providing for the payment of benefits in merchandise or service to be rendered to such policyholder or his beneficiary. (1945, c. 377.)

§ 58-3-60. Publication of assets and liabilities; penalty for failure.

When any company publishes its assets, it must in the same connection and with equal conspicuousness publish its liabilities computed on the basis allowed for its annual statements; and any publications purporting to show its capital must exhibit only the amount of such capital as has been actually paid in cash. Any company or agent thereof who violates this section shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be punished only by a fine of not less than five hundred dollars (\$500.00) nor more than one thousand dollars (\$1,000). (1899, c. 54, ss. 18, 96; Rev., ss. 3492, 4812; C.S., s. 6293; 1985, c. 666, s. 14; 1993, c. 539, s. 446; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 58-3-65. Publication of financial information.

Notwithstanding any other provision of the laws of this State an insurer may, subject to requirements set forth by regulation promulgated by the Commissioner, publish financial statements or information based on financial statements prepared on a basis which is in accordance with requirements of a competent authority and which differs from the basis of the statements which have been filed with the Commissioner. Such differing financial statements or information based on financial statements shall not be made the basis for the application of provisions of any laws of this State not relating solely to the publication of financial information unless such provisions specifically so require. (1973, c. 1130; 1991, c. 720, s. 5.)

§ 58-3-70: Repealed by Session Laws 1993, c. 452, s. 65.

§ 58-3-71. Unearned premium reserves.

(a) Every insurance company, other than a life or real estate title insurance company, shall maintain reserves equal to the unearned portions of the gross premiums charged on unexpired or unexpired risks and policies.

(b) No deductions may be made from the gross premiums in force except for original premiums canceled on risks terminated or reduced before expiration, or except for premiums paid or credited for risks reinsured with other solvent assuming insurers authorized to transact business in this State.

(c) Premiums charged for bulk or portfolio reinsurance assumed from other insurers shall be included as premiums in force on the basis of the original premiums and original terms of the policies of the ceding insurer.

(d) Reinsurance ceded to an authorized assuming insurer may be deducted on the basis of original premiums and original terms, except in the case of excess loss or catastrophe reinsurance, which may be deducted only on the basis of actual reinsurance premiums and actual reinsurance terms.

(e) The reserve for unearned premiums shall be computed on an actual basis or may be computed on the monthly pro rata fractional basis if in the opinion of the Commissioner this method produces an adequate reserve.

(f) With respect to marine insurance, premiums on trip risks not terminated shall be deemed unearned; and the Commissioner may require a reserve to be carried thereon equal to one hundred percent (100%) of the premiums on trip risks written during the month ended as of the statement date.

(g) The Commissioner may adopt rules for the unearned premium reserve computation for premiums covering indefinite terms. (1993, c. 452, s. 1.)

§ 58-3-72. Premium deficiency reserves.

(a) In determining the financial condition of any casualty, fidelity, and surety company and any fire and marine company referred to in G.S. 58-7-75, and in any financial statement or report of the company, there shall be included in the liabilities of the company premium deficiency reserves at least equal to the amounts required under this section. The date as of which the determination, statement, or report is made is known as the "date of determination."

(b) For all recorded unearned premium reserves, a premium deficiency reserve shall be calculated to include the amount by which the anticipated losses, loss adjustment expenses, commissions and other acquisition costs, and maintenance costs exceed the sum of those unearned premium reserves and any related expected future installment premiums as of the date of determination.

(c) Except as provided in subsection (f) of this section, commissions, other acquisition costs, and premium taxes do not have to be considered in the determination of the premium deficiency reserve, to the extent that they have previously been incurred.

(d) Except as provided in subsection (f) of this section, no reduction shall be taken for anticipated investment income in the determination of the premium deficiency reserve.

(e) For purposes of determining if a premium deficiency exists, insurance contracts shall be grouped in a manner consistent with the way in which such policies are marketed or serviced.

(f) If the Commissioner determines that the premium deficiency reserves of any company that have been calculated in accordance with this section are inadequate or excessive, the

Commissioner may prescribe any other basis that will produce adequate and reasonable reserves. (2001-223, s. 1.1.)

§ 58-3-75. Loss and loss expense reserves of fire and marine insurance companies.

In any determination of the financial condition of any fire or marine or fire and marine insurance company authorized to do business in this State, such company shall be charged, in addition to its unearned premium liability as prescribed in G.S. 58-3-71, with a liability for loss reserves in an amount equal to the aggregate of the estimated amounts payable on all outstanding claims reported to it which arose out of any contract of insurance or reinsurance made by it, and in addition thereto an amount fairly estimated as necessary to provide for unreported losses incurred on or prior to the date of such determination, as defined in G.S. 58-3-81(a), and including, both as to reported and unreported claims, an amount estimated as necessary to provide for the expense of adjusting such claims, and there shall be deducted, in determining such liability for loss reserves, the amount of reinsurance recoverable by such company, in respect to such claims, from assuming insurers in accordance with G.S. 58-7-21. Such loss and loss expense reserves shall be calculated in accordance with any method adopted or approved by the NAIC, unless the Commissioner determines that another more conservative method is appropriate. (1945, c. 377; 1993, c. 452, s. 2; 1993 (Reg. Sess., 1994), c. 678, s. 4.)

§ 58-3-80: Repealed by Session Laws 1993, c. 452, s. 65.

§ 58-3-81. Loss and loss expense reserves of casualty insurance and surety companies.

(a) In determining the financial condition of any casualty insurance or surety company and in any financial statement or report of any such company, there shall be included in the liabilities of that company loss reserves and loss expense reserves at least equal to the amounts required under this section. The amount of those reserves shall be diminished by an allowance or credit for reinsurance recoverable from assuming reinsurers in accordance with G.S. 58-7-21 or G.S. 58-7-26. The date as of which the determination, statement, or report is made is known as the date of determination.

(b) For all outstanding losses and loss expenses, the reserves shall be valued as of the date of determination and shall include the following:

(1) The aggregate estimated amounts due for losses and loss adjustment expenses on account of all known claims.

(2) The aggregate estimated amounts due for losses and loss adjustment expenses on account of all unknown, incurred but not reported claims.

(c) Except as provided in subsection (e) of this section, the minimum loss and loss expense reserves for workers' compensation insurance shall be determined as follows:

(1) In the case of indemnity benefits where tabular reserves are prescribed for the reporting of such benefits under the Workers' Compensation Statistical Plan (WCSP) of the National Council on Compensation Insurance, the minimum reserve shall be the result obtained by the application of the appropriate pension table in the WCSP, unless the reserve required by any method adopted or approved by the NAIC is greater, in which case that greater reserve shall be used.

(2) In all other cases, including other indemnity benefits, medical benefits, and loss adjustment expense, the reserve shall be determined by subsection (b) of this

section, unless the reserve required by any method adopted or approved by the NAIC is greater, in which case that greater reserve shall be used.

(d) Repealed by Session Laws 2001-223, s. 1.2.

(e) Whenever in the judgment of the Commissioner the loss and loss expense reserves of any casualty or surety company doing business in this State calculated in accordance with the foregoing provisions are inadequate or excessive, he may prescribe any other basis that will produce adequate and reasonable reserves.

(f) Every casualty insurance and every surety company doing business in this State shall keep a complete and itemized record showing all losses and claims on which it has received notices, including all notices received by it of the occurrence of any event that may result in a loss. (1993, c. 452, s. 3; 2001-223, s. 1.2.)

§ 58-3-85. Corporation or association maintaining office in State required to qualify and secure license.

Any corporation or voluntary association, other than an association of companies, the members of which are licensed in this State, issuing contracts of insurance and maintaining a principal, branch, or other office within this State, whether soliciting business in this State or in foreign states, shall qualify under the insurance laws of this State applicable to the type of insurance written by such corporation or association and secure license from the Commissioner as provided under Articles 1 through 64 of this Chapter on insurance, as amended, and the officers and agents of any such corporation or association maintaining offices within this State and failing to qualify and secure license as herein provided shall be deemed guilty of a Class 1 misdemeanor. (1937, c. 39; 1991, c. 720, s. 4; 1993, c. 539, s. 447; 1994, Ex. Sess., c. 24, s. 14(c).)

§ 58-3-90: Repealed by Session Laws 2001-223, s. 2.1.

§ 58-3-95: Repealed by Session Laws 1991, c. 720, s. 71.

§ 58-3-100. Insurance company licensing provisions.

(a) The Commissioner may, after notice and opportunity for a hearing, revoke, suspend, or restrict the license of any insurer if:

- (1) The insurer fails or refuses to comply with any law, order or rule applicable to the insurer.
- (2) After considering the standards under G.S. 58-30-60(b), the Commissioner determines that the continued operation of the insurer is hazardous to its policyholders, to its creditors, or to the general public.
- (3) The insurer has published or made to the Department or to the public any false statement or report.
- (4) The insurer or any of the insurer's officers, directors, employees, or other representatives refuse to submit to any examination authorized by law or refuse to perform any legal obligation in relation to an examination.
- (5) The insurer is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.

(b) Any suspension, revocation or refusal to renew an insurer's license under this section may also be made applicable to the license or registration of any individual regulated under this

Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.

(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be one of the following:

- (1) A statement made to the claimant or to the claimant's legal representative advising that the claim is being investigated.
- (2) Payment of the claim.
- (3) A bona fide written offer of settlement.
- (4) A written denial of the claim.

A claimant includes an insured, a beneficiary of a life or annuity contract, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer, HMO, service corporation, or MEWA. With respect to a claim under an accident, health, or disability policy, if the acknowledgement sent to the claimant indicates that the claim remains under investigation, within 45 days after receipt by the insurer of the initial claim, the insurer shall send a claim status report to the insured and every 45 days thereafter until the claim is paid or denied. The report shall give details sufficient for the insured to understand why processing of the claim has not been completed and whether the insurer needs additional information to process the claim. If the claim acknowledgement includes information about why processing of the claim has not been completed and indicates whether additional information is needed, it may satisfy the requirement for the initial claim status report. This subsection does not apply to HMOs, service corporations, MEWAs or insurers subject to G.S. 58-3-225.

(d) If a foreign insurance company's license is suspended or revoked, the Commissioner shall cause written notification of the suspension or revocation to be given to all of the company's insurance producers in this State. Until the Commissioner restores the company's license, the company shall not write any new business in this State.

(e) The Commissioner may, after considering the standards under G.S. 58-30-60(b), restrict an insurer's license by prohibiting or limiting the kind or amount of insurance written by that insurer. For a foreign insurer, this restriction relates to the insurer's business conducted in this State. The Commissioner shall remove any restriction under this subsection once the Commissioner determines that the operations of the insurer are no longer hazardous to the public or the insurer's policyholders or creditors. As used in this subsection, "insurer" includes an HMO, service corporation, and MEWA. (1899, c. 54, ss. 66, 75, 112; 1901, c. 391, s. 5; Rev., ss. 4703, 4705; C.S., s. 6297; 1947, c. 721; 1963, c. 1234; 1993, c. 409, s. 1; 1995, c. 193, s. 10; 1999-294, s. 9; 2000-162, s. 4(b); 2001-223, s. 2.2; 2001-334, s. 15; 2003-212, s. 26(a); 2005-215, s. 2; 2005-223, s. 7; 2022-46, s. 14(h).)

§ 58-3-102: Repealed by Session Laws 2021-64, s. 3(c), effective October 1, 2021.

§ 58-3-105. Limitation of risk.

Except as otherwise provided in Articles 1 through 64 of this Chapter, no insurer doing business in this State shall expose itself to any loss on any one risk in an amount exceeding ten percent (10%) of its surplus to policyholders. Any risk or portion of any risk which shall have been reinsured shall be deducted in determining the limitation of risk prescribed in this section. This

section shall not apply to (i) life insurance, (ii) accident and health insurance, (iii) the insurance of marine risks, or marine protection and indemnity risks, (iv) workers' compensation or employer's liability risks, and (v) certificates of title, guaranties of title or policies of title insurance. For the purpose of determining the limitation of risk under any provision of Articles 1 through 64 of this Chapter, "surplus to policyholders" shall

- (1) Be deemed to include any voluntary reserves, or any part thereof, which are not required by or pursuant to law, and
- (2) Be determined from the last sworn statement of such insurer on file with the Commissioner pursuant to law, or by the last report on examination filed by the Commissioner, whichever is more recent at the time of assumption of such risk.

In applying the limitation of risk under any provision of Articles 1 through 64 of this Chapter to alien insurers, such provision shall be deemed to refer to the exposure to risk and to the surplus to policyholders of the United States branch of such alien insurer. (1945, c. 377; 1991, c. 636, s. 3; 2013-199, s. 1.)

§ 58-3-110. Limitation of liability assumed.

(a) No company transacting fidelity or surety business in this State shall expose itself to any loss on any one fidelity or surety risk or hazard in an amount exceeding ten per centum (10%) of its policyholders' surplus, unless it shall be protected in excess of that amount by:

- (1) Reinsurance in such form as to enable the obligee or beneficiary to maintain an action thereon against the company reinsured jointly with such reinsurer and, upon recovering judgment against such reinsured, to have recovery against such reinsurer for payment to the extent in which it may be liable under such reinsurance and in discharge thereof; or
- (2) The cosuretyship of such a company similarly authorized; or
- (3) By deposit with it in pledge or conveyance to it in trust for its protection of property; or
- (4) By conveyance or mortgage for its protection; or
- (5) In case a suretyship obligation was made on behalf or on account of a fiduciary holding property in a trust capacity, by deposit or other disposition of a portion of the property so held in trust that no future sale, mortgage, pledge or other disposition can be made thereof without the consent of such company; except by decree or order of a court of competent jurisdiction;

(b) Provided:

- (1) That such company may execute what are known as transportation or warehousing bonds for United States internal revenue taxes to an amount equal to fifty per centum (50%) of its policyholders' surplus;
- (2) That, when the penalty of the suretyship obligation exceeds the amount of a judgment described therein as appealed from and thereby secured, or exceeds the amount of the subject matter in controversy or of the estate in the hands of the fiduciary for the performance of whose duties it is conditioned, the bond may be executed if the actual amount of the judgment or the subject matter in controversy or estate not subject to the supervision or control of the surety is not in excess of such limitation; and

(3) That, when the penalty of the suretyship obligation executed for the performance of a contract exceeds the contract price, the latter shall be taken as the basis for estimating the limit of risk within the meaning of this section.

