

Article 68.

Health Insurance Portability and Accountability.

**§§ 58-68-1 through 58-68-20: Repealed by Session Laws 1997-259, s. 1(a).**

Part A. Group Market Reforms.

Subpart 1. Portability, Access, and Renewability Requirements.

**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. – In addition to other definitions throughout this Article, the following definitions and their cognates apply in this Article:

- (1) "Bona fide association". – With respect to health insurance coverage offered in this State, an association that:
  - a. Has been actively in existence for at least five years.
  - b. Has been formed and maintained in good faith for purposes other than obtaining insurance.
  - c. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee).
  - d. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).
  - e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.
  - f. Meets the additional requirements as may be imposed under State law.
- (2) "COBRA continuation provision". – Any of the following:
  - a. Section 4980B of the Internal Revenue Code of 1986, other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.
  - b. Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of the Act.
  - c. Title XXII of the Public Health Service Act (42 U.S.C.S. § 300bb, et seq.) as requirements for certain group health plans for certain State and local employees.
  - d. Article 53 of this Chapter or the health insurance continuation law of another state.
- (3) "Employee". – The meaning given the term under section 3(6) of the Employee Retirement Income Security Act of 1974.
- (4) "Employer". – The meaning given the term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term shall include only employers of two or more employees.
- (4a) "Group health insurance coverage". – Health insurance coverage offered in connection with a group health plan.
- (4b) "Group health plan". – The meaning given the term under 45 C.F.R. § 146.145(a).

- (4c) "Group market." – The market for health insurance coverage offered in connection with a group health plan.
- (5) "Health insurance coverage" or "coverage" or "health insurance plan" or "plan". – Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.
- (6) "Health insurer". – An insurance company subject to this Chapter, a hospital or medical service corporation subject to Article 65 of this Chapter, a health maintenance organization subject to Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 50A of this Chapter, that offers and issues health insurance coverage.
- (7) "Health status-related factor". – Any of the factors described in G.S. 58-68-35(a)(1).
- (8) "Individual health insurance coverage". – Health insurance coverage offered to individuals in the individual market, but not short-term limited duration insurance.
- (9) "Individual market". – The market for health insurance coverage offered to individuals.
- (10) "Large employer". – An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the health insurance plan year.
- (11) "Large group market". – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a large employer.
- (12) "Medical care". – Amounts paid for:
  - a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.
  - b. Amounts paid for transportation primarily for and essential to medical care referred to in sub-subdivision a. of this subdivision.
  - c. Amounts paid for insurance covering medical care referred to in sub-subdivisions a. and b. of this subdivision.
- (13) "Network plan". – Health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.
- (14) "Participant". – The meaning given the term under section 3(7) of the Employee Retirement Income Security Act of 1974.
- (15) "Placed for adoption". – The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the

child. The child's placement with the person terminates upon the termination of the legal obligation.

- (16) "Small employer". – The meaning given to the term in G.S. 58-50-110(22).
- (17) "Small group market". – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer.

(b) Excepted Benefits. – Excepted benefits are not subject to requirements under this Chapter regarding coverage of a specific person, provider, treatment, service, condition, or disease unless that coverage is expressly required by law. For the purposes of this Article, "excepted benefits" means benefits under one or more or any combination of the following:

- (1) Benefits not subject to requirements. –
  - a. Coverage only for accident or disability income insurance or any combination of these.
  - b. Coverage issued as a supplement to liability insurance.
  - c. Liability insurance, including general liability insurance and automobile liability insurance.
  - d. Workers' compensation or similar insurance.
  - e. Automobile medical payment insurance.
  - f. Credit-only insurance.
  - g. Coverage for on-site medical clinics.
  - h. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
  - i. Short-term limited-duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.
- (2) Benefits not subject to requirements if offered separately. –
  - a. Limited scope dental or vision benefits.
  - b. Benefits for long-term care, nursing care, home health care, community-based care, or any combination of these.
  - c. The other similar, limited benefits as are specified in federal regulations.
- (3) Benefits not subject to requirements if offered as independent, noncoordinated benefits. –
  - a. Coverage only for a specified disease or illness.
  - b. Hospital indemnity or other fixed indemnity insurance.
- (4) Benefits not subject to requirements if offered as separate insurance policy. – Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health insurance plan.

(c) Application of certain rules in determination of employer size. –

For the purposes of this Article:

- (1) Application of aggregation rule for employers. – All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

- (2) Employers not in existence in preceding year. – In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.
- (3) Predecessors. – Any reference in this subsection to an employer shall include a reference to any predecessor of the employer. (1997-259, s. 1(c); 2002-187, s. 5.1; 2009-382, ss. 2, 3; 2018-120, s. 4.11; 2019-202, s. 8.)

