North Carolina Department of Insurance

Life & Health Division

Mandated Benefits for Health Benefit Plans

The following are some North Carolina General Statutes (NCGS) or Administrative Codes which either mandate benefits, level of benefits, or offering of benefits for health benefit plans subject to regulation by North Carolina Department of Insurance. Some of the statutes listed below are duplicated in Articles 65 and 67 of Chapter 58 that are the Medical Service Corporations and Health Maintenance Organizations articles respectively. Refer to statutes directly for effective dates, applicability, limitations or exceptions. The information may include statutes which address contractual renewablity, provider access, and administration of policies which would not traditionally be considered "mandates. Additionally, some of the listed statutes may no longer be applicable given federal laws which may preempt the state provision. Additionally this list does not include federal mandates which are not also or similarly incorporated in state law.

Statute/Reg Number	Short Description	Longer Description
58-3-121	TMJ Joint Dysfunction Coverage	Requires coverage for diagnostic, therapeutic, or surgical procedures involving any bone or joint of the jaw, face, or head, so long as the plan provides such services for any other bone or joint, 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.
58-3-122	Anesthesia and hospital charges for dental procedures for certain individuals	Requires payment for anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for qualified individuals.
58-3-168	Coverage for postmastetomy inpatient care.	The decision whether to discharge a patient following mastectomy shall be made by the physician and the patient and based upon the individual situation presented.
58-3-169 + federal mandate	Minimum inpatient stays following delivery of a baby	Requires that when a plan provides maternity coverage is provided with respect to a mother 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.
58-3-170	Treat maternity as any other illness	Requires that when a plan provides maternity coverage that the benefits for the necessary care and treatment of maternity are no less favorable than physical illness in general.
58-3-174	Coverage for bone mass measurement	Requires coverage for qualified for scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass.
58-3-178	Coverage for prescription drug contraceptives or devices	Requires coverage for prescription contraceptive drugs or devices when a plan provides prescription drug coverage.
58-3-179	Coverage for colorectal cancer screening	Requires coverage for colorectal cancer examinations and laboratory tests for cancer in accordance with the most recently published American Cancer Society guidelines.
58-3-181 (effective 1/1/16)	Synchronization of prescription refills	Requires health benefit plans to provide for synchonization of medication when the insured, provider, and a pharmacist agree that synchronization of multiple prescriptions for the treatment of chronic illness is in the best interest of the the insured. The health benefit plan shall apply a prorated daily cost-sharing rate to any medication dispensed by a network pharmacy pursuant to the statute.
58-3-190	Coverage for emergency care	Requires 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. This includes requiring treating emergency care provided at an out-of-network provider as an in-network benefit.
58-3-192 (effective 7/1/16)	Coverage for autism spectrum disorder	Standardizes definitions associated with autism spectrum disorder and treatments; mandates coverage for adaptive behavior treatment (permitting annual dollar limits) as well as coverage for screening, disagnosis, and treatment of autism spectrum disorder. Coverage shall be provided in accordance with MHPAEA requiring parity to the medical and surgical benefits in the plan, and prohibits discrimination based on autism. Applies only to large employer group health benefit plans (51 or more employees), and grandfathered and trasitional health benefit plans in the individual and small emplover group markets.
58-3-200(d)	Coverage for services provided outside provider networks	Prohibits penalizing an insured or subjecting the insured to the out-of-network benefit levels offered under the insured's plan unless contracting health care providers able to meet the health needs of the insured are reasonably available to the insured without unreasonable delay.