(c) No such company shall, anything to the contrary in this section notwithstanding, execute suretyship obligations guaranteeing the deposits of any single financial institution in an aggregate amount in excess of ten per centum (10%) of the policyholders' surplus of such surety, unless it shall be protected in excess of that amount by credits in accordance with subdivisions (1), (2), (3) or (4) of subsection (a) of this section: Provided, nothing in this section shall be construed to make invalid any contract entered into by such company with another person, firm, corporation or municipal corporation, notwithstanding any provisions of this section. (1911, c. 28; C.S., s. 6382; 1931, c. 285; 1945, c. 377.)

§ 58-3-115. Twisting with respect to insurance policies; penalties.

No insurer shall make or issue, or cause to be issued, any written or oral statement that willfully misrepresents or willfully makes an incomplete comparison as to the terms, conditions, or benefits contained in any policy of insurance for the purpose of inducing or attempting to induce a policyholder in any way to terminate or surrender, exchange, or convert any insurance policy. Any person who violates this section is subject to the provisions of G.S. 58-2-70 or G.S. 58-3-100. (1961, c. 823; 1987, c. 629, s. 4; c. 787, s. 2; c. 864, ss. 3(a), 74; 1989, c. 485, s. 25; 1999-132, s. 1.3.)

§ 58-3-120. Discrimination forbidden.

(a) No company doing the business of insurance as defined in G.S. 58-7-15 shall make any discrimination in favor of any person.

(b) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through 55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. (1903, c. 488, s. 2; 1905, c. 170, s. 2; Rev., s. 4766; C.S., s. 6430; 1923, c. 4, s. 70; 1925, c. 70, s. 6; 1945, c. 458; 1987, c. 629, s. 5; 2001-297, s. 4.)

§ 58-3-121. Discrimination against coverage of certain bones and joints prohibited.

(a) Discrimination against coverage of procedures involving bones or joints of the jaw, face, or head is prohibited in any health benefit plan. Whenever a health benefit plan provides coverage on a group or individual basis for diagnostic, therapeutic, or surgical procedures involving bones or joints of the human skeletal structure, that plan may not exclude or deny the same coverage for procedures involving any bone or joint of the jaw, face, or head, so long as the procedure is medically necessary to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, disease, or traumatic injury. The coverage required by this section involving bones or joints of the jaw, face, or head shall be subject to the same conditions and limitations as are applicable to coverage of procedures involving other bones and joints of the human skeletal structure.

(b) For purposes of this section, in providing coverage for the treatment of conditions of the jaw (temporomandibular joint), authorized therapeutic procedures shall include splinting and use of intraoral prosthetic appliances to reposition the bones. Payment for these therapeutic procedures, and for procedures involved in any other nonsurgical treatment of temporomandibular joint dysfunction, may be subjected to a reasonable lifetime maximum dollar amount. Nothing in

this subsection shall require a health benefit plan to cover orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals.

(c) For purposes of this section, "health benefit plan" means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA. (1995, c. 483, s. 1.)

§ 58-3-122. Anesthesia and hospital charges necessary for safe and effective administration of dental procedures for young children, persons with serious mental or physical conditions, and persons with significant behavioral problems; coverage in health benefit plans.

(a) All health benefit plans shall provide coverage for payment of anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the provider treating the patient involved certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. The same deductibles, coinsurance, network requirements, medical necessity provisions, and other limitations as apply to physical illness benefits under the health benefit plan shall apply to coverage for anesthesia and hospital or facility charges required to be covered under this section.

(b) As used in this section, the term:

(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

- a. Accident.
- b. Credit.
- c. Disability income.
- d. Long-term care or nursing home care.
- e. Medicare supplement.
- f. Specified disease.
- g. Dental or vision.
- h. Coverage issued as a supplement to liability insurance.
- i. Workers' compensation.
- j. Medical payments under automobile or homeowners.
- k. Hospital income or indemnity.

otherwise readily ascertainable or publicly available by proper means by other persons from another source in the same configuration as requested by the office. This subsection does not apply to sales of insurance regulated under Articles 35, 57, and 58 of this Chapter or under 12 U.S.C. §§ 4901-4910.

(b) The Department of Insurance may investigate the affairs of any person to whom this section applies to determine whether such person has violated this section. If a violation of this section is found to have been committed knowingly, the person in violation shall be subject to the same procedures and penalties as provided in Articles 3 and 63 of this Chapter. (2022-46, s. 16(a).)

§ 58-3-140. Temporary contracts of insurance permitted.

A lender engaged in making or servicing real estate mortgage or deed of trust loans on one to four family residences shall accept as evidence of insurance a temporary written contract of insurance meeting the requirements of G.S. 58-44-20(4) and issued by any duly licensed insurance producer or insurance company.

Nothing herein prohibits the lender from refusing to accept a binder or from disapproving such insurer or insurance producer provided such refusal or disapproval is reasonable.

Such lender need not accept a binder unless such binder:

- (1) Includes:
 - a. The name and address of the insured;
 - b. The name and address of the mortgagee;
 - c. A description of the insured collateral;
 - d. A provision that it may not be cancelled within a term of the binder except upon 10 days' written notice to the mortgagee; and
 - e. The amount of insurance bound.
- (2) Is accompanied by a paid receipt for one year's premium, except in the case of the renewal of a policy subsequent to the closing of a loan; and
- (3) Includes an undertaking of insurance producer to use his best efforts to have the insurance company issue a policy.

The Department may require binders to contain any additional information to permit the binders to comply with the reasonable requirements of Fannie Mae, the Government National Mortgage Association, or the Federal Home Loan Mortgage Corporation for purchase of mortgage loans. (1989, c. 459, s. 1; 1991, c. 720, s. 4; 2001-487, s. 14(f); 2022-46, s. 14(j).)

§ 58-3-145. Solicitation, negotiation or payment of premiums on insurance policies.

(a) An insurer or insurance producer may accept electronic payment, as defined in G.S. 147-86.20, of an insurance premium if the insurer or insurance producer complies with the prohibition against unfair discrimination contained in G.S. 58-63-15(7).

(b) An insurer or insurance producer accepting electronic payment by credit or debit card may charge the person using electronic payment a convenience fee in an amount not to exceed four percent (4%) of the electronic payment. (1967, c. 1245; 1979, c. 528; 1991, c. 720, s. 7; 1999-365, s. 1; 2011-215, s. 1; 2022-46, s. 14(k); 2023-133, s. 11(a).)

§ 58-3-147. Credit card guaranty or collateral prohibited.

No insurer, representative of any insurer, or insurance producer shall enter into any arrangement that involves the sale of insurance or the pledging of existing insurance as guaranty or collateral for the issuance of any credit card. (1993, c. 226, s. 9; c. 504, s. 40; 2022-46, s. 14(l).)

§ 58-3-149. Certificates of insurance.

(a) For the purposes of this section, the following definitions apply:

- (1) Certificate of insurance. – A document prepared or issued exclusively by an insurance company or licensed producer that is used to verify or evidence the existence of property or casualty insurance coverage, including a document submitted or created electronically. Certificate of insurance shall not include a document prepared or issued by an insurance company or producer that is used to verify or evidence the existence of property insurance provided to a lender covering real or personal property which serves as the lender's security for commercial mortgages.
- (2) Commercial mortgages. – Mortgages or other instruments given for the purpose of creating a lien encumbering office, multiunit residential, apartments, commercial, or industrial properties. Commercial mortgages shall not include a lien encumbering one- to four-family residential properties.

(b) A certificate of insurance is not a policy of insurance and does not amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate of insurance holder new or additional rights beyond what the referenced policy of insurance expressly provides.

(c) It is unlawful for any person to knowingly prepare, issue, request, or require a certificate of insurance that meets any of the following criteria:

- (1) Has not been filed with and approved by the Commissioner.
- (2) Contains any false or misleading information concerning the policy of insurance to which the certificate of insurance makes reference.
- (3) Purports to alter, amend, or extend the coverage provided by the policy of insurance to which the certificate of insurance makes reference.
- (4) Includes information not contained in the underlying insurance policy.

(d) Any person not otherwise subject to regulation under Chapter 58 of the General Statutes who prepares, issues, requests, or requires a certificate of insurance that meets the criteria of subdivision (2) or (3) of subsection (c) of this section is subject to a civil penalty of up to five thousand dollars (\$5,000). The clear proceeds of the penalty shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2. Payment of the civil penalty under this section shall be in addition to payment of any other penalty for a violation of the criminal laws of this State.

(e) A holder of a certificate of insurance shall have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance, only if the holder is named within the policy or any endorsement and the policy or endorsement requires notice to be provided to the holder. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance. (2011-196, s. 3; 2021-177, s. 2; 2023-133, s. 10(a).)

§ 58-3-150. Forms to be approved by Commissioner.

(a) It is unlawful for any insurance company licensed and admitted to do business in this State to issue, sell, or dispose of any policy, contract, certificate, or certificate of insurance, or use applications in connection therewith, until the forms of the same have been submitted to and approved by the Commissioner, and copies filed in the Department. If a policy form filing is

disapproved by the Commissioner, the Commissioner may return the filing to the filer. As used in this section, "policy form" includes endorsements, riders, or amendments to policies that have already been approved by the Commissioner.

(b) With respect to group and blanket accident and health insurance, group life insurance, and group annuity policies issued and delivered to a trust or to an association outside of this State and covering persons resident in this State, the group certificates to be delivered or issued for delivery in this State shall be filed with and approved by the Commissioner pursuant to subsection (a) of this section.

(c) If not submitted electronically, all contracts, literature, advertising materials, letters, and other documents submitted to the Department to comply with the filing requirements of this Chapter or an administrative rule adopted pursuant to this Chapter shall be submitted on paper eight and one-half inches by eleven inches. Brochures and pamphlets shall not be stapled or bound.

(d) through (g) Recodified as G.S. 58-3-149 by Session Laws 2021-177, s. 2, effective January 1, 2022. (1907, c. 879; 1913, c. 139; C.S., s. 6312; 1945, c. 377; 1987, c. 752, s. 7; 1989, c. 485, s. 9; 1991, c. 720, ss. 5, 51; 1993, c. 506, s. 1; 1998-211, s. 37.3(a); 2003-290, s. 3; 2011-196, s. 3; 2021-177, s. 2.)

§ 58-3-151. Deemer provisions.

No entity subject to the Commissioner's jurisdiction and regulation shall be fined or penalized by the Commissioner for using forms, contracts, schedules of premiums, or other documents required to be filed and approved under this Chapter or for executing contracts required to be filed and approved under this Chapter if those forms, contracts, schedules of premiums, or other documents have been by law deemed to have been approved, and the entity has notified the Commissioner before using the filing or executing the contract that the law has deemed the filing or the contract to be approved. (2001-334, s. 14.)

§ 58-3-152. Excess liability policies; uninsured and underinsured motorist coverages.

With respect to policy forms that provide excess liability coverage, an insurer may limit or exclude coverage for uninsured motorists as provided in G.S. 20-279.21(b)(3) and for underinsured motorists as provided in G.S. 20-279.21(b)(4). (1997-396, s. 1.)

§ 58-3-155. Business transacted with insurer-controlled brokers.

(a) As used in this section:

(1) "Broker" has the same meaning as defined in G.S. 58-33-10(3).

(2) "Control" or "controlled" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or a corporate office held by the person. Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person.

(b) The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support that determination, that control exists in fact, notwithstanding the absence of a presumption to that effect. The

Commissioner may determine upon application that any person does not or will not upon the taking of some proposed action control another person. The Commissioner may prospectively revoke or modify that determination, after notice and opportunity to be heard whenever in the Commissioner's judgment revocation or modification is consistent with this section.

(c) No licensed property or casualty insurer that has control of a broker may accept insurance from the broker in any transaction in which the broker, when the insurance is placed, is acting as such on behalf of the insured for any compensation, commission, or thing of value unless the broker, before the effective date of the coverage, delivers written notice to the prospective insured disclosing the relationship between the insurer and broker. The disclosure must be signed by the insured and must be retained in the insurer's underwriting file until the completion and release of the examination report under G.S. 58-2-131 through G.S. 58-2-134 for the period in which the coverage is in effect. If the insurance is placed through a subbroker that is not a controlled broker, the controlling insurer shall retain in its records a signed commitment from the subbroker that the subbroker is aware of the relationship between the insurer and the broker and that the subbroker has notified or will notify the insured.

(d) This section does not affect the rights of policyholders, claimants, creditors, or other third parties. (1991, c. 681, s. 9; 1999-132, s. 11.1; 2022-46, s. 14(m).)

§ 58-3-160. Sale of company or major reorganization; license to be restricted.

The Commissioner shall restrict the license by prohibiting new or renewal insurance business transacted in this State by any licensed insurer that, in anticipation of a sale of the insurer to new owners or a major reorganization of the business or management of the insurer, transfers all of its existing insurance business to another insurer through an assumption reinsurance agreement or does not write any new insurance business for over one year. The restriction shall remain in force until after the insurer has filed the following information with the Commissioner and the Commissioner has granted approval:

- (1) Biographical information in a form acceptable to the Commissioner for each new owner, director, or management person;
- (2) A detailed and complete plan of operation describing the kinds of insurance to be written and the method in which the reorganized insurer will perform its various functions;
- (3) Financial projections of the anticipated operational results of the reorganized insurer for the succeeding three years based on the capitalization of the reorganized insurer and its plan of operation, which must be prepared by a properly qualified individual, be in sufficient detail for a complete analysis to be performed, and be accompanied by a list of the assumptions used in making the projections; and
- (4) Any other information the Commissioner considers to be pertinent for a proper analysis of the reorganized insurer. (1991, c. 681, s. 10.)