**§ 58-68-30. Increased portability through limitation on preexisting condition exclusions.**

(a) Limitation on Preexisting Condition Exclusion Period; Crediting for Periods of Previous Coverage. – Subject to subsection (d) of this section, a group health insurer may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

- (1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date.
- (2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.
- (3) The period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions. – For the purposes of this Part:

- (1) Enrollment date. – With respect to an individual covered under a group health insurance plan, the date of enrollment of the individual in the coverage or, if earlier, the first day of the waiting period for the enrollment. An individual's enrollment date does not change if the individual receiving benefits under a group health insurance plan changes benefit packages or if the plan changes health insurers.
- (2) Late enrollee. – With respect to coverage under a group health insurance plan, a participant or beneficiary who enrolls under the plan other than during:
  - a. The first period in which the individual is eligible to enroll under the plan, or
  - b. A special enrollment period under subsection (f) of this section.
- (3) Preexisting condition exclusion. –
  - a. In general. – "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to

the individual, or review of medical records relating to the preenrollment period.

- b. Treatment of genetic information. – Genetic information shall not be treated as a condition described in subdivision (a)(1) of this subsection in the absence of a diagnosis of the condition related to the information.

(4) Waiting period. –

- a. With respect to a group health insurance plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.
- b. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before the late or special enrollment is not a waiting period.
- c. If an individual seeks individual health insurance coverage, a waiting period begins on the date the individual submits a substantially complete application and ends on: (i) the date coverage begins if the application results in coverage; or (ii) the date on which the application is denied by the health insurer or the date on which the offer for coverage lapses if the application does not result in coverage.

(c) Rules Relating to Crediting Previous Coverage. –

(1) Creditable coverage defined. – For the purposes of this Article, "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

- a. A group health plan.
- b. Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise.
- c. Part A or part B of title XVIII of the Social Security Act.
- d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
- e. Chapter 55 of title 10, United States Code.
- f. A medical care program of the Indian Health Service or of a tribal organization.
- g. A State health benefits risk pool.
- h. A health plan offered under chapter 89 of title 5, United States Code.
- i. A public health plan (as defined in federal regulations).
- j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).
- k. Title XXI of the Social Security Act (State Children's Health Insurance Program).

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits. However, short-term limited-duration health insurance coverage shall be considered creditable coverage for purposes of this section.

(2) Not counting periods before significant breaks in coverage. –

- a. In general. – A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health insurance plan, if, after the period and before the enrollment date, there was a

- 63-day period during all of which the individual was not covered under any creditable coverage.
- b. Waiting period not treated as a break in coverage. – For the purposes of sub-subdivision a. of this subdivision and subdivision (d)(4) of this subsection, any period that an individual is in a waiting period for any coverage under a group health insurance plan or is in an affiliation period shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision.
  - c. Time spent on short term limited duration health insurance not treated as a break in coverage. – For the purposes of sub-subdivision a. of this subdivision, any period that an individual is enrolled on a short term limited duration health insurance policy shall not be taken into account in determining the continuous period under sub-subdivision a. of this subdivision so long as the period of time spent on the short term limited duration health insurance policy or policies does not exceed 12 months.
  - d. For an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period shall not be considered when determining whether a significant break in coverage has occurred.
- (3) Method of crediting coverage. –
- a. Standard method. – Except as otherwise provided under sub-subdivision b. of this subdivision for the purposes of applying subdivision (a)(3) of this subsection, a group health insurer shall count a period of creditable coverage without regard to the specific benefits covered during the period.
  - b. Election of alternative method. – A group health insurer may elect to apply subdivision (a)(3) of this subsection based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations rather than as provided under sub-subdivision a. of this subdivision. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election a group health insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.
  - c. Health insurer notice. – In the case of an election under sub-subdivision b. of this subdivision with respect to health insurance coverage in the small or large group market, the health insurer: (i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the health insurer has made the election, and (ii) shall include in the statements a description of the effect of the election.
- (4) Establishment of period. – Periods of creditable coverage for an individual shall be established through presentation of certifications described in subsection (e) of this section or in another manner that is specified in federal regulations.
- (5) Determination of creditable coverage. –