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Statute/Reg Number	Short Description	Longer Description
58-3-220	Mental Illness Minimum Coverage Requirements (Applicable only to group policies)	Mandates equitable coverage for mental illness benefits in group health benefit plans providing that the plan shall provide benefits for the necessary care and treatment of mental illness that are no less favorable than benefits for physical illness generally, including the application of the same limits which include the deductible, co-payments, lifetime and annual dollar limits, maximum out-of-pocket limits, and any other dollar limits or fees for covered services. Permits for most mental illness conditions a 30-day inpatient/outpatient limit of visits per year and a 30 office visits per year. For certain specified conditions, the durational limits must be the same as for general physical illness.
58-3-220(i) + federal mandate	Equity in benefits for Mental Health in employer group health benefit plans covering 51 or more employees.	Requires when a plan that provides both surgical and medical benefits AND mental health benefits that the plan must comply with the applicable standards of the federal Paul Wellstone and Pete Domenci Mental Health Parity and Addiction Equity Act of 2008; only applicable to employer groups with 51 or more employees.
58-3-221	Access to nonformulary drugs	Requires when an insurer who maintains one or more closed drug formularies, to establish and maintain a process that allows an enrollee to obtain, without penalty or additional cost-sharing, specific nonformulary drugs or devices determined to be medically necessary and appropriate by the enrollee's participating physician without prior approval from the insurer.
58-3-223	Access to specialist care for managed care plan enrollees	If a plan does not allow direct access to a specialist, the then plan shall develop a policy by which an insured may receive a extended or standing referral to an in-plan specialist when the insured meets certain conditions such as a chronic condition.
58-3-228	Coverage for prescription drugs during an emergency or disaster	Provides that all health benefit plans must develop and implement a procedure to waive time restrictions on filling or refilling prescriptions for medication if request by the covered person or subscriber when there is an emergency or disaster declared. The procedure must permit for the waiver or override of "refill too soon" edits to pharmacies, and the procedure must include a provision for payment to the pharmacy for any prescription dispensed under the statute.
58-3-235	Selection of a specialist as a primary care provider	Permits an insured with a chronic or degenerative disease to pick a in-plan specialist as their primary care physician.
58-3-240	Direct access to pediatrician for a minor	If a plan has a network, a minor shall be permitted to choose an in-plan pediatrician as their primary care physician
58-3-255	Coverage for certain clinical trials	Requires coverage for participation in phase II, phase III, and phase IV covered clinical trials for qualified individuals.
58-3-260	Coverage for newborn hearing screening	Requires coverage for newborn hearing screening ordered by the attending physician pursuant to G.S. 130A-125
58-3-270	Coverage for ovarian cancer surveillance tests	Requires coverage for surveillance tests for women age 25 and older at risk for ovarian cancer.
58-3-280	Coverage for the diagnosis and treatment of lymphadema	Requires coverage for the diagnosis, evaluation, and treatment of lymphadema, including 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.
58-3-285	Coverage for hearing aids	Requires coverage for one hearing aid per hearing-impaired ear up to $2500 dollars per hearing aid every 36 months for covered individuals under the age of 22 years of age.
58-3-300	Health insurance issuers subject to certain requirements of federal law	Provides that insurers of "health benefit plans" must meet the applicable requirements of the edeal Public Health Service Act and any regulations thereunder
58-50-25	Nurses' services	Requires the insurer to recognize services provided by a nurse acting with the authority granted under statute.

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Statute/Reg Number	Short Description	Longer Description
58-50-26	Physician assistant services	Requires the insurer to recognize services provided by a physician assistant acting within the authority granted under statute.
58-50-30	Right to choose providers as noted	Requires the insurer to recognize services provided by various listed providers acting with the authority granted under statute.
58-50-30(a3)	Right to choose provider - chiropractor	An insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.
58-51-5(a)(8)	Limits on exclusion of claims that are subject to Workers' Compensation Act	Prohibits an exclusion of claims that are subject to the Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes unless the exclusion extends to only specific medical charges for which the employee, employer, or carrier is liable or responsible according to a final adjudication of the claim under that Article or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article.
58-51-15(a)(2)b.	Pre-existing condition definition and limitations on exclusionary period - for individual health insurance contracts	Provides the maximum period prior to the effective date of coverage that an insurer may utilize to consider a condition that arose during that time period as a pre-existing condition, and the maximum amount of time the insurer may limit coverage for a pre-existing condition after the effective date of coverage. Also provides for credit against the exclusionary period for time covered under previous creditable coverage.
58-51-16	Coverage for Intoxicants and narcotics	Prohibits an exclusion in medical expense policies for claims related to or resulting from being intoxicated or under the influence of any narcotic.
58-51-17	Credit for previous creditable coverage for individual (non-employer group) health insurance plans	Provides that the pre-existing condition exclusion shall be reduced by the number of days an insured was covered under prior creditable coverage, including defining creditable coverage, and providing guidance on how to count the prior coverage. Applicable to individual (non-employer group) health insurance plans.
58-51-25	Eligibility extension for certain dependents who are mentally or physically handicapped	Requires that the attainment of the limiting age shall not operate to terminate the coverage of a child while the child is and continues to be (i) incapable of self-sustaining employment by reason of mental retardation or physical handicap; and (ii) chiefly dependent upon the policyholder or subscriber for support and maintenance.
58-51-25(b) + federal mandate	Extension of eligibility for a dependent child who takes a leave of absence from a postsecondary institution of learning due to a medical leave of absence from the institution	Requires insurers to extend the eligibility of a dependent child in accordance with the requirements of the Federal "Michelle's Law" when a dependent child takes a leave of absence from a postsecondary institution of learning due to medical leave of absence.
58-51-30	Coverage for newborn and foster children and coverage for congenital defects and anomalies	Requires coverage for benefits for any sickness, illness, or disability shall be provided with the moment of the child's birth or placement in the home as a foster child. Benefits in such plans shall be the same for congenital defects or anomalies as are provided for most sicknesses or illnesses suffered by minor children that are covered by the plans. Benefits for congenital defects or anomalies shall specifically include, but not be limited to, all necessary treatment and care needed by individuals born with cleft lip or cleft palate.
58-51-37	Pharmacy of Choice	Provides "any-willing-provider" type requirements for pharmacies.
58-51-38	Direct access to OB/GYN	Provides direct access without referral to an OB/GYN for all female plan participants age 13 or older.