§ 58-3-165. Business transacted with producer-controlled property or casualty insurers.

(a) As used in this section:

- (1) "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the NAIC.

- (2) "Captive insurer" means an insurance company that is owned by another organization and whose exclusive purpose is to insure risks of the parent organization and affiliated companies. In the case of groups and associations, "captive insurer" means an insurance organization that is owned by the insureds, and whose exclusive purpose is to insure risks of member organizations or group members and their affiliates. "Captive insurer" does not include a risk retention group licensed under Part 9 of Article 10 of this Chapter.
- (3) "Control" and its cognates mean the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person.
- (4) "Controlled insurer" means an insurer that is controlled, directly or indirectly, by a producer.
- (5) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.
- (6) "Insurer" means any person licensed to write property or casualty insurance in this State. "Insurer" includes a risk retention group licensed under Part 9 of Article 10 of this Chapter but excludes a residual market mechanism, a joint underwriting authority, and a captive insurer.
- (7) "Producer" means an insurance broker or brokers or any other person, when, for any compensation, commission, or other thing of value, that person acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than that person. "Producer" does not mean an exclusive agent or any independent agent acting on behalf of a controlled insurer, including any subagent or representative of the agent, who acts as such in the solicitation of, negotiation for, or procurement or making of an insurance contract, if the agent is not also acting in the capacity of an insurance broker in the transaction in question.

(b) The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect. The Commissioner may determine upon application that any person does not or will not upon the taking of some proposed action control another person. The Commissioner may prospectively revoke or modify that determination, after notice and opportunity to be heard, whenever in the Commissioner's judgment revocation or modification is consistent with this section.

(c) This section applies to insurers that are either domiciled in this State or domiciled in a state that is not an accredited state having in effect a substantially similar law. The provisions of Article 19 of this Chapter, to the extent they are not superseded by this section, apply to all parties within holding company systems subject to this section.

(d) The provisions of this section apply if, in any calendar year, the aggregate amount of gross written premiums on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent (5%) of the admitted assets of the controlled insurer, as

reported in the controlled insurer's most recent annual statement or its quarterly statement filed as of September 30 of the prior year. The provisions of this section do not apply if:

- (1) The controlling producer places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate, or subsidiary and receives no compensation based upon the amount of premiums written in connection with that insurance; and the controlling producer accepts insurance placements only from nonaffiliated subproducers, and not directly from insureds; and
- (2) The controlled insurer, except for insurance business written through a residual market mechanism, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

(e) A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the producer and the insurer specifying the responsibilities of each party, and unless the contract has been approved by the board of directors of the insurer and contains all of the following minimum provisions:

- (1) The insurer may terminate the contract for cause, upon written notice to the producer. The insurer shall suspend the producer's authority to write business during the pendency of any dispute regarding the cause for the termination.
- (2) The producer shall render accounts to the insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by, or owing to, the producer.
- (3) The producer shall remit all funds due under the contract terms to the insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments of premiums collected shall be remitted no later than 90 days after the effective date of any policy placed with the insurer under this contract.
- (4) The producer shall hold all funds collected for the insurer's account in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the provisions of this Chapter as applicable. Funds of a producer who is not required to be licensed in this State shall be maintained in compliance with the requirements of the producer's domiciliary jurisdiction.
- (5) The producer shall maintain separately identifiable records of business written for the insurer.
- (6) The producer shall not assign the contract in whole or in part.
- (7) The insurer shall provide the producer with its underwriting standards, rules and procedures, the manual setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The producer shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions shall be the same as those applicable to comparable business placed with the insurer by a producer other than a controlling producer.
- (8) The rates and terms of the producer's commissions, charges, or other fees and the purposes for the charges or fees. The rates of the commissions, charges, and

other fees shall be no greater than those applicable to comparable business placed with the insurer by producers other than controlling producers. For the purposes of this subdivision and subdivision (7) of this subsection, "comparable business" includes the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

- (9) If the contract provides that the producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then the compensation shall not be determined and paid until at least five years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the insurer's reserves on remaining claims has been independently verified under subsection (g) of this section.
- (10) A limit on the producer's writings in relation to the insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The insurer shall notify the producer when the applicable limit is approached and shall not accept business from the producer if the limit is reached. The producer shall not place business with the insurer if it has been notified by the insurer that the limit has been reached.
- (11) The producer may negotiate but shall not bind reinsurance on behalf of the insurer on business the producer places with the insurer; however, the producer may bind facultative reinsurance contracts under obligatory facultative agreements if the producer's contract with the insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(f) Every controlled insurer shall have an audit committee, consisting of independent directors, of the insurer's board of directors. The audit committee shall meet annually with the insurer's management, the insurer's independent certified public accountants, and an independent casualty actuary or another independent loss reserve specialist acceptable to the Commissioner, to review the adequacy of the insurer's loss reserves.

(g) In addition to any other required loss reserve certification, the controlled insurer shall, on or before April 1 of each year, file with the Commissioner an opinion of an independent casualty actuary or of another independent loss reserve specialist acceptable to the Commissioner, reporting loss ratios for each kind of insurance written and attesting to the adequacy of loss reserves established for losses incurred and outstanding and for incurred but not reported losses as of the end of the prior calendar year on business placed by the producer.

(h) The controlled insurer shall report annually to the Commissioner the amount of commissions paid to the controlling producer, the percentage that amount represents of the net premiums written, and comparable amounts and percentages paid to noncontrolling producers for placements of the same kinds of insurance.

(i) The controlling producer, before the effective date of any policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controlled insurer: However, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in the controlling producer's records a signed commitment from the subproducer that the subproducer is aware of the relationship

between the insurer and the producer and that the subproducer has or will notify the prospective insured.

(j) If the Commissioner believes that a controlling producer or any other person has not materially complied with this section or with any rule adopted or order issued under this section, after notice and opportunity to be heard, the Commissioner may order the controlling producer to stop placing business with the controlled insurer. If it is found that, because of the material noncompliance, the controlled insurer or any policyholder of the controlled insurer has suffered any loss or damage, the Commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

(k) If an order for liquidation or rehabilitation of the controlled insurer has been entered under Article 30 of this Chapter, and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this section or any rule adopted or order issued under this section, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(l) In addition to any other remedies provided in this section, whenever the Commissioner believes that a person has not materially complied with this section, the Commissioner may institute a proceeding under G.S. 58-2-60 or under G.S. 58-2-70. In addition to the civil penalty or restitution proceedings provided for in G.S. 58-2-70, the Commissioner may issue a cease and desist order against the person.

(m) This section does not affect the Commissioner's right to impose any other penalties provided for in this Chapter nor the rights of policyholders, claimants, creditors, or other third parties.

(n) Controlled insurers and controlling producers who are not in compliance with subsection (e) of this section on October 1, 1991, have until December 1, 1991, to come into compliance and shall comply with subsection (i) of this section beginning with all policies written or renewed on or after December 1, 1991. (1991, c. 681, s. 28; c. 720, s. 92; 2014-65, s. 20.)

§ 58-3-167. Applicability of acts of the General Assembly to health benefit plans.

(a) As used in this section:

- (1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" does not mean any plan implemented or administered by the State Health Plan for Teachers and State Employees. "Health benefit plan" does not mean any plan consisting of one or more of any combination of benefits described in G.S. 58-68-25(b).
- (2) "Insurer" includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance

organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 50A of this Chapter.

(b) Whenever a law is enacted by the General Assembly on or after October 1, 1999 that applies to a health benefit plan, the term "health benefit plan" shall be defined for purposes of that law as provided in subsection (a) of this section unless that law provides a different definition or otherwise expressly provides that the definition in this section is not applicable.

(c) Whenever a law is enacted by the General Assembly that applies to health benefit plans that are delivered, issued for delivery, or renewed on and after a certain date, the renewal of a health benefit plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan. (1999-294, s. 5; 1999-456, s. 16; 2007-298, s. 7.2; 2007-484, s. 43.5; 2016-104, s. 8; 2019-202, s. 8.)

§ 58-3-168. Coverage for postmastectomy inpatient care.

(a) Every entity providing a health benefit plan that provides coverage for mastectomy, including coverage for postmastectomy inpatient care, shall ensure that the decision whether to discharge the patient following mastectomy is made by the attending physician in consultation with the patient, and shall further ensure that the length of postmastectomy hospital stay is based on the unique characteristics of each patient taking into consideration the health and medical history of the patient.

(b) As used in this section, "health benefit plans" means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA.

(c) As used in this section, "mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease. (1997-440, s. 1.)

§ 58-3-169. Required coverage for minimum hospital stay following birth.

(a) Definitions. – As used in this section:

(1) "Attending providers" includes:

- a. The obstetrician-gynecologists, pediatricians, family physicians, and other physicians primarily responsible for the care of a mother and newborn; and
- b. The nurse midwives and nurse practitioners primarily responsible for the care of a mother and her newborn child in accordance with State licensure and certification laws.

(2) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" does not mean any of the following kinds of insurance:

- a. Accident,
- b. Credit,

- c. Disability income,
- d. Long-term or nursing home care,
- e. Medicare supplement,
- f. Specified disease,
- g. Dental or vision,
- h. Coverage issued as a supplement to liability insurance,
- i. Workers' compensation,
- j. Medical payments under automobile or homeowners, and
- k. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
- l. Hospital income or indemnity.

(3) "Insurer" means an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 50A of this Chapter.

(b) In General. – Except as provided in subsection (c) of this section, an insurer that provides a health benefit plan that contains maternity benefits, including benefits for childbirth, shall ensure that coverage is provided with respect to a mother who is a participant, beneficiary, or policyholder under the plan and her newborn child for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requiring the attending provider to obtain authorization from the insurer or its representative.

(c) Exception. – Notwithstanding subsection (b) of this section, an insurer is not required to provide coverage for postdelivery inpatient length of stay for a mother who is a participant, beneficiary, or policyholder under the insurer's health benefit plan and her newborn child for the period referred to in subsection (b) of this section if:

- (1) A decision to discharge the mother and her newborn child before the expiration of the period is made by the attending provider in consultation with the mother; and
- (2) The health benefit plan provides coverage for postdelivery follow-up care as described in subsections (d) and (e) of this section.

(d) Postdelivery Follow-Up Care. – In the case of a decision to discharge a mother and her newborn child from the inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, the health benefit plan shall provide coverage for timely postdelivery care. This health care shall be provided to a mother and her newborn child by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in:

- (1) The home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or
- (2) Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

The attending provider in consultation with the mother shall decide the most appropriate location for follow-up care.

(e) Timely Care. – As used in subsection (d) of this section, "timely postdelivery care" means health care that is provided:

- (1) Following the discharge of a mother and her newborn child from the inpatient setting; and
- (2) In a manner that meets the health care needs of the mother and her newborn child, that provides for the appropriate monitoring of the conditions of the mother and child, and that occurs not later than the 72-hour period immediately following discharge.

(f) Prohibitions. – An insurer shall not:

- (1) Deny enrollment, renewal, or continued coverage with respect to its health benefit plan to a mother and her newborn child who are participants, beneficiaries, or policyholders, based on compliance with this section;
- (2) Provide monetary payments or rebates to mothers to encourage the mothers to request less than the minimum coverage required under this section;
- (3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided treatment to an individual policyholder, participant, or beneficiary in accordance with this section; or
- (4) Provide monetary or other incentives to an attending provider to induce the provider to provide treatment to an individual policyholder, participant, or beneficiary in a manner inconsistent with this section.

(g) Effect on Mother. – Nothing in this section requires that a mother who is a participant, beneficiary, or policyholder covered under this section:

- (1) Give birth in a hospital; or
- (2) Stay in the hospital for a fixed period of time following the birth of her child.

(h) Level and Type of Reimbursements. – Nothing in this section prevents an insurer from negotiating the level and type of reimbursement with an attending provider for care provided in accordance with this section. (1997-259, s. 19; 2019-202, s. 8.)

§ 58-3-170. Requirements for maternity coverage.

(a) Every entity providing a health benefit plan that provides maternity coverage in this State shall provide benefits for the necessary care and treatment related to maternity that are no less favorable than benefits for physical illness generally.

(a1) Repealed by Session Laws 1997-259, s. 20.

(b) As used in this section, "health benefit plans" means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts; and plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA. (1993, c. 506, s. 2; 1995, c. 517, s. 3.1; 1997-259, s. 20.)

§ 58-3-171. Uniform claim forms.

(a) All claims submitted by health care providers to health benefit plans shall be submitted on a uniform form or format that shall be developed by the Department and approved by the Commissioner. Additional information beyond that contained on the uniform form or format may be collected subject to rules adopted by the Commissioner. This section applies to the submission of claims in writing and by electronic means.

(b) After consultation with the North Carolina Industrial Commission, the Commissioner may include workers' compensation insurance policies as "health benefit plans" for the purpose of administering the provisions of this section.

(c) For purposes of this section, "health benefit plans" means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health maintenance organization (HMO) subscriber contracts and other plans provided by managed-care organizations; plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA; the State Health Plan for Teachers and State Employees and any optional plans or programs operating under Part 2 of Article 3 of Chapter 135 of the General Statutes; and medical payment coverages under homeowners and automobile insurance policies. (1993, c. 529, s. 4.2; 2007-298, s. 8.2; 2007-323, s. 28.22A(o); 2007-345, s. 12.)

§ 58-3-172. Notice of claim denied.

(a) For all claims denied for health care provider services under health benefit plans, written notification of the denied claim shall be given to the insured and to the health care provider submitting the claim if the health care provider would otherwise be eligible for payment. This subsection does not apply to insurers subject to G.S. 58-3-225.