- a. Determination within reasonable time. – If a group health insurer receives creditable coverage information under subsection (e) of this section, the group health insurer shall, within a reasonable time following receipt of the information, make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care.
  - b. No time limit on presenting evidence of creditable coverage. – A group health insurer shall not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.
- (d) Exceptions. –
- (1) Exclusion not applicable to certain newborns. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the individual's date of birth, is covered under creditable coverage.
  - (2) Exclusion not applicable to certain adopted children. – Subject to subdivision (4) of this subsection, a group health insurer shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence does not apply to coverage before the date of the adoption or placement for adoption.
  - (3) Exclusion not applicable to pregnancy. – A group health insurer shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.
  - (4) Loss if break in coverage. – Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.
  - (5) Condition first diagnosed under previous coverage. – A group health insurer shall not impose any preexisting condition exclusion for a condition for which medical advice, diagnosis, care, or treatment was recommended or received for the first time while the covered person held qualifying previous coverage or prior creditable coverage and the condition was covered under the qualifying previous coverage or prior creditable coverage; provided that the qualifying previous coverage or prior creditable coverage was continuous to a date not more than 63 days before the enrollment date for the new coverage.
- (e) Certifications and Disclosure of Coverage. –
- (1) Requirement for certification of period of creditable coverage. –
    - a. In general. – A group health insurer shall provide the certification described in sub-subdivision b. of this subdivision: (i) at the time an individual ceases to be covered under the plan or otherwise becomes

covered under a COBRA continuation provision, (ii) in the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision, and (iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii) of this sub-subdivision, whichever is later.

The certification under clause (i) of this sub-subdivision may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

b. Certification. – The certification described in this sub-subdivision is a written certification of: (i) the period of creditable coverage of the individual under the plan and any coverage under the COBRA continuation provision, and (ii) any waiting period and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

(2) Disclosure of information on previous benefits. – In the case of an election described in sub-subdivision (c)(3)b. of this subsection by a group health insurer, if the health insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under subdivision (1) of this subsection:

a. Upon request of the health insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or health insurer information on coverage of classes and categories of health benefits available under the entity's coverage.

b. The entity may charge the requesting plan or health insurer for the reasonable cost of disclosing the information.

(f) Special Enrollment Periods. –

(1) Individuals losing other coverage. – A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

a. The employee or dependent was covered under an ERISA group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

b. The employee stated in writing at the time that coverage under the group health plan or health insurance coverage was the reason for declining enrollment, but only if the health insurer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

c. With respect to the employee's or dependent's coverage described in sub-subdivision a. of this subsection: (i) the coverage was under a COBRA continuation provision and the coverage under the provision was exhausted; (ii) the coverage was not under that provision and either the coverage was terminated because of loss of eligibility for the



coverage, including legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing; (iii) employer contributions toward the coverage were terminated; (iv) in the case of coverage offered through an arrangement that does not provide benefits to individuals who no longer reside, live, or work in a service area, there has been loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; (v) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or (vi) a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or (vii) the health insurer terminated coverage under G.S. 58-68-45(c)(2).

d. Under the terms of the plan, the employee requests the enrollment not later than 30 days after the date of the applicable event described in sub-subdivision c. of this subdivision.

(2) For dependent beneficiaries. –

a. In general. – If: (i) a group health insurance plan makes coverage available with respect to a dependent of an individual, (ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and (iii) a person becomes the dependent of the individual through marriage, birth, or adoption or placement for adoption.

The plan shall provide for a dependent special enrollment period described in sub-subdivision b. of this subdivision during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

b. Dependent special enrollment period. – A dependent special enrollment period under this sub-subdivision shall be a period of not less than 30 days and shall begin on the later of: (i) the date dependent coverage is made available, or (ii) the date of the marriage, birth, or adoption or placement for adoption described in sub-subdivision a.(iii) of this subdivision.

c. No waiting period. – If an individual seeks to enroll a dependent during the first 30 days of the dependent's special enrollment period, the coverage of the dependent shall become effective: (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received; (ii) in the case of a dependent's birth, as of the date of the birth; or (iii) in the case of a

- dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
- (3) Treatment of special enrollees.
    - a. If an individual requests enrollment while the individual is entitled to special enrollment under this subsection, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be considered a late enrollee.
    - b. Special enrollees shall be offered all of the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible.
  - (4) Special rules for application in case of Medicaid or State Children's Health Insurance Program (Title XXI of the Social Security Act). – A group health insurer shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under the terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:
    - a. Termination of Medicaid or State Children's Health Insurance Program. – The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State children's health plan under Title XXI of the Social Security Act and coverage of the employee or dependent under such a plan is terminated as a result of the loss of eligibility for such coverage and the employee requests coverage under the group health insurance coverage not later than 60 days after the termination of such coverage.
    - b. Eligibility for employment assistance under Medicaid or State Children's Health Insurance Program. – The employee or dependent becomes eligible for assistance, with respect to coverage under the group health insurance coverage, under such Medicaid plan or State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.
  - (g) Use of Affiliation Period by HMO as Alternative to Preexisting Condition Exclusion. –
    - (1) In general. – A health maintenance organization that does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for the coverage option, but only if:

- a. The period is applied uniformly without regard to any health status-related factors.
  - b. The period does not exceed two months (or three months in the case of a late enrollee).
- (2) Affiliation period. –
- a. Defined. – For the purposes of this Subpart, "affiliation period" means a period that, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during the period and no premium shall be charged to the participant or beneficiary for any coverage during the period.
  - b. Beginning. – The period shall begin on the enrollment date.
  - c. Runs concurrently with waiting periods. – An affiliation period under a plan shall run concurrently with any waiting period under the plan.
- (3) Alternative methods. – A health maintenance organization described in subdivision (1) of this subsection may use alternative methods, as approved by the Commissioner, from those described in that subdivision, to address adverse selection.

(h) General Notice of Preexisting Condition Exclusion. – A group health insurer offering group health insurance coverage subject to a preexisting condition exclusion shall provide a written general notice of preexisting condition exclusion to participants under the plan; and shall not impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until the notice is provided.

A group health insurer shall provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the insurer for enrollment. If the insurer does not distribute these materials, the notice shall be provided by the earliest date following a request for enrollment that the insurer, acting in a reasonable and prompt fashion, can provide the notice.

The general notice of preexisting condition exclusion shall notify participants of the following:

- (1) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period, which shall not exceed six months under subdivision (a)(1) of this section; the maximum preexisting condition exclusion period under the plan, which shall not exceed 12 months (18 months for late enrollees) under subdivision (a)(2) of this section; and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage, as described in subsection (c) of this section.
- (2) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage, as required by subsection (e) of this section, or through other means as described in federal regulations. This shall include a description of the right of the individual to request a certificate from a prior insurer, if necessary, and a statement that the current insurer will assist in obtaining a certificate from any prior plan or insurer, if necessary.

- (3) A person to contact, including an address or telephone number for obtaining additional information or assistance about the preexisting condition exclusion.

Nothing in this subsection affects a group health insurer's responsibility under this section to fully disclose in the master group policy, the certificate or evidence of coverage, and the member handbook the plan's preexisting condition limitation, the rules relating to creditable coverage, including how an individual may provide proof of creditable coverage, and the methods of counting and crediting coverage.

(i) **Individual Notice of Period of Preexisting Condition Exclusion.** – After an individual has presented evidence of creditable coverage and the group health insurer has made a determination of creditable coverage under subdivision (c)(5) of this section, the group health insurer shall provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. In the notice, the insurer is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A group health insurer is not required to provide this notice if the plan does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage.

The individual notice must be provided by the earliest date following a determination that the group health insurer, acting in a reasonable and prompt fashion, can provide the notice.

A group health insurer shall disclose:

- (1) Its determination of any preexisting condition exclusion period that applies to the individual, including the last day on which the preexisting condition exclusion applies.
- (2) The basis for that determination, including the source and substance of any information on which the plan or insurer relied.
- (3) An explanation of the individual's right to submit additional evidence of creditable coverage.
- (4) A description of any applicable appeal procedures established by the group health insurer.

(j) **Determination Modification.** – Nothing in this section prevents a plan or insurer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that:

- (1) A notice of the new determination, consistent with the requirements of subsection (i) of this section, is provided to the individual; and
- (2) Until the notice of the new determination is provided, the group health insurer, for purposes of approving access to medical services (such as a presurgery authorization), acts in a manner consistent with the initial determination.

(k) **Notice Form and Content.** – Any notices required under this section shall be in the form and content and be delivered as prescribed by, in accordance with, or as specified in federal regulations, unless otherwise provided in this Chapter. (1997-259, s. 1(c); 1998-211, s. 7; 2001-334, s. 9; 2005-224, ss. 1, 4, 2.1, 2.2; 2007-298, ss. 2.3-2.5; 2009-382, ss. 4, 23.)

### **§ 58-68-35. Prohibiting discrimination against individual participants and beneficiaries based on health status.**

(a) **In Eligibility To Enroll.** –

- (1) **In general.** – Subject to subdivision (2) of this subsection, a group health insurer shall not establish rules for eligibility, including continued eligibility, of any

individual to enroll under the terms of the health insurer's plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- a. Health status.
  - b. Medical condition (including both physical and mental illnesses).
  - c. Claims experience.
  - d. Receipt of health care.
  - e. Medical history.
  - f. Genetic information.
  - g. Evidence of insurability (including conditions arising out of acts of domestic violence).
  - h. Disability.
- (2) No application to benefits or exclusions. – To the extent consistent with G.S. 58-68-30, subdivision (1) of this subsection shall not be construed:
- a. To require a group health insurance plan to provide particular benefits other than those provided under the terms of the plan, or
  - b. To prevent the plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan.
- (3) Construction. – For the purposes of subdivision (1) of this subsection, rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for the enrollment.
- (b) In Premium Contributions. –
- (1) In general. – A group health insurance plan shall not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of individual.
  - (2) Construction. – Nothing in subdivision (1) of this subsection shall be construed:
    - a. To restrict the amount that an employer may be charged for coverage under a group health insurance plan; or
    - b. To prevent a group health insurer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. (1997-259, s. 1(c).)