(b) For purposes of this section, "health benefit plans" means accident and health insurance policies or certificates; nonprofit hospital or medical service corporation contracts; health, hospital, or medical service corporation plan contracts; health maintenance organization (HMO) subscriber contracts and other plans provided by managed-care organizations; plans provided by a MEWA or plans provided by other benefit arrangements, to the extent permitted by ERISA; and the State Health Plan for Teachers and State Employees and any optional plans or programs operating under Part 2 of Article 3 of Chapter 135 of the General Statutes. (1993, c. 529, s. 4.2; 1993 (Reg. Sess., 1994), c. 678, s. 6; 2000-162, s. 4(c); 2007-298, s. 8.3; 2007-323, s. 28.22A(o); 2007-345, s. 12.)

§ 58-3-173: Repealed by Session Laws 1997-259, s. 24.

§ 58-3-174. Coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass.

(a) Every entity providing a health benefit plan shall provide coverage for a qualified individual for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan shall apply to coverage for bone mass measurement.

(b) A health benefit plan may provide that bone mass measurement will be covered if at least 23 months have elapsed since the last bone mass measurement was performed, except that a plan must provide coverage for follow-up bone mass measurement performed more frequently than every 23 months if the follow-up measurement is medically necessary. Conditions under which more frequent bone mass measurement coverage may be medically necessary include, but are not limited to:

- (1) Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months.
- (2) Allowing for a central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified individual who is

proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

(c) Nothing in this section shall be construed to require health benefit plans to cover screening for nonqualified individuals.

(d) As used in this section, the term:

(1) "Bone mass measurement" means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

(2) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

- a. Accident
- b. Credit
- c. Disability income
- d. Long-term care or nursing home care
- e. Medicare supplement
- f. Specified disease
- g. Dental or vision
- h. Short-term limited duration coverage
- i. Coverage issued as a supplement to liability insurance
- j. Workers' compensation
- k. Medical payments under automobile or homeowners
- l. Hospital income or indemnity
- m. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(3) "Insurer" includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 50A of this Chapter.

(4) "Qualified individual" means any one or more of the following:

- a. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass.
- b. An individual with radiographic osteopenia anywhere in the skeleton.
- c. An individual who is receiving long-term glucocorticoid (steroid) therapy.
- d. An individual with primary hyperparathyroidism.

- e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.
- f. An individual who has a history of low-trauma fractures.
- g. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass. (1999-197, s. 1; 2019-202, s. 8.)

§ 58-3-175. Direct payment to government agencies.

(a) As used in this section, "health benefit plan" has the same meaning as in G.S. 58-50-110(11) and includes the State Health Plan for Teachers and State Employees and any optional plans or programs operating under Part 2 of Article 3 of Chapter 135 of the General Statutes.

(b) Every entity providing or administering a health benefit plan covering persons in this State shall make payment for health care services covered by the health benefit plan that are provided by any State, county, or city agency, directly to the agency providing the services.

(c) This section does not apply to the extent the agency providing the services has been paid for the services by or on behalf of the person receiving the services.

(d) Nothing in this section shall require any entity providing or administering a health benefit plan covering persons in this State to pay any agency directly:

- (1) If the agency is outside of the health benefit plan's service area;
- (2) If the entity operates a program by which it only pays the health care provider directly upon the acceptance of certain rates and the agency does not accept said rates; or
- (3) If the entity operates a program by which it provides, authorizes, or arranges for a covered person to receive health care from a designated provider or refers the covered person to a designated provider, and the agency is not a designated provider. (1993, c. 41, s. 1; 2007-298, s. 8.4; 2007-323, s. 28.22A(o); 2007-345, s. 12.)

§ 58-3-176. Treatment discussions not limited.

(a) An insurer shall not limit either of the following:

- (1) The participating plan provider's ability to discuss with an enrollee the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment.
- (2) The participating plan provider's professional obligations to patients as specified under the provider's professional license.

(b) Nothing in this section shall be construed to expand or revise the scope of benefits covered by a health benefit plan.

(c) As used in this section:

- (1) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

- a. Accident.
 - b. Credit.
 - c. Disability income.
 - d. Long-term or nursing home care.
 - e. Medicare supplement.
 - f. Specified disease.
 - g. Dental or vision.
 - h. Coverage issued as a supplement to liability insurance.
 - i. Workers' compensation.
 - j. Medical payments under automobile or homeowners insurance.
 - k. Hospital income or indemnity.
 - l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
- (2) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 50A of this Chapter. (1997-443, s. 11A.122; 1997-474, s. 1; 2019-202, s. 8.)

§ 58-3-177. Uniform prescription drug identification cards.

(a) Every health benefit plan that provides coverage for prescription drugs or devices and that issues a prescription drug card, shall issue to its insureds a uniform prescription drug identification card. The uniform prescription drug identification card shall contain the information listed in subdivisions (1) through (7) of this subsection in the following order beginning at the top left margin of the card:

- (1) The health benefit plan's name and/or logo.
- (2) The American National Standards Institute assigned Issuer Identification Number.
- (3) The processor control number.
- (4) The insured's group number.
- (5) The health benefit plan's card issuer identifier.
- (6) The insured's identification number.
- (7) The insured's name.

(b) In addition to the information required under subsection (a), the uniform prescription drug card shall contain, in one of the lower-most elements on the back side of the card, the following information:

- (1) The health benefit plan's claims submission name and address.
- (2) The health benefit plan's help desk telephone number and name.

Nothing in this section shall require a health benefit plan to violate a contractual agreement, service mark agreement, or trademark agreement.

(c) A new uniform prescription drug identification card as required under subsection (a) of this section shall be issued annually by a health benefit plan if there has been any change in the insured's coverage in the previous 12 months. A change in the insured's coverage shall include, but is not limited to, the addition or deletion of a dependent of the insured covered by a health benefit plan.

(d) Not later than January 1, 2003, the uniform prescription drug identification card provided under subsection (a) of this section shall contain one of the following mediums capable of the processing or adjudicating of a claim through electronic verification:

- (1) A magnetic strip.
- (2) A bar code.
- (3) Any new technology available that is capable of processing or adjudicating a claim by electronic verification.

(e) As used in this section, "health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" does not mean any of the following kinds of insurance:

- (1) Accident.
- (2) Credit.
- (3) Disability income.
- (4) Long-term or nursing home care.
- (5) Medicare supplement.
- (6) Specified disease.
- (7) Dental or vision.
- (8) Coverage issued as a supplement to liability insurance.
- (9) Workers' compensation.
- (10) Medical payments under automobile or homeowners.
- (11) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
- (12) Hospital income or indemnity.

(f) This section shall not apply to an entity that has its own facility and employs or contracts with physicians, pharmacists, nurses, and other health care personnel, to the extent that the entity dispenses prescription drugs or devices from its own pharmacies to its employees and to enrollees of its health benefit plan. This section does not apply to a health benefit plan that issues a single identification card to its insureds for all services covered under the plan. (1999-343, s. 1.)

§ 58-3-178. Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services; exemption for religious employers.

(a) Except as provided in subsection (e) of this section, every insurer providing a health benefit plan that provides coverage for prescription drugs or devices shall provide coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device. Except as otherwise provided in this subsection, the same deductibles, coinsurance, and other limitations as apply to prescription drugs or devices covered under the health benefit plan shall apply to coverage for prescribed contraceptive drugs or devices. A health benefit plan may require that the total coinsurance, based on the useful life of the drug or device, be paid in advance for those drugs or devices that are inserted or prescribed and do not have to be refilled on a periodic basis.

(b) Every insurer providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall provide coverage for outpatient contraceptive services. The same deductibles, coinsurance, and other limitations as apply to outpatient services covered under the health benefit plan shall apply to coverage for outpatient contraceptive services.

(c) As used in this section, the term:

- (1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
 - a. Accident.
 - b. Credit.
 - c. Disability income.
 - d. Long-term care or nursing home care.
 - e. Medicare supplement.
 - f. Specified disease.
 - g. Dental or vision.
 - h. Coverage issued as a supplement to liability insurance.
 - i. Workers' compensation.
 - j. Medical payments under automobile or homeowners.
 - k. Hospital income or indemnity.
 - l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
 - m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.
- (2) "Insurer" includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 50A of this Chapter.
- (3) "Outpatient contraceptive services" means consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy.
- (4) "Prescribed contraceptive drugs or devices" means drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State. Prescription drugs or devices required to be covered under this section shall not include:

- a. The prescription drug known as "RU-486" or any "equivalent drug product" as defined in G.S. 90-85.27.
 - b. The prescription drug marketed under the name "Preven" or any "equivalent drug product" as defined in G.S. 90-85.27.
- (d) A health benefit plan subject to this section shall not do any of the following:
- (1) Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section.
 - (2) Provide monetary payments or rebates to an individual participant or beneficiary to encourage the individual participant or beneficiary to accept less than the minimum protections available under this section.
 - (3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider prescribed contraceptive drugs or devices, or provided contraceptive services in accordance with this section.
 - (4) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to withhold from an individual participant or beneficiary contraceptive drugs, devices, or services.

(e) A religious employer may request an insurer providing a health benefit plan to provide to the religious employer a health benefit plan that excludes coverage for prescription contraceptive drugs or devices that are contrary to the employer's religious tenets. Upon request, the insurer shall provide the requested health benefit plan. An insurer providing a health benefit plan requested by a religious employer pursuant to this section shall provide written notice to each person covered under the health benefit plan that prescription contraceptive drugs or devices are excluded from coverage pursuant to this section at the request of the employer. The notice shall appear, in not less than 10-point type, in the health benefit plan, application, and sales brochure for the health benefit plan. Nothing in this subsection authorizes a health benefit plan to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes, or for prescription contraception that is necessary to preserve the life or health of a person covered under the plan. As used in this subsection, the term "religious employer" means an entity for which all of the following are true:

- (1) The entity is organized and operated for religious purposes and is tax exempt under section 501(c)(3) of the U.S. Internal Revenue Code.
- (2) The inculcation of religious values is one of the primary purposes of the entity.
- (3) The entity employs primarily persons who share the religious tenets of the entity. (1999-231, s. 1; 1999-456, s. 15(a); 2015-27, s. 4; 2019-202, s. 8.)

§ 58-3-179. Coverage for colorectal cancer screening.

(a) Every health benefit plan, as defined in G.S. 58-3-167, shall provide coverage for colorectal cancer examinations and laboratory tests for cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control for colorectal cancer screening, for any nonsymptomatic covered individual who is:

- (1) At least 50 years of age, or
- (2) Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American

Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan apply to coverage for colorectal examinations and laboratory tests required to be covered under this section.

(b) Reserved for future codification purposes. (2001-116, s. 1.)

§ 58-3-180. Motor vehicle repairs; selection by claimant.

(a) A policy covering damage to a motor vehicle shall allow the claimant to select the repair service or source for the repair of the damage.

(b) The amount determined by the insurer to be payable under a policy covering damage to a motor vehicle shall be paid regardless of the repair service or source selected by the claimant.

(b1) No insurer or insurer representative shall recommend the use of a particular motor vehicle repair service without clearly informing the claimant that (i) the claimant is under no obligation to use the recommended repair service, (ii) the claimant may use the repair service of the claimant's choice, (iii) the amount determined by the insurer to be payable under the policy will be paid regardless of whether or not the claimant uses the recommended repair service, and (iv) that the insurer or insurer representative has, at the time the recommendations are made, a financial interest in the recommended motor vehicle repair service. No insurer shall require that the insured or claimant must have a damaged vehicle repaired at an insurer-owned motor vehicle repair service.

(b2) The provisions of subsection (b1) of this section shall be included in nonfleet private passenger motor vehicle insurance policy forms promulgated by the Bureau and approved by the Commissioner.

(c) Any person who violates this section is subject to the applicable provisions of G.S. 58-2-70 and G.S. 58-33-46, provided that the maximum civil penalty that can be assessed under G.S. 58-2-70(d) for a violation of this section is two thousand dollars (\$2,000).

(d) As used in this section, "insurer representative" includes an insurance producer, limited representative, adjuster, and appraiser. (1993, c. 525, s. 2; 2001-203, s. 26; 2001-451, s. 1; 2003-395, s. 1; 2022-46, s. 14(n).)

§ 58-3-181. Synchronization of prescription refills.

(a) Every health benefit plan that provides coverage for prescription drugs shall provide for synchronization of medication when it is agreed among the insured, the provider, and a pharmacist that synchronization of multiple prescriptions for the treatment of a chronic illness is in the best interest of the insured for the management or treatment of a chronic illness, provided all of the following apply:

- (1) The medications are covered by the clinical coverage policy.
- (2) The medications are used for treatment and management of chronic conditions, and the medications are subject to refills.
- (3) The medications are not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.
- (4) The medications meet all prior authorization criteria specific to the medications at the time of the synchronization request.
- (5) The medications are of a formulation that can be effectively split over required short-fill periods to achieve synchronization.

(6) The medications do not have quantity limits or dose optimization criteria or requirements that would be violated in fulfilling synchronization.

(b) When applicable to permit synchronization, the health benefit plan shall apply a prorated daily cost-sharing rate to any medication dispensed by a network pharmacy pursuant to this section. Any dispensing fee shall not be prorated and shall be based on an individual prescription filled or refilled.

(c) The following definitions apply in this section:

(1) Health benefit plan. – As defined in G.S. 58-3-167. The phrase also applies to limited-scope dental and vision insurance.

(2) Health care provider or provider. – As defined in G.S. 58-3-225(a)(4).

(3) Insured. – An individual who is eligible to receive benefits from the health benefit plan.

(4) Insurer. – As defined in G.S. 58-3-225(a)(5). (2015-241, s. 20.2(a).)

§ 58-3-185. Lien created for payment of past-due child support obligations.

(a) In the event that the Department of Health and Human Services or any other obligee, as defined in G.S. 110-129, provides written notification to an insurance company authorized to issue policies of insurance pursuant to this Chapter that a claimant or beneficiary under a contract of insurance owes past-due child support and accompanies this information with a certified copy of the court order ordering support together with proof that the claimant or beneficiary is past due in meeting this obligation, there is created a lien upon any insurance proceeds in favor of the Department or obligee. This section shall apply only in those instances in which there is a nonrecurring payment of a lump-sum amount equal to or in excess of three thousand dollars (\$3,000) or periodic payments with an aggregate amount that equals or exceeds three thousand dollars (\$3,000).

(b) Liens arising under this section shall be subordinate to liens upon insurance proceeds for personal injuries arising under Article 9 of Chapter 44 of the General Statutes and valid health care provider claims covered by health benefit plans as defined in G.S. 58-3-172. As used in this section, the term health benefit plans does not include disability income insurance. (1995, c. 538, s. 6(a); 1995 (Reg. Sess., 1996), c. 674, ss. 1, 2; 1997-443, s. 11A.118(a).)

§ 58-3-190. Coverage required for emergency care.

(a) Every insurer shall provide coverage for emergency services to the extent necessary to screen and to stabilize the person covered under the plan and shall not require prior authorization of the services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(b) With respect to emergency services provided by a health care provider who is not under contract with the insurer, the services shall be covered if:

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or

(2) The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person.

(c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the

authorization was based on a material misrepresentation about the covered person's health condition made by the provider of the emergency services or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

(e) Both the emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

(f) Insurers shall provide information to their covered persons on all of the following:

- (1) Coverage of emergency medical services.
- (2) The appropriate use of emergency services, including the use of the "911" system and other telephone access systems utilized to access prehospital emergency services.
- (3) Any cost-sharing provisions for emergency medical services.
- (4) The process and procedures for obtaining emergency services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which covered persons may receive medical care.

(g) As used in this section, the term:

- (1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:
 - a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
 - b. Serious impairment to bodily functions.
 - c. Serious dysfunction of any bodily organ or part.
- (2) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.
- (3) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
 - a. Accident.

- b. Credit.
 - c. Disability income.
 - d. Long-term or nursing home care.
 - e. Medicare supplement.
 - f. Specified disease.
 - g. Dental or vision.
 - h. Coverage issued as a supplement to liability insurance.
 - i. Workers' compensation.
 - j. Medical payments under automobile or homeowners insurance.
 - k. Hospital income or indemnity.
 - l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
- (4) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 50A of this Chapter.
- (5) "To stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred. (1997-443, s. 11A.122; 1997-474, s. 2; 2019-202, s. 8)

§ 58-3-191. Managed care reporting and disclosure requirements.

- (a) Repealed by Session Laws 2015-92, s. 6, effective June 19, 2015.
- (b) Disclosure requirements. – Each health benefit plan shall provide the following applicable information to plan participants and bona fide prospective participants upon request:
 - (1) The evidence of coverage (G.S. 58-67-50), subscriber contract (G.S. 58-65-60, 58-65-140), health insurance policy (G.S. 58-51-80, 58-50-125, 58-50-126, 58-50-55), or the contract and benefit summary of any other type of health benefit plan;
 - (2) An explanation of the utilization review criteria and treatment protocol under which treatments are provided for conditions specified by the prospective participant. This explanation shall be in writing if so requested;
 - (3) If denied a recommended treatment, written reasons for the denial and an explanation of the utilization review criteria or treatment protocol upon which the denial was based;
 - (4) The plan's formularies, restricted access drugs or devices as defined in G.S. 58-3-221, or prior approval requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its

formulary, and the circumstances under which a nonformulary drug may be covered; and

(5) The plan's procedures and medically based criteria for determining whether a specified procedure, test, or treatment is experimental.

(b1) Repealed by Session Laws 2015-92, s. 6, effective June 19, 2015.

(c) For purposes of this section, "health benefit plan" or "plan" means (i) health maintenance organization (HMO) subscriber contracts and (ii) insurance company or hospital and medical service corporation preferred provider benefit plans as defined in G.S. 58-50-56. (1997-480, s. 1; 1997-519, s. 1.1; 2001-334, s. 2.2; 2001-446, s. 2.1; 2006-154, s. 13; 2008-124, s. 10.1; 2015-92, s. 6.)

§ 58-3-192. Coverage for autism spectrum disorder.

(a) As used in this section, the following definitions apply:

(1) Adaptive behavior treatment. – Behavioral and developmental interventions that systematically manage instructional and environmental factors or the consequences of behavior that have been shown to be clinically effective through research published in peer reviewed scientific journals and based upon randomized, quasi-experimental, or single subject designs. Both of the following requirements must be met:

a. The intervention must be necessary to (i) increase appropriate or adaptive behaviors, (ii) decrease maladaptive behaviors, or (iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

b. The treatment must be ordered by a licensed physician or licensed psychologist and the treatment must be provided or supervised by one of the following professionals, so long as the services or supervision provided is commensurate with the professional's training, experience, and scope of practice:

1. A licensed psychologist or psychological associate.
2. A licensed psychiatrist or developmental pediatrician.
3. A licensed speech and language pathologist.
4. A licensed occupational therapist.
5. A licensed clinical social worker.
6. A licensed clinical mental health counselor.
7. A licensed marriage and family therapist.
8. A board certified behavior analyst.

(2) Autism spectrum disorder. – As defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most recent edition of the International Statistical Classification of Diseases and Related Health Problems. Autism spectrum disorder is not considered a mental illness as defined in G.S. 58-3-220, 58-51-55, 58-65-90, or 58-67-75.

(3) Diagnosis of autism spectrum disorder. – Any medically necessary assessments, evaluations, or tests to determine whether an individual has autism spectrum disorder.

(4) Health benefit plan. – As defined in G.S. 58-3-167.

(5) Pharmacy care. – Medications prescribed by a licensed health care provider.

- (6) Psychiatric care. – Direct or consultative services provided by a licensed psychiatrist.
- (7) Psychological care. – Direct or consultative services provided by a licensed psychologist or licensed psychological associate.
- (8) Therapeutic care. – Direct or consultative services provided by a licensed speech therapist, licensed occupational therapist, licensed physical therapist, licensed clinical social worker, licensed clinical mental health counselor, or licensed marriage and family therapists.
- (9) Treatment for autism spectrum disorder. – Any of the following care for an individual diagnosed with autism spectrum disorder, or equipment related to that care, ordered by a licensed physician or a licensed psychologist who determines the care to be medically necessary:
 - a. Adaptive behavior treatment.
 - b. Pharmacy care.
 - c. Psychiatric care.
 - d. Psychological care.
 - e. Therapeutic care.

(b) Except as provided in subsection (c) of this section, health benefit plans shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to issue, amend, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder.

(c) Coverage for adaptive behavior treatment under this section may be subject to a maximum benefit of up to forty thousand dollars (\$40,000) per year and may be limited to individuals 18 years of age or younger. Beginning in 2017 and for subsequent years, the amount shall be indexed using the Consumer Price Index for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of March of the year preceding the change divided by the index as of March 2015. This amount shall be posted by the Commissioner no later than April 1 of each year and shall apply to policies renewed or purchased the following calendar year.

(d) Coverage under this section may not be denied on the basis that the treatments are habilitative or educational in nature.

(e) Coverage under this section may be subject to co-payment, deductible, and coinsurance provisions of a health benefit plan that are not less favorable than the co-payment, deductible, and coinsurance provisions that apply to substantially all medical services covered by the health benefit plan.

(f) This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

(g) Nothing in this section shall apply to non-grandfathered health plans in the individual and small group markets that are subject to the requirement to cover the essential health benefit package under 45 C.F.R. § 147.150(a).

(h) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

(i) Except as provided in subsection (c) of this section, health benefit plans shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder in accordance

with the standards contained in Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and the applicable regulations, as amended. (2015-271, s. 2; 2017-57, s. 22.3(a); 2019-240, s. 3(e).)

§ 58-3-200. Miscellaneous insurance and managed care coverage and network provisions.

(a) Definitions. – As used in this section:

(1) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

- a. Accident.
- b. Credit.
- c. Disability income.
- d. Long-term or nursing home care.
- e. Medicare supplement.
- f. Specified disease.
- g. Dental or vision.
- h. Coverage issued as a supplement to liability insurance.
- i. Workers' compensation.
- j. Medical payments under automobile or homeowners insurance.
- k. Hospital income or indemnity.
- l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 50A of this Chapter.

(b) Medical Necessity. – An insurer that limits its health benefit plan coverage to medically necessary services and supplies shall define "medically necessary services or supplies" in its health benefit plan as those covered services or supplies that are:

- (1) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
- (2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- (3) Within generally accepted standards of medical care in the community.
- (4) Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

(c) Coverage Determinations. – If an insurer or its authorized representative determines that services, supplies, or other items are covered under its health benefit plan or dental plan, including any determination under G.S. 58-50-61, the insurer shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the insured's health condition that was knowingly made by the insured or the provider of the service, supply, or other item. For purposes of this subsection, a pretreatment estimate means a voluntary request for a projection of dental benefits or payment that does not require authorization and a pretreatment estimate for dental services shall not be considered a coverage determination.

(d) Services Outside Provider Networks. – No insurer shall penalize an insured or subject an insured to the out-of-network benefit levels offered under the insured's approved health benefit plan, including an insured receiving an extended or standing referral under G.S. 58-3-223, unless contracting health care providers able to meet health needs of the insured are reasonably available to the insured without unreasonable delay.

(e) Nondiscrimination Against High-Risk Populations. – No insurer shall establish provider selection or contract renewal standards or procedures that are designed to avoid or otherwise have the effect of avoiding enrolling high-risk populations by excluding providers because they are located in geographic areas that contain high-risk populations or because they treat or specialize in treating populations that present a risk of higher-than-average claims or health care services utilization. This subsection does not prohibit an insurer from declining to select a provider or from not renewing a contract with a provider who fails to meet the insurer's selection criteria.

(f) Continuing Care Retirement Community Residents. – As used in this subsection, "Medicare benefits" means medical and health products, benefits, and services used in accordance with Title XVIII of the Social Security Act. If an insured with coverage for Medicare benefits or similar benefits under a plan for retired federal government employees is a resident of a continuing care retirement community regulated under Article 64 of this Chapter, and the insured's primary care physician determines that it is medically necessary for the insured to be referred to a skilled nursing facility upon discharge from an acute care facility, the insurer shall not require that the insured relocate to a skilled nursing facility outside the continuing care retirement community if the continuing care retirement community:

- (1) Is a Medicare-certified skilled nursing facility.
- (2) Agrees to be reimbursed at the insurer's contract rate negotiated with similar providers for the same services and supplies.
- (3) Agrees not to bill the insured for fees over and above the insurer's contract rate.
- (4) Meets all guidelines established by the insurer related to quality of care, including:
 - a. Quality assurance programs that promote continuous quality improvement.
 - b. Standards for performance measurement for measuring and reporting the quality of health care services provided to insureds.

- c. Utilization review, including compliance with utilization management procedures.
 - d. Confidentiality of medical information.
 - e. Insured grievances and appeals from adverse treatment decisions.
 - f. Nondiscrimination.
- (5) Agrees to comply with the insurer's procedures for referral authorization, risk assumption, use of insurer services, and other criteria applicable to providers under contract for the same services and supplies.

A continuing care retirement community that satisfies subdivisions (1) through (5) of this subsection shall not be obligated to accept, as a skilled nursing facility, any patient other than a resident of the continuing care retirement community, and neither the insurer nor the retirement community shall be allowed to list or otherwise advertise the skilled nursing facility as a participating network provider for Medicare benefits for anyone other than residents of the continuing care retirement community. (1997-443, s. 11A.122; 1997-519, s. 2.1; 2001-446, ss. 5(b), 1.2A; 2019-26, s. 3; 2019-202, s. 8.)

§ 58-3-215. Genetic information in health insurance.

(a) Definitions. – As used in this section:

- (1) "Genetic information" means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member. "Genetic information" does not include the results of routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus.
- (2) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:
 - a. Accident
 - b. Credit
 - c. Disability income
 - d. Long-term or nursing home care
 - e. Medicare supplement
 - f. Specified disease
 - g. Dental or vision
 - h. Coverage issued as a supplement to liability insurance
 - i. Workers' compensation
 - j. Medical payments under automobile or homeowners
 - k. Hospital income or indemnity

- l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance
 - m. Blanket accident and sickness.
- (3) "Insurer" means an insurance company subject to this Chapter; a service corporation organized under Article 65 of this Chapter; a health maintenance organization organized under Article 67 of this Chapter; or a multiple employer welfare arrangement subject to Article 50A of this Chapter.
- (b) For the purpose of this section, routine physical measurements, blood chemistries, blood counts, urine analyses, tests for abuse of drugs, and tests for the presence of human immunodeficiency virus are not to be considered genetic tests.
- (c) No insurer shall:
- (1) Raise the premium or contribution rates paid by a group for a group health benefit plan on the basis of genetic information obtained about an individual member of the group.
 - (2) Refuse to issue or deliver a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan.
 - (3) Charge a higher premium rate or charge for a health benefit plan because of genetic information obtained about any person to be insured by the health benefit plan.
- (d) Notwithstanding any other provision of this section, a health benefit plan, as defined in G.S. 58-3-167, and insurers, as defined in G.S. 58-3-167, shall comply with all applicable standards of Public Law 110-233, known as the Genetic Information Nondiscrimination Act of 2008, as amended by Public Law 110-343, and as further amended. (1997-350, s. 1; 1997-443, s. 11A.118(b); 2009-382, s. 18; 2019-202, s. 8.)

§ 58-3-220. Mental illness benefits coverage.

(a) **Mental Health Equity Requirement.** – Except as provided in subsection (b), an insurer shall provide in each group health benefit plan benefits for the necessary care and treatment of mental illnesses that are no less favorable than benefits for physical illness generally, including application of the same limits. For purposes of this subsection, mental illnesses are as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent edition as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes. For purposes of this subsection, "limits" includes deductibles, coinsurance factors, co-payments, maximum out-of-pocket limits, annual and lifetime dollar limits, and any other dollar limits or fees for covered services.