#### Subpart 2. Health Insurance Availability and Renewability.

### **§ 58-68-40. Guaranteed availability of coverage for employers in the small group market.**

- (a) Issuance of Coverage in the Small Group Market. –
- (1) In general. – Subject to subsections (c) through (f) of this section, each health insurer that offers health insurance coverage in the small group market in this State:
    - a. Must accept every small employer that applies for the coverage; and
    - b. Must accept for enrollment under the coverage every eligible individual who applies for enrollment during the period in which the individual

first becomes eligible to enroll under the terms of the group health insurance plan and shall not place any restriction that is inconsistent with G.S. 58-68-35 on an eligible individual being a participant or beneficiary.

- (2) Eligible individual defined. – For the purposes of this section, "eligible individual" means, with respect to a health insurer that offers health insurance coverage to a small employer in the small group market, such an individual in relation to the employer as shall be determined:
  - a. In accordance with the terms of the plan,
  - b. As provided by the health insurer under rules of the health insurer that are uniformly applicable in this State to small employers in the small group market, and
  - c. In accordance with all applicable State laws governing the health insurer and the market.
- (b) Special Rules for Network Plans. –
  - (1) In general. – In the case of a health insurer that offers health insurance coverage in the small group market through a network plan, the health insurer may:
    - a. Limit the employers that may apply for coverage to those with eligible individuals who live, work, or reside in the service area for the network plan; and
    - b. Within the service area of the network plan, deny coverage to the employers if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and (ii) it is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.
  - (2) 180-day suspension upon denial of coverage. – A health insurer, upon denying health insurance coverage in any service area in accordance with sub-subdivision (1)b. of this subsection, shall not offer coverage in the small group market within the service area for a period of 180 days after the date the coverage is denied.
- (c) Application of Financial Capacity Limits. –
  - (1) In general. – A health insurer may deny health insurance coverage in the small group market if the health insurer has demonstrated to the Commissioner that:
    - a. It does not have the financial reserves necessary to underwrite additional coverage; and
    - b. It is applying this subdivision uniformly to all employers in the small group market in the State consistent with this Chapter and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to the employees and dependents.
  - (2) 180-day suspension upon denial of coverage. – A health insurer upon denying health insurance coverage in accordance with subdivision (1) of this subsection

shall not offer coverage in the small group market in the State for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later. The Commissioner may apply this subsection on a service-area-specific basis.

(d) Exception to Requirement for Failure to Meet Certain Minimum Participation or Contribution Rules. –

(1) In general. – Subsection (a) of this section does not preclude a health insurer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health insurance plan in the small group market, as allowed under this Chapter.

(2) Rules defined. – For the purposes of subdivision (1) of this subsection:

a. "Employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

b. "Group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(e) Exception for Coverage. – Subsection (a) of this section does not apply to:

(1) Health insurance coverage offered by a health insurer if the coverage is made available in the small group market only through one or more bona fide associations.

(2) A self-employed individual as defined in G.S. 58-50-110(21a), except as otherwise provided for the basic and standard health care plans or other plans under G.S. 58-50-126 under the North Carolina Small Employer Group Health Coverage Reform Act. (1997-259, s. 1(c); 1999-132, s. 4.6; 2006-154, s. 4.)

#### **§ 58-68-45. Guaranteed renewability of coverage for employers in the group market.**

(a) In General. – Except as provided in this section, if a health insurer offers health insurance coverage in the small or large group market, the health insurer must renew or continue in force the coverage at the option of the employer.

(b) General Exceptions. – A health insurer may nonrenew or discontinue health insurance coverage in the small or large group market based only on one or more of the following:

(1) Nonpayment of premiums. – The policyholder has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurer has not received timely premium payments.

(2) Fraud. – The policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

(3) Violation of participation or contribution rules. – The policyholder has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under G.S. 58-68-40(d) in the case of the small group market or pursuant to this Chapter in the case of the large group market.