(b) **Minimum Required Benefits.** – Except as provided in subsection (c), a group health benefit plan may apply durational limits to mental illnesses that differ from durational limits that apply to physical illnesses. A group health benefit plan shall provide at least the following minimum number of office visits and combined inpatient and outpatient days for all mental illnesses and disorders not listed in subsection (c), as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or a subsequent edition published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or

subsequent edition as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes:

- (1) Thirty combined inpatient and outpatient days per year.
- (2) Thirty office visits per year.

(c) Durational limits for the following mental illnesses shall be subject to the same limits as benefits for physical illness generally:

- (1) Bipolar Disorder.
- (2) Major Depressive Disorder.
- (3) Obsessive Compulsive Disorder.
- (4) Paranoid and Other Psychotic Disorder.
- (5) Schizoaffective Disorder.
- (6) Schizophrenia.
- (7) Post-Traumatic Stress Disorder.
- (8) Anorexia Nervosa.
- (9) Bulimia.

(d) Nothing in this section prevents an insurer from offering a group health benefit plan that provides greater than the minimum required benefits, as set forth in subsection (b).

(e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care.

(f) **Weighted Average.** – If a group health benefit plan contains annual limits, lifetime limits, co-payments, deductibles, or coinsurance only on selected physical illness and injury benefits, and these benefits do not represent substantially all of the physical illness and injury benefits under the group health benefit plan, then the insurer may impose limits on the mental health benefits based on a weighted average of the respective annual, lifetime, co-payment, deductible, or coinsurance limits on the selected physical illness and injury benefits. The weighted average shall be calculated in accordance with rules adopted by the Commissioner.

(g) Nothing in this section prevents an insurer from applying utilization review criteria to determine medical necessity as defined in G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and, where applicable, health benefit plan external review as provided for in Part 4 of Article 50 of Chapter 58 of the General Statutes.

(h) **Definitions.** – As used in this section:

- (1) "Health benefit plan" has the same meaning as in G.S. 58-3-167.
- (2) "Insurer" has the same meaning as in G.S. 58-3-167.
- (3) "Mental illness" has the same meaning as in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent editions as autism spectrum disorder (299.00), substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

(i) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and mental health benefits shall, with respect to the

mental health benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and the applicable regulations, as amended.

(j) Subsection (i) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-25(a)(10). (2007-268, s. 2; 2009-382, s. 19; 2015-271, s. 1.)

§ 58-3-221. Access to nonformulary and restricted access prescription drugs.

(a) If an insurer (i) maintains one or more closed formularies for or restricts access to covered prescription drugs or devices or (ii) requires an enrollee in a plan with an open or closed formulary to use a prescription drug or sequence of prescription drugs, other than the drug the enrollee's health care provider recommends, before the insurer provides coverage for the recommended prescription drug, then the insurer shall do all of the following:

- (1) Develop the formularies or protocols and any restrictions on access to covered prescription drugs or devices in consultation with and with the approval of a pharmacy and therapeutics committee.
- (2) Make available to participating providers, pharmacists, and enrollees the complete drugs or devices formulary or formularies maintained by the insurer including a list of the devices and prescription drugs on the formulary by major therapeutic category that specifies whether a particular drug or device is preferred over other drugs or devices, as well as any utilization management program indicators.
- (3) Update protocols based on a review of new evidence, research, and newly developed treatments.
- (4) An insurer, or a pharmacy benefits manager under contract with an insurer, shall require that its pharmacy and therapeutics committee either meet the requirements for conflict of interest set by the Center for Medicare and Medicaid Services or meet the accreditation standards of the National Committee for Quality Assurance or another independent accrediting organization.

(b) An insurer may not void a contract or refuse to renew a contract between the insurer and a prescribing provider because the prescribing provider has prescribed a medically necessary and appropriate nonformulary or restricted access drug or device as provided in this section.

(b1) Exception Process. – Each insurer shall establish and maintain an expeditious process or procedure, published on either the insurer's Web site or in policies provided to health care providers, that allows an enrollee or the enrollee's prescribing provider acting on behalf of the enrollee to obtain, without penalty or additional cost-sharing beyond that provided for in the health benefit plan, coverage for a specific nonformulary drug or device or the drug requested by the prescribing provider, if it is determined to be medically necessary and appropriate by the enrollee's prescribing provider and the prescription drug is covered under the current health benefit plan. [The following provisions apply:]

- (1) An insurer shall grant an exception request if the prescribing provider's submitted justification and supporting clinical documentation are sufficient to demonstrate any of the following:
 - a. The enrollee has tried the alternate drug or drugs while covered by the current or the previous health benefit plan.

- b. The formulary or alternate drug or drugs has been ineffective in the treatment of the enrollee's disease or condition.
 - c. The formulary or alternate drug or drugs causes or is reasonably expected by the prescribing provider to cause a harmful or adverse clinical reaction in the enrollee.
 - d. Either (i) the drug is prescribed in accordance with any applicable clinical protocol of the insurer for the prescribing of the drug or (ii) the drug has been approved as an exception to the clinical protocol pursuant to the insurer's exception procedure.
 - e. The enrollee's prescribing provider certifies in writing that the enrollee has previously used an alternative nonrestricted access drug or device and the alternative drug or device has been detrimental to the enrollee's health or has been ineffective in treating the same condition and, in the opinion of the prescribing health care provider, is likely to be detrimental to the enrollee's health or ineffective in treating the condition again.
- (2) Nothing in this section shall preclude an insurer from requiring prior authorization for the coverage of a prescribed drug that was covered by the enrollee's previous health benefit plan.
- (b2) Pharmaceutical drug samples or patient incentive programs, including coupons or debit cards, shall not be considered trial and failure of a preferred prescription drug in lieu of trying the formulary-preferred prescription drug.
- (b3) Exception Process Requirements. –
- (1) The insurer, health benefit plan, or utilization review organization may request relevant documentation from the patient or health care provider to support the exception request. Relevant information includes the results of any patient examination, clinical evaluation, or second opinion that may be required.
 - (2) A licensed physician or licensed pharmacist shall evaluate the clinical appropriateness of the exception request.
 - (3) For nonurgent exception requests for a prospective or concurrent review:
 - a. The insurer shall communicate to the enrollee's health care provider if additional information is required within 72 hours after the insurer receives the exception request.
 - b. The insurer shall communicate an exception request determination to the enrollee's providers within 72 hours after receiving all relevant information.
 - (4) In the case of an urgent review:
 - a. The insurer shall communicate to the enrollee's health care provider if additional information is required within 24 hours after the insurer receives the exception request.
 - b. The insurer shall communicate an exception request determination to the enrollee's providers within 24 hours after receiving all relevant information.
- (c) As used in this section:
- (1) "Closed formulary" means a list of prescription drugs and devices reimbursed by the insurer that excludes coverage for drugs and devices not listed.

- (1a) "Health benefit plan" has definition provided in G.S. 58-3-167.
- (2) "Insurer" has the meaning provided in G.S. 58-3-167.
- (3) "Restricted access drug or device" means those covered prescription drugs or devices for which reimbursement by the insurer is conditioned on the insurer's prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

(d) Nothing in this section requires an insurer to pay for drugs or devices or classes of drugs or devices related to a benefit that is specifically excluded from coverage by the insurer.

(e) This section shall not be construed to prevent the health benefit plan from requiring an enrollee to try an A-rated generic equivalent drug, or a biosimilar, as defined under 42 U.S.C. § 262(i)(2), prior to providing coverage for the equivalent branded prescription drug. (1999-178, s. 1; 1999-294, s. 14(a), (b); 2001-446, s. 1.5; 2020-82, s. 4(a).)

§ 58-3-223. Managed care access to specialist care.

(a) Each insurer offering a health benefit plan that does not allow direct access to all in-plan specialists shall develop and maintain written policies and procedures by which an insured may receive an extended or standing referral to an in-plan specialist. The insurer shall provide for an extended or standing referral to a specialist if the insured has a serious or chronic degenerative, disabling, or life-threatening disease or condition, which in the opinion of the insured's primary care physician, in consultation with the specialist, requires ongoing specialty care. The extended or standing referral shall be for a period not to exceed 12 months and shall be made under a treatment plan coordinated with the insurer in consultation with the primary care physician, the specialist, and the insured or the insured's designee.

(b) As used in this section:

- (1) "Health benefit plan" has the meaning applied in G.S. 58-3-167.
- (2) "Insurer" has the meaning applied in G.S. 58-3-167.
- (3) "Serious or chronic degenerative, disabling, or life-threatening disease or condition" means a disease or condition, which in the opinion of the patient's treating primary care physician and specialist, requires frequent and periodic monitoring and consultation with the specialist on an ongoing basis.
- (4) "Specialist" includes a subspecialist. (1999-168, s. 1; 2001-446, s. 1.2.)

§ 58-3-225. Prompt claim payments under health benefit plans.

(a) As used in this section:

- (1) "Claimant" includes a health care provider or facility that is responsible or permitted under contract with the insurer or by valid assignment of benefits for directly making the claim with an insurer.
- (2) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United

States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

- a. Credit.
 - b. Disability income.
 - c. Coverage issued as a supplement to liability insurance.
 - d. Hospital income or indemnity.
 - e. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
 - f. Long-term or nursing home care.
 - g. Medical payments under motor vehicle or homeowners' insurance policies.
 - h. Medicare supplement.
 - i. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.
 - j. Workers' compensation.
- (3) "Health care facility" means a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.
- (4) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.
- (5) "Insurer" includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 50A of this Chapter, that writes a health benefit plan.

(b) An insurer shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:

- (1) Payment of the claim.
- (2) Notice of denial of the claim.
- (3) Notice that the proof of loss is inadequate or incomplete.
- (4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.
- (5) Notice that coordination of benefits information is needed in order to pay the claim.
- (6) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to the insurer or an electronic claim transmitted to the insurer or a designated clearinghouse on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

(c) If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through the insurer which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, the insurer shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or HCFA form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information.

(d) If an insurer requests additional information under subsection (c) of this section and the insurer does not receive the additional information within 90 days after the request was made, the insurer shall deny the claim and send the notice of denial to the claimant in accordance with subsection (c) of this section. The insurer shall include the specific reason or reasons for denial in the notice, including the fact that information that was requested was not provided. The insurer shall inform the claimant in the notice that the claim will be reopened if the information previously requested is submitted to the insurer within one year after the date of the denial notice closing the claim.

(e) Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by the insurer under subsection (b) of this section, interest on health benefit claim payments shall begin to accrue on the 31st day after the insurer received the additional information. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the claimant. This subsection does not apply to claims for benefits that are not covered by the health benefit plan; nor does this subsection apply to deductibles, co-payments, or other amounts for which the insurer is not liable.

(f) Insurers may require that claims be submitted within 180 days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 days after the date of the patient's discharge from the facility. However, an insurer may not limit the time in which claims may be submitted to fewer than 180 days. Unless

otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required.

(g) If a claim for which the claimant is a health care provider or health care facility has not been paid or denied within 60 days after receipt of the initial claim, the insurer shall send a claim status report to the insured. Provided, however, that the claims status report is not required during the time an insurer is awaiting information requested under subsection (c) of this section. The report shall indicate that the claim is under review and the insurer is communicating with the health care provider or health care facility to resolve the matter. While a claim remains unresolved, the insurer shall send a claim status report to the insured with a copy to the provider 30 days after the previous report was sent.

(h) Subject to the time lines required under this section, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Not less than 30 calendar days before an insurer seeks overpayment recovery or offsets future payments, the insurer shall give written notice to the health care provider or health care facility, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two years after the date of the original claim payment unless the insurer has reasonable belief of fraud or other intentional misconduct by the health care provider or health care facility or its agents, or the claim involves a health care provider or health care facility receiving payment for the same service from a government payor. The health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The recovery of underpayments or nonpayments shall be made within the two years after the date of the original claim adjudication, unless the claim involves a health provider or health care facility receiving payment for the same service from a government payor.

(i) Every insurer shall maintain written or electronic records of its activities under this section, including records of when each claim was received, paid, denied, or pending, and the insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.

(j) A violation of this section by an insurer subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner under this subsection does not impair the right of a claimant to pursue any other action or remedy available under law. With respect to a specific claim, an insurer paying statutory interest in good faith under this section is not subject to sanctions for that claim under this subsection.

(k) An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, an insurer is not in violation of this section or subject to interest payments to the claimant under this section if the insurer has a

reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

(l) Expired January 1, 2003.

(m) Nothing in this section limits or impairs the patient's liability under existing law for payment of medical expenses. (2000-162, s. 4(a); 2001-417, s. 1; 2007-362, s. 1; 2009-382, s. 16; 2019-202, s. 8.)

§ 58-3-227. Health plans fee schedules.

(a) Definitions. – As used in this section, the following terms mean:

- (1) Claim submission policy. – The procedure adopted by an insurer and used by a provider or facility to submit to the insurer claims for services rendered and to seek reimbursement for those services.
- (2) Health care facility or facility. – A facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.
- (3) Health care provider or provider. – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.
- (4) Insurer. – An entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 50A of this Chapter.
- (5) Reimbursement policy. – Information relating to payment of providers and facilities including policies on the following:
 - a. Claims bundling and other claims editing processes.
 - b. Recognition or nonrecognition of CPT code modifiers.
 - c. Downcoding of services or procedures.
 - d. The definition of global surgery periods.
 - e. Multiple surgical procedures.
 - f. Payment based on the relationship of procedure code to diagnosis code.
- (6) Schedule of fees. – CPT, HCPCS, ICD-9-CM codes, ICD-10-CM codes, ASA codes, modifiers, and other applicable codes for the procedures billed for that class of provider.

(b) Purpose. – The purpose of this section is to establish the minimum required provisions for the disclosure and notification of an insurer's schedule of fees, claims submission, and reimbursement policies to health care providers and health care facilities. Nothing in this section shall supercede (i) the schedule of fees, claim submission, and reimbursement policy terms in an insurer's contract with a provider or facility that exceed the minimum requirements of this section nor (ii) any contractual requirement for mutual written consent of changes to reimbursement policies, claims submission policies, or fees. Nothing in this section shall prevent an insurer from requiring that providers and facilities keep confidential, and not disclose to third parties, the information that an insurer must provide under this section.

(c) Disclosure of Fee Schedules. – An insurer shall make available to contracted providers the following information:

- (1) The insurer's schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider, and, upon request, the full schedule of fees for services or procedures billed by that class of provider, in accordance with subdivision (3) of this subsection.
- (2) In the case of a contract incorporating multiple classes of providers, the insurer's schedule of fees associated with the top 30 services or procedures most commonly billed for each class of provider, and, upon request, the full schedule of fees for services or procedures billed for each class of provider, in accordance with subdivision (3) of this subsection.
- (3) If a provider requests fees for more than 30 services and procedures, the insurer may require the provider to specify the additional requested services and procedures and may limit the provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the provider. The insurer may also limit the frequency of requests for the additional codes by each provider, provided that such additional codes will be made available upon request at least annually and at any time there are changes for which notification is required pursuant to subsection (f) of this section.

(d) Disclosure of Policies. – An insurer shall make available to contracted providers and facilities a description of the insurer's claim submission and reimbursement policies.

(e) Availability of Information. – Insurers shall notify contracted providers and facilities in writing of the availability of information required or authorized to be provided under this section. An insurer may satisfy this requirement by indicating in the contract with the provider the availability of this information or by providing notice in a manner authorized under subsection (f) of this section for notification of changes.

(f) Notification of Changes. – Insurers shall provide advance notice to providers and facilities of changes to the information that insurers are required to provide under this section. The notice period for a change in the schedule of fees, reimbursement policies, or submission of claims policies shall be the contractual notice period, but in no event shall the notices be given less than 30 days prior to the change. An insurer is not required to provide advance notice of changes to the information required under this section if the change has the effect of increasing fees, expanding health benefit plan coverage, or is made for patient safety considerations, in which case, notification of the changes may be made concurrent with the implementation of the changes. Information and notice of changes may be provided in the medium selected by the insurer, including an electronic medium. However, the insurer must inform the affected contracted provider or facility of the notification method to be used by the insurer and, if the insurer uses an electronic medium to provide notice of changes required under this section, the insurer shall provide clear instructions regarding how the provider or facility may access the information contained in the notice.

(g) Reference Information. – If an insurer references source information that is the basis for a schedule of fees, reimbursement policy, or claim submission policy, and the source information is developed independently of the insurer, the insurer may satisfy the requirements of this section by providing clear instructions regarding how the provider or facility may readily access the source information or by providing for actual access if agreed to in the contract between the insurer and the provider.

(h) Contract Negotiations. – When an insurer offers a contract to a provider, the insurer shall also make available its schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider. Upon the request of a provider, the insurer shall also make available the full schedule of fees for services or procedures billed by that class of provider or for each class of provider in the case of a contract incorporating multiple classes of providers. If a provider requests fees for more than 30 services and procedures, the insurer may require the provider to specify the additional requested services and procedures and may limit the provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the provider.

(i) Expired pursuant to Session Laws 2003-364, s. 3, effective January 1, 2005. (2003-369, s. 1; 2017-205, s. 1; 2019-202, s. 8.)

§ 58-3-228. Coverage for extra prescriptions during a state of emergency or disaster.

(a) All health benefit plans as defined in G.S. 58-3-167, the State Health Plan for Teachers and State Employees, and any optional plans or programs operating under Part 2 of Article 3 of Chapter 135 of the General Statutes, and other stand-alone prescription medication plans issued by entities that are licensed by the Department shall have, when an event described in subdivision (b)(1) of this section occurs and the requirements of subdivisions (b)(2) and (b)(3) of this section are satisfied, a procedure in place to waive time restrictions on filling or refilling prescriptions for medication if requested by the covered person or subscriber. The procedure shall include waiver or override of electronic "refill too soon" edits to pharmacies and shall include provision for payment to the pharmacy in accordance with the prescription benefit plan and applicable pharmacy provider agreement. The procedure shall enable covered persons or subscribers to:

- (1) Obtain one refill on a prescription if there are authorized refills remaining, or
- (2) Fill one replacement prescription for one that was recently filled, as prescribed or approved by the prescriber of the prescription that is being replaced and not contrary to the dispensing authority of the dispensing pharmacy.

(b) All entities subject to this section shall authorize payment to pharmacies for any prescription dispensed in accordance with subsection (a) of this section regardless of the date upon which the prescription had most recently been filled by a pharmacist, if all of the following conditions apply:

- (1) The Commissioner issues a Bulletin Advisory notifying all insurance carriers licensed in this State of a declared state of disaster or state of emergency in North Carolina. The Department shall provide a copy of the Bulletin to the North Carolina Board of Pharmacy.
- (2) The covered person requesting coverage of the refill or replacement prescription resides in a county that:
 - a. Is covered under a state of emergency issued by the Governor or General Assembly under G.S. 166A-19.20, or a declaration of major disaster issued by the President of the United States under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121, et seq., as amended; or
 - b. Repealed by Session Laws 2012-12, s. 2(k), effective October 1, 2012.
- (3) The prescription medication is requested within 29 days after the origination date of the conditions stated in subdivision (b)(1) of this section.

(c) The time period for the waiver of prescription medication refills may be extended in 30-day increments by an order issued by the Commissioner. Additional refills still remaining on a prescription shall be covered by the insurer as long as consistent with the orders of the prescriber or authority of the dispensing pharmacy.

(d) This section does not excuse or exempt an insured or subscriber from any other terms of the policy or certificate providing coverage for prescription medications.

(e) Quantity limitations shall be consistent with the original prescription and the extra or replacement fill may recognize proportionate dosage use prior to the disaster.

(f) No requirements additional to those under the pharmacy provider agreement or the prescription benefit plan may be placed upon the provider for coverage of the replacement fill or extra fill.

(g) Nothing in this section is intended to affect the respective authority or scope of practice of prescribers or pharmacies. (2007-133, s. 1; 2007-323, s. 28.22A(o); 2007-345, s. 12; 2012-12, s. 2(k).)

§ 58-3-230. Uniform provider credentialing.

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care practitioner within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. If the insurer has not approved or denied the provider credentialing application form within 60 days of receipt of the completed application, upon receipt of a written request from the applicant and within five business days of its receipt, the insurer shall issue a temporary credential to the applicant if the applicant has a valid North Carolina professional or occupational license to provide the health care services to which the credential would apply. The insurer shall not issue a temporary credential if the applicant has reported on the application a history of medical malpractice claims, a history of substance abuse or mental health issues, or a history of Medical Board disciplinary action. The temporary credential shall be effective upon issuance and shall remain in effect until the provider's credentialing application is approved or denied by the insurer. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide health benefit plans with the information necessary to adequately assess and verify the qualifications of an applicant. The Commissioner may update the uniform provider credentialing application form, as necessary. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

(c) As used in this section, the terms "health benefit plan" and "insurer" shall have the meaning provided under G.S. 58-3-167. (2001-172, s. 1; 2002-126, s. 6.9(a); 2005-223, s. 9; 2009-487, s. 1.)

§ 58-3-231. Payment under locum tenens arrangements.

(a) As used in this section, the following definitions apply:

(1) Covered visit services. – All office visits, emergency visits, and any related service performed by a physician that is covered by the insurer.

- (2) Insurer. – Defined in G.S. 58-3-167(a).
- (3) Locum tenens agency. – A company authorized to conduct business in North Carolina that provides, through contract, locum tenens placement and administrative services for regular physicians, locum tenens physicians, medical groups, and hospitals.
- (4) Locum tenens physician. – A physician who substitutes for a regular physician on a temporary basis and is not an employee of the regular physician.
- (5) Regular physician. – The physician that is normally scheduled to see a patient, including physician specialists and a physician who has left a group practice for whom a locum tenens physician is retained.

(b) An insurer that provides a health benefit plan shall establish and maintain a process to allow a patient's regular physician to submit a claim and, if the claim is accepted, receive payment for covered visit services that the regular physician or a locum tenens agency arranges to be provided by a locum tenens physician, provided the following are true:

- (1) The regular physician is unavailable to provide the covered visit services or the locum tenens physician is assisting the regular physician in providing covered visit services.
- (2) The insured patient has arranged or seeks to receive the covered visit services from the regular physician.
- (3) The locum tenens physician does not provide the covered visit services to insured patients of a single regular physician for more than 90 consecutive days.
- (4) The regular physician identifies the covered visit services as locum tenens physician services meeting the requirements of this section by entering the proper code required by the insurer after the procedure code.
- (5) The regular physician pays for the locum tenens physician's covered visit services on a per diem or similar fee-for-time basis.
- (6) The regular physician maintains a record of each covered visit service provided by the locum tenens physician and makes this record available to the insurer upon request.

(c) A medical group or hospital may submit claims for the covered visit services of a locum tenens physician substituting for a regular physician who is a member of the group or an employee of the hospital if the requirements of subsection (b) of this section are met. For purposes of these requirements, per diem or similar fee-for-time compensation that the group or hospital pays for the locum tenens physician is considered paid by the regular physician. A physician who has left the group and for whom the group has engaged a locum tenens physician as a temporary replacement may bill for the temporary physician for up to 90 consecutive days.

(d) An insurer shall allow a locum tenens physician credentialed with that insurer to substitute for a regular physician in accordance with this section without a statement of supervision if (i) the regular physician is a solo practitioner or (ii) there is not otherwise a regular physician who is able to provide a statement of supervision.

(e) Locum tenens agencies may contract with regular physicians, medical groups, hospitals, and locum tenens physicians to provide placement and administrative services related to the locum tenens substitution, provided the following are true:

- (1) The locum tenens agency charges fees that are reasonably related to the value of the services that the locum tenens agency provides.

- (2) The locum tenens agency does not interfere with or attempt to influence the clinical judgment of a physician providing locum tenens services. (2011-315, s. 1.)

§ 58-3-235. Selection of specialist as primary care provider.

(a) Each insurer that offers a health benefit plan shall have a procedure by which an insured diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, either of which requires specialized medical care may select as his or her primary care physician a specialist with expertise in treating the disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the insurer determines that the insured's care would not be appropriately coordinated by that specialist, the insurer may deny access to that specialist as a primary care provider.

(b) The selection of the specialist shall be made under a treatment plan approved by the insurer, in consultation with the specialist and the insured or the insured's designee and after notice to the insured's primary care provider, if any. The specialist may provide ongoing care to the insured and may authorize such referrals, procedures, tests, and other medical services as the insured's primary care provider would otherwise be allowed to provide or authorize, subject to the terms of the treatment plan. Services provided by a specialist who is providing and coordinating primary and specialty care remain subject to utilization review and other requirements of the insurer, including its requirements for primary care providers. (2001-446, s. 1.3.)

§ 58-3-240. Direct access to pediatrician for minors.

Each insurer offering a health benefit plan that uses a network of contracting health care providers shall allow an insured to choose a contracting pediatrician in the network as the primary care provider for the insured's children under the age of 18 and covered under the policy. (2001-446, s. 1.4.)

§ 58-3-245. Provider directories; cost tools for insured.

(a) Every health benefit plan utilizing a provider network shall maintain a provider directory that includes a listing of network providers available to insureds and shall update the listing no less frequently than once a year. In addition, every health benefit plan shall maintain a telephone system and may maintain an electronic or on-line system through which insureds can access up-to-date network information. The health benefit plan shall ensure that a patient is provided accurate and current information on each provider's network status through the telephone system and any electronic or online system. If the health benefit plan produces printed directories, the directories shall contain language disclosing the date of publication, frequency of updates, that the directory listing may not contain the latest network information, and contact information for accessing up-to-date network information.

(b) Each directory listing shall include the following network information:

- (1) The provider's name, address, telephone number, and, if applicable, area of specialty.
- (2) Whether the provider may be selected as a primary care provider.
- (3) To the extent known to the health benefit plan, an indication of whether the provider:
 - a. Is or is not currently accepting new patients.

b. Has any other restrictions that would limit an insured's access to that provider.

(c) The directory listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the insurer's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified consistent with the requirements for the type of information required to be verified under G.S. 58-3-230.

(d) A health care provider shall provide to a patient or prospective patient, upon request, information on that provider's network status with a particular health benefit plan. (2001-446, s. 2.2; 2013-382, s. 13.4.)

§ 58-3-247. Insurance identification card.

(a) Every insurer offering a health benefit plan as defined under G.S. 58-3-167 shall provide the health benefit plan subscriber or members with an insurance identification card. The card shall contain, at a minimum, all of the following information:

- (1) The subscriber's name and identification number.
- (2) The member's name and identification number, if applicable and different from the subscriber's name and identification number.
- (3) The group number.
- (4) The name of the organization issuing the policy, the name of the organization administering the policy, and the name of the network, whichever applies.
- (5) The effective date of health benefits plan coverage or the date the card is issued if it is after the effective date.
- (6) The address where claims are to be filed and, if applicable, the electronic claims filing payor identification number.
- (7) The policyholder's obligations with regard to copayments, if applicable, for at least all of the following:
 - a. Primary care office visit.
 - b. Specialty care office visit.
 - c. Urgent care visit.
 - d. Emergency room visit.
- (8) The phone number or website address whereby the subscriber, member, or service provider, in compliance with privacy rules under the Health Insurance Portability and Accountability Act may readily obtain the following:
 - a. Confirmation of eligibility.
 - b. Benefits verification in order to estimate patient financial responsibility.
 - c. Prior authorization for services and procedures.
 - d. The list of participating providers in the network.
 - e. The employer group number.
 - f. Special mental health medical benefits under the health plan, if applicable.