- (4) Termination of coverage. – The health insurer is ceasing to offer coverage in the market in accordance with subsection (c) of this section and this Chapter.
  - (5) Movement outside service area. – In the case of a health insurer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with the network plan who lives, resides, or works in the service area of the health insurer or in the area for which the health insurer is authorized to do business and, in the case of the small group market, the health insurer would deny enrollment with respect to the network plan under G.S. 58-68-40(c)(1)a.
  - (6) Association membership ceases. – In the case of health insurance coverage that is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor relating to any covered individual.
- (c) Requirements for Uniform Termination of Coverage. –
- (1) Particular type of coverage not offered. – In any case in which a health insurer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of the type may be discontinued by the health insurer in accordance with this Chapter in the market only if:
    - a. The health insurer provides notice to each policyholder provided coverage of this type in the market and to the participants and beneficiaries covered under the coverage of the discontinuation at least 90 days before the date of the discontinuation of the coverage;
    - b. The health insurer offers to each policyholder provided coverage of this type in the market the option to purchase all, or in the case of the large group market, any other health insurance coverage currently being offered by the health insurer to a group health insurance plan in the market; and
    - c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under sub-subdivision b. of this subdivision, the health insurer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.
  - (2) Discontinuance of all coverage. –
    - a. In general. – In any case in which a health insurer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in this State, health insurance coverage may be discontinued by the health insurer only in accordance with this Chapter and if: (i) the health insurer provides notice to the Commissioner and to each policyholder and to the participants and beneficiaries covered under the coverage of the discontinuation at least 180 days before the date of the discontinuation of the coverage; and (ii) all health insurance issued or delivered for issuance in this State in the



market or markets are discontinued and coverage under the health insurance coverage in the market or markets is not renewed.

- b. Prohibition on market reentry. – In the case of a discontinuation under sub-subdivision a. of this subdivision in a market, the health insurer shall not provide for the issuance of any health insurance coverage in that market in this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. – At the time of coverage renewal, a health insurer may modify the health insurance coverage for a product offered to a group health insurance plan:

- (1) In the large group market; or
- (2) In the small group market if, for coverage that is available in the market other than only through one or more bona fide associations, the modification is consistent with this Chapter and effective on a uniform basis among group health insurance plans with that product.

(e) Application to Coverage Offered Only Through Associations. – In applying this section in the case of health insurance coverage that is made available by a health insurer in the small or large group market to employers only through one or more associations, a reference to "policyholder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. (1997-259, s. 1(c); 1997-456, s. 42.)

#### **§ 58-68-50. Disclosure of information.**

(a) Disclosure of Information by Health Insurers. – In connection with the offering of any health insurance coverage to a small employer, a health insurer:

- (1) Shall make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in subsection (b) of this section, and
- (2) Shall upon request of the small employer, provide the information.

(b) Information Described. –

- (1) In general. – Subject to subdivision (3) of this subsection, with respect to a health insurer offering health insurance coverage to a small employer, information described in this subsection is information concerning:
  - a. The provisions of the coverage concerning the health insurer's right to change premium rates and the factors that may affect changes in premium rates;
  - b. The provisions of the coverage relating to renewability of coverage;
  - c. The provisions of the coverage relating to any preexisting condition exclusion; and
  - d. The benefits and premiums available under all health insurance coverage for which the employer is qualified.
- (2) Form of information. – Information under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

- (3) Exception. – A health insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law. (1997-259, s. 1(c).)

Subpart 3. Exclusion of Plans.

**§ 58-68-55. Exclusion of certain plans.**

(a) Exception for Certain Benefits. – The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(1).

(b) Exception for Certain Benefits if Certain Conditions Met. –

- (1) Limited, excepted benefits. – The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(2) if the benefits:
  - a. Are provided under a separate policy, certificate, or contract of insurance; or
  - b. Are otherwise not an integral part of the plan.
- (2) Noncoordinated, excepted benefits. – The requirements of Subparts 1 and 2 of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(3) if all of the following conditions are met:
  - a. The benefits are provided under a separate policy, certificate, or contract of insurance.
  - b. There is no coordination between the provision of the benefits and any exclusion of benefits under any group health insurance plan maintained by the same policyholder.
  - c. The benefits are paid with respect to an event without regard to whether benefits are provided with respect to that event under any group health insurance plan maintained by the same policyholder.
- (3) Supplemental, excepted benefits. – The requirements of this Part do not apply to any group health insurance plan in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance. (1997-259, s. 1(c).)

Part B. Individual Market Reforms.

**§ 58-68-60. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.**

(a) Guaranteed Availability. –

- (1) In general. – Subject to the succeeding subsections of this section, each health insurer that offers health insurance coverage in the individual market in this State shall not, with respect to an eligible individual desiring to enroll in individual health insurance coverage:
  - a. Decline to offer the coverage to, or deny enrollment of, the individual; or
  - b. Impose any preexisting condition exclusion with respect to the coverage.