- (9) An indication of whether the health benefit plan is a fully insured or self-funded plan. Plans that are fully insured shall be noted by using the phrase "fully insured" to indicate to the consumer that the Department is able to provide assistance regarding the regulation of the plan.

(b) The insurance identification card must be designed such that if the card is photocopied or electronically scanned, the resulting image is clearly legible. The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology. (2007-362, s. 2; 2021-30, s. 1(a).)

§ 58-3-250. Payment obligations for covered services.

(a) If an insurer calculates a benefit amount for a covered service under a health benefit plan through a method other than a fixed dollar co-payment, the insurer shall clearly explain in its evidence of coverage and plan summaries how it determines its payment obligations and the payment obligations of the insured. The explanation shall include:

- (1) An example of the steps the insurer would take in calculating the benefit amount and the payment obligations of each party.
- (2) Whether the insurer has obtained the agreement of health care providers not to bill an insured for any amounts by which a provider's charge exceeds the insurer's recognized charge for a covered service and whether the insured may be liable for paying any excess amount.
- (3) Which party is responsible for filing a claim or bill with the insurer.

(b) If an insured is liable for an amount that differs from a stated fixed dollar co-payment or may differ from a stated coinsurance percentage because the coinsurance amount is based on a plan allowance or other such amount rather than the actual charges and providers are permitted to balance bill the insured, the evidence of coverage, plan summaries, and marketing and advertising materials that include information on benefit levels shall contain the following statement: "NOTICE: Your actual expenses for covered services may exceed the stated [coinsurance percentage or co-payment amount] because actual provider charges may not be used to determine [plan/insurer or similar term] and [insured/member/enrollee or similar term] payment obligations." (2001-446, s. 2.3.)

§ 58-3-255. Coverage of clinical trials.

(a) As used in this section:

- (1) "Covered clinical trials" means phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that: (i) involve the treatment of life-threatening medical conditions, (ii) are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives, and (iii) have clinical and preclinical data that shows the trial will likely be more effective for that patient than available noninvestigational alternatives. Covered clinical trials must also meet the following requirements:
 - a. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.
 - b. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration,

the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.

c. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

(2) "Health benefit plan" is defined by G.S. 58-3-167.

(3) "Insurer" is defined by G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for participation in phase II, phase III, and phase IV covered clinical trials by its insureds or enrollees who meet protocol requirements of the trials and provide informed consent.

(c) Only medically necessary costs of health care services, as defined in G.S. 58-50-61, associated with participation in a covered clinical trial, including those related to health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and medically necessary monitoring, are required to be covered by the health benefit plan and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials. Nothing in this section shall be construed to require a health benefit plan to pay or reimburse for non-FDA approved drugs provided or made available to a patient who received the drug during a covered clinical trial after the clinical trial has been discontinued.

(d) Clinical trial costs not required to be covered by a health benefit plan include the costs of services that are not health care services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the patient. In the event a claim contains charges related to services for which coverage is required under this section, and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this section, the health benefit plan may deny the claim. (2001-446, s. 3.1.)

§ 58-3-256. Coverage related to organ transplants.

(a) For the purposes of this section, the following definitions apply:

(1) Anatomical gift. – The donation of all or part of a human body to take effect after the donor's death for the purpose of a transplant.

(2) Disability. – As defined in the Americans with Disabilities Act of 1990, 42 U.S.C. § 12102 et seq., as amended.

(3) Health benefit plan. – As defined in G.S. 58-3-167.

(4) Insurer. – As defined in G.S. 58-3-167.

(5) Transplant. – The transplantation or transfusion of a part of a human body into the body of another human for the purpose of treating or curing a medical condition.

(b) No insurer offering a health benefit plan in this State that provides coverage for anatomical gifts, organ transplants, or treatment and services related to anatomical gifts or transplants shall do any of the following:

(1) Deny coverage to an insured solely on the basis of that individual's disability.

- (2) Deny to an individual eligibility, or continued eligibility, to enroll or to renew coverage under the terms of a health benefit plan solely for the purpose of avoiding the requirements of this section.
- (3) Attempt to induce a health care provider to provide care to an insured in a manner inconsistent with this section by doing either of the following:
 - a. Penalizing, or otherwise reducing or limiting the reimbursement of, a health care provider.
 - b. Providing monetary or nonmonetary incentives to a health care provider.
- (4) Reduce or limit health benefit plan coverage benefits to an insured for any services related to organ transplantation performed determined to be necessary in consultation with the attending physician and the insured.

(c) When a person or that person's health care provider or representative requests that person's insurer to determine whether a transplant is eligible for benefits under that person's health benefit coverage, the insurer shall, within 10 business days after receipt of the request and medical documentation necessary to determine if there is coverage, inform the requesting person as to whether there is coverage; provided coverage exists at the time of the transplant.

(d) In the case of a health benefit plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers, any amendment to the health benefit plan made pursuant to a collective bargaining agreement solely to conform to this section shall not be treated as a termination of the collective bargaining agreement.

(e) Nothing in this section shall be deemed to require an insurer to provide coverage for a medically inappropriate organ transplant. (2021-64, s. 3(a); 2021-64, s. 3(b).)

§ 58-3-260. Insurance coverage for newborn hearing screening mandated.

(a) As used in this section, the terms "health benefit plan" and "insurer" have the meanings applied under G.S. 58-3-167.

(b) Each health benefit plan shall provide coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125. The same deductibles, coinsurance, reimbursement methodologies, and other limitations and administrative procedures as apply to similar services covered under the health benefit plan shall apply to coverage for newborn hearing screening. (2001-446, s. 3.2.)

§ 58-3-265. Prohibition on managed care provider incentives.

An insurer offering a health benefit plan may not offer or pay any type of material inducement, bonus, or other financial incentive to a participating provider to deny, reduce, withhold, limit, or delay specific medically necessary and appropriate health care services covered under the health benefit plan to a specific insured or enrollee. This section does not prohibit insurers from paying a provider on a capitated basis or withholding payment or paying a bonus based on the aggregate services rendered by the provider or the insurer's financial performance. (2001-446, s. 1.8.)

§ 58-3-270. Coverage for surveillance tests for women at risk for ovarian cancer.

(a) Every health benefit plan, as defined in G.S. 58-3-167, shall provide coverage for surveillance tests for women age 25 and older at risk for ovarian cancer. As used in this section:

- (1) "At risk for ovarian cancer" means either:
 - a. Having a family history:

1. With at least one first-degree relative with ovarian cancer; and
 2. A second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or
- b. Testing positive for a hereditary ovarian cancer syndrome.
- (2) "Surveillance tests" mean annual screening using:
 - a. Transvaginal ultrasound; and
 - b. Rectovaginal pelvic examination.

(b) The same deductibles, coinsurance, and other limitations as apply to similar services covered under the plan apply to coverage for transvaginal ultrasound and rectovaginal pelvic examinations required to be covered under this section. (2003-223, s. 1.)

§ 58-3-275. Closure of a block of business.

(a) An insurer that determines to create a closed block of business in this State shall no later than 60 days prior to the closure date:

- (1) Notify the Commissioner in writing of the insurer's decision to cease sales of the policy form(s) and provide a reasonable estimate, based on sound actuarial principles, of the expected impact on future premiums of ceasing sales of the policy form(s). If the insurer's qualified actuary estimates that the expected impact on future annual premiums of ceasing sales of the policy form(s) exceeds five percent (5%) per annum, then the insurer shall comply with the requirements of subdivision (3) of this subsection. If each subsequent annual premium rate filing results in an approved annual premium rate increase no greater than the last premium rate increase approved when the block of insurance was open, plus five percent (5%) per annum, then the insurer shall not be required to comply with the requirements of subdivision (3) of this subsection. If any subsequent annual premium rate filing results in an approved premium rate increase in excess of five percent (5%) per annum more than the last premium rate increase approved while the block of insurance was open, then the insurer shall comply with the requirements of subdivision (3) of this subsection at the time the filing is approved, unless the insurer can demonstrate to the satisfaction of the Commissioner that the portion of the increase that is due to the closing of the block is not more than five percent (5%) per annum.
- (2) Inform each insurance producer selling the product of the decision and the date of closure.
- (3) If required pursuant to subdivision (1) of this subsection, notify all affected policyholders of the determination and provide a statement of the general effect that might be expected to result from the closure of the block. Notice shall comply with any rules adopted pursuant to subsection (b) of this section.

(b) The Commissioner may adopt rules to carry out the purposes and provisions of this section, including rules establishing the language, content, format, and methods of distribution of the notices required by this section.

(c) As used in this section, the term:

- (1) "Accident and health insurance" means insurance against death or injury resulting from accident or from accidental means and insurance against disablement, disease, or sickness of the insured. This includes Medicare supplemental insurance, long-term care, nursing home, or home health care

insurance, or any combination thereof, specified disease or illness insurance, hospital indemnity or other fixed indemnity insurance, short-term limited duration health insurance, dental insurance, vision insurance, and medical, hospital, or surgical expense insurance or any combination thereof.

- (2) "Block of business" means a particular policy form or contract of individual accident and health insurance issued by an insurer.
- (3) "Closed block of business" means a block of business for which an insurer ceases to actively market, sell, and issue new contracts under a particular policy form in this State.
- (4) "Closure date" means the effective date that no new insureds will be issued coverage of the particular policy form(s).
- (5) "Insurer" includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 50A of this Chapter.
- (6) "Policyholders" includes those applicants for the particular policy form that is being closed and for which the policy is not yet issued.

(d) This section does not apply when an insurer makes a decision to discontinue a particular policy form or contract of accident and health insurance coverage subject to Article 68 of this Chapter, cancels or nonrenews the coverage, and offers replacement coverage pursuant to G.S. 58-68-65(c)(1). (2005-412, s. 2; 2019-202, s. 8; 2022-46, s. 14(o).)

§ 58-3-276: Repealed by Session Laws 2013-410, s. 28.5(e), effective August 23, 2013.

§ 58-3-280. Coverage for the diagnosis and treatment of lymphedema.

(a) Every health benefit plan, as defined in G.S. 58-3-167, shall provide coverage for the diagnosis, evaluation, and treatment of lymphedema. The coverage required by this section shall include benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be medically necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.

(b) The same deductibles, coinsurance, and other limitations as apply to similar services covered under the health benefit plan apply to coverage for the diagnosis, evaluation, and treatment of lymphedema required to be covered under this section. Nothing in this section requires a health benefit plan to provide a separate set of benefit limitations or maximums for the diagnosis, evaluation, or treatment of lymphedema.

(c) As used in this section, gradient compression garments:

- (1) Require a prescription;
- (2) Are custom-fit for the covered individual; and
- (3) Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products. (2009-313, s. 1.)

§ 58-3-285. Coverage for hearing aids.

(a) Every health benefit plan, including the State Health Plan for Teachers and State Employees, shall provide coverage for one hearing aid per hearing-impaired ear up to two

thousand five hundred dollars (\$2,500) per hearing aid every 36 months for covered individuals under the age of 22 years subject to subsection (b) of this section. The coverage shall include all medically necessary hearing aids and services that are ordered by a physician or an audiologist licensed in this State. Only those persons authorized by law to fit hearing aids, including individuals licensed under Chapter 93D of the General Statutes, are eligible to fit a hearing aid under this section. Coverage shall be as follows:

- (1) Initial hearing aids and replacement hearing aids not more frequently than every 36 months.
- (2) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the covered individual.
- (3) Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

(b) The same deductibles, coinsurance, and other limitations as apply to similar services covered under the health benefit plan apply to hearing aids and related services and supplies required to be covered under this section.

(c) Nothing in this section prevents an insurer from applying utilization review criteria to determine medical necessity as defined by G.S. 58-50-61 as long as it does so in accordance with all requirements for utilization review programs and medical necessity determinations specified in that section, including the offering of an insurer appeal process and where applicable, health benefit plans external review as provided in Part 4 of Article 50 of Chapter 58 of the General Statutes. (2010-2, s. 1; 2010-97, s. 7.)

§ 58-3-290. Nondependent child coverage defined; open enrollment.

(a) As used in this section, the following definitions apply:

- (1) "Health benefit plan" has the same meaning as G.S. 58-3-167(a)(1).
- (2) "Individual market" has the same meaning as G.S. 58-68-25(a)(9).
- (3) "Insurer" has the same meaning as G.S. 58-3-167(a)(2).
- (4) "Nondependent child coverage" or "nondependent child policy" means an individual health benefit plan which provides coverage to an individual under age 19. This shall not include health benefit plans that cover children under age 19 as dependents.
- (5) "Open enrollment" means, with respect to "nondependent child coverage," the period of time during which any individual under age 19 has the opportunity to apply for coverage under a health benefit plan offered by an insurer and shall not be denied eligibility for coverage under the plan due to factors relating to the individual's health status.

(b) An insurer who offers nondependent child coverage shall offer open enrollment either continuously throughout the year or for the months of January and July of each year. Coverage issued under this section shall be issued without any riders based on the health status of the child. Nothing in this section shall require an insurer to offer nondependent child coverage or maternity coverage within an offer of nondependent child coverage.

(c) The Commissioner shall adopt rules as necessary or proper to implement the provisions of this section.

(d) Nothing in this section shall prohibit an insurer from adjusting the initial premium charged an individual afforded coverage under this section based upon medical underwriting to the

extent that such an adjustment is in compliance with the applicable product's current rate filing approved by the Commissioner. (2011-196, s. 5.)

§ 58-3-295: Reserved for future codification purposes.

§ 58-3-300. Health insurance issuers subject to certain requirements of federal law.

Pursuant to the authority granted to the states under 42 U.S.C. § 300gg-22(a)(1), health insurance issuers that issue, sell, renew, or offer health benefit plans, as defined in G.S. 58-3-167(a)(1), in the State in the individual or group market shall meet the requirements of Part A of Subchapter XXV of Chapter 6A of Title 42 of the United States Code and regulations issued thereunder. (2013-199, s. 24.)