- (2) Reserved.
- (b) Eligible Individual Defined. – In this Part, "eligible individual" means an individual:
  - (1) (i) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and (ii) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);
  - (2) Who is not eligible for coverage under (i) a group health plan, (ii) part A or part B of title XVIII of the Social Security Act, or (iii) a State plan under title XIX of the Act (or any successor program), and does not have other health insurance coverage;
  - (3) With respect to whom the most recent coverage within the coverage period described in subdivision (1)(i) was not terminated based on a factor described in G.S. 58-68-45(b)(1) or (b)(2);
  - (4) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under Article 53 of this Chapter, who elected the coverage; and
  - (5) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program.
- (c) Alternative Coverage Permitted. –
  - (1) In general. – In the case of health insurance coverage offered in this State, a health insurer may elect to limit the coverage offered under subsection (a) of this section as long as it offers at least two different policy forms of health insurance coverage both of which:
    - a. Are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the health insurer; and
    - b. Meet the requirement of subdivision (2) or (3) of this subsection, as elected by the health insurer.

For the purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders shall be considered to be different policy forms.
  - (2) Choice of most popular policy forms. – The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all the policy forms offered by the health insurer in this State or applicable marketing or service area (as may be prescribed by rules or regulations) by the health insurer in the individual market in the period involved.
  - (3) Choice of two policy forms with representative coverage. –
    - a. In general. – The requirement of this subdivision is met, for health insurance coverage policy forms offered by a health insurer in the individual market, if the health insurer offers a lower-level coverage policy form (as described in sub-subdivision b. of this subdivision) and a higher-level coverage policy form (as described in sub-subdivision c. of this subdivision) each of which includes benefits substantially similar to

- other individual health insurance coverage offered by the health insurer in this State.
- b. Lower-level of coverage described. – A policy form is described in this sub-subdivision if the actuarial value of the benefits under the coverage is at least eighty-five percent (85%) but not greater than one hundred percent (100%) of a weighted average (described in sub-subdivision d. of this subdivision).
  - c. Higher-level of coverage described. – A policy form is described in this sub-subdivision if: (i) the actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater than the actuarial value of the coverage described in sub-subdivision b. of this subdivision offered by the health insurer in the area involved; and (ii) the actuarial value of the benefits under the coverage is at least one hundred percent (100%) but not greater than one hundred twenty percent (120%) of a weighted average (described in sub-subdivision d. of this subdivision).
  - d. Weighted average. – For the purposes of this subdivision, the weighted average described in this sub-subdivision is the average actuarial value of the benefits provided by all the health insurance coverage issued, as elected by the health insurer, either by that health insurer or by all health insurers in this State in the individual market during the previous year, not including coverage issued under this section, weighted by enrollment for the different coverage.
- (4) Election. – The health insurer elections under this subsection shall apply uniformly to all eligible individuals in this State for that health insurer. The election shall be effective for policies offered during a period of not less than two years.
  - (5) Assumptions. – For the purposes of subdivision (3) of this subsection, the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.
- (d) Special Rules for Network Plans. –
- (1) In general. – In the case of a health insurer that offers health insurance coverage in the individual market through a network plan, the health insurer may:
    - a. Limit the individuals who may be enrolled under the coverage to those who live, reside, or work within the service area for the network plan; and
    - b. Within the service area of the plan, deny the coverage to the individuals if the health insurer has demonstrated to the Commissioner that: (i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees, and (ii) it is applying this subdivision uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.
  - (2) 180-day suspension upon denial of coverage. – A health insurer, upon denying health insurance coverage in any service area in accordance with

sub-subdivision (1)b. of this subdivision, shall not offer coverage in the individual market within the service area for a period of 180 days after the coverage is denied.

(e) Application of Financial Capacity Limits. –

(1) In general. – A health insurer may deny health insurance coverage in the individual market to an eligible individual if the health insurer has demonstrated to the Commissioner that:

- a. It does not have the financial reserves necessary to underwrite additional coverage; and
- b. It is applying this subdivision uniformly to all individuals in the individual market in this State consistent with this Chapter and without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

(2) 180-day suspension upon denial of coverage. – A health insurer, upon denying individual health insurance coverage in any service area in accordance with subdivision (1) of this subsection, shall not offer the coverage in the individual market within the service area for a period of 180 days after the date the coverage is denied or until the health insurer has demonstrated to the Commissioner that the health insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(f) Market Requirements. –

(1) In general. – Subsection (a) of this section does not require that a health insurer offering health insurance coverage only in connection with ERISA group health plans or through one or more bona fide associations, or both, offer the health insurance coverage in the individual market.

(2) Conversion policies. – A health insurer offering health insurance coverage in connection with group health plans under title XXVII of the federal Public Health Service Act shall not be deemed to be a health insurer offering individual health insurance coverage solely because the health insurer offers a conversion policy.

(g) Construction. – Nothing in this section shall be construed:

(1) To restrict the amount of the premium rates that a health insurer may charge an individual for health insurance coverage provided in the individual market under this Chapter; or

(2) To prevent a health insurer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

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

(1) "Church plan". – The meaning given the term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(2) "Governmental plan". –

- a. The meaning given the term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

- b. Federal governmental plan. – A governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the government.
- c. Nonfederal governmental plan. – A governmental plan that is not a federal governmental plan.

(i) Rights of Replacement Coverage Upon Termination. – Subsection (a) of this section shall apply to an eligible individual whose coverage issued under this section is terminated by a health insurer under G.S. 58-68-65(c)(2) the application for the replacement coverage is dated not more than 63 days following the termination date.

(j) Waiting Period. – In determining the length of any break in coverage for an individual as prescribed in G.S. 58-68-60(b)(1)(i), a significant break in coverage does not occur during the waiting period. The "waiting period" is defined as the period that begins on the date the individual submits a substantially complete application for coverage and ends on:

- (1) The date coverage begins, if the application results in coverage, or
- (2) The date on which the application is denied by the issuer or the date on which the offer for coverage lapses, if the application does not result in coverage. (1997-259, s. 1(c); 1999-132, s. 4.7; 2005-224, s. 3; 2009-382, s. 5.)

**§ 58-68-65. Guaranteed renewability of individual health insurance coverage.**

(a) In General. – Except as provided in this section, a health insurer that provides individual health insurance coverage to an individual shall renew or continue in force the coverage at the option of the individual.

(b) General Exceptions. – A health insurer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

- (1) Nonpayment of premiums. – The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the health insurer has not received timely premium payments.
- (2) Fraud. – The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
- (3) Termination of plan. – The health insurer is ceasing to offer coverage in the individual market in accordance with subsection (c) of this section and this Chapter.
- (4) Movement outside service area. – In the case of a health insurer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the health insurer is authorized to do business) but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.
- (5) Association membership ceases. – In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if the coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(c) Requirements for Uniform Termination of Coverage. –

- (1) Particular type of coverage not offered. – In any case in which a health insurer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of the type may be discontinued by the health insurer only if:
  - a. The health insurer provides notice, notwithstanding G.S. 58-51-20 or G.S. 58-65-60(c)(3)b., to each covered individual provided coverage of this type in the market of the discontinuation at least 90 days before the date of the discontinuation of the coverage;
  - b. The health insurer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the health insurer for individuals in the market; and
  - c. In exercising the option to discontinue coverage of this type and in offering the option of coverage under sub-subdivision b. of this subdivision, the health insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.
- (2) Discontinuance of all coverage. –
  - a. In general. – Subject to sub-subdivision c. of this subdivision, in any case in which a health insurer elects to discontinue offering all health insurance coverage in the individual market in this State, health insurance coverage may be discontinued by the health insurer only if: (i) the health insurer provides notice to the Commissioner and to each individual of the discontinuation at least 180 days before the date of the expiration of the coverage, and (ii) all health insurance coverage issued or delivered for issuance in this State in the market is discontinued and the health insurance coverage in the market is not renewed.
  - b. Prohibition on market reentry. – In the case of a discontinuation under sub-subdivision a. of this subdivision in the individual market, the health insurer shall not provide for the issuance of any health insurance coverage in the market and this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for Uniform Modification of Coverage. – At the time of coverage renewal, a health insurer may modify the health insurance coverage for a policy form offered to individuals in the individual market as long as the modification is consistent with State law and effective on a uniform basis among all individuals with that policy form.

(e) Application to Coverage Offered Only Through Associations. – In applying this section in the case of health insurance coverage that is made available by a health insurer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to the association of which the individual is a member. (1997-259, s. 1(c).)

**§ 58-68-70. Certification of coverage.**

G.S. 58-68-30(e) applies to health insurance coverage offered by a health insurer in the individual market in the same manner that it applies to health insurance coverage offered by a health insurer in the small or large group market. (1997-259, s. 1(c).)

**§ 58-68-75. General exceptions.**

(a) Exception for Certain Benefits. – This Part does not apply to any health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(1).

(b) Exception for Certain Benefits if Certain Conditions Met. – This Part does not apply to any health insurance coverage in relation to its provision of excepted benefits described in G.S. 58-68-25(b)(2), (3), or (4) if the benefits are provided under a separate policy, certificate, or contract of insurance. (1997-259, s. 1(c).)