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Statute/Reg Number	Short Description	Longer Description
58-51-50	Minimum benefit offering for Alcoholism/Drug Abuse Treatment (Applicable only to group and blanket policies)	Provides for a minimum benefit offering for chemical dependency treatment for a group or blanket accident and health insurance policy.
58-51-50(f) + federal mandate	Equity in benefits for Chemical Dependency/Addiction in employer group health benefit plans covering 51 or more employees.	Requires when a plan that provides both surgical and medical benefits AND chemical dependency/addiction benefits that the plan must comply with the applicable standards of the federal Paul Wellstone and Pete Domenci Mental Health Parity and Addiction Equity Act of 2008; only applicable to employer groups with 51 or more employees.
58-51-57	Coverage for mammograms and cervical cancer screening	Requires coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography.
58-51-58	Coverage for prostate cancer screening	Requires coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer
58-51-59	Coverage for certain off-label drug use for the treatment of cancer	Prohibits the exclusion of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the FDA. The drug does have to be approved by the FDA and the efficacy must have been proven and accepted for treatment in an established compendium.
58-51-61	Coverage for certain treatment of diabetes	Requires coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes.
58-51-62 + federal mandate	Coverage for reconstructive breast surgery following a mastectomy	Requires coverage for reconstructive breast surgery following a mastectomy if the plan provides coverage for the mastectomy.
58-51-110	Group replacement requirements	Requires an insurer who is issuing coverage to replace an existing group to cover all persons who were validly covered under the previous contract as of the day the coverage is issued.
58-51-120	Coverage of children	Prohibits certain practices or provisions which would limit access to health insurance by dependent children - such as requiring the child be claimed on taxes or reside with the insured, etc.
58-51-125	Coverage for adopted children	Provides for coverage to be extended to adopted children on the same basis as that extended to newborn and foster children under GS 58-51-30.
58-53-5	Group continuation	Provides the right for a former group member to continue their insurance for up to 18 months if they pay all of the premiums.
58-53-45	Individual conversion policy	Provides guaranteed access to individual coverage for a former group member who has exhausted their group continuation.
58-68-30	Pre-existing condition definition and limitations on exclusionary period - for employer group health insurance contracts	Places limits on the definition of a pre-existing condition and how long such a condition may be excluded; defines how to give credit for previous coverage and when a pre-ex is not applicable. This section includes a prohibition of exercising a pre-existing condition limitation to pregnancy in employer group health insurance coverage. Provides that the pre-existing condition exclusion shall be reduced by the number of days an insured was covered under prior creditable coverage, including defining creditable coverage, and providing guidance on how to count the prior coverage.
58-68-40	Small employer group guaranteed availability provision	An insurer who markets health insurance coverage to small employers (in NC, 50 or less full time employees, and self-employed individuals) shall issue all small group health plans to a small employer except for stated reasons. Self-employed individuals guaranteed availability rights are limited to the small group statutory plans defined in Article 50.

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Statute/Reg Number	Short Description	Longer Description
58-68-45	Guaranteed renewability of employer group health insurance plans.	An employer group health insurance plan is guaranteed renewable at the option of the policyholder except for stated reasons.
58-68-60	HIPAA Eligible Individual guaranteed availability provision	Provides that all insurers who market individual health insurance coverage shall provide at least two benefit plans on a guaranteed basis and without pre-existing condition limitations to individuals who qualify as Federally defined eligible individuals.
58-68-65	Guaranteed renewability of individual health insurance plans.	An individual health insurance plan shall be guaranteed renewable at the option of the policyholder except for stated reasons.
T11 12.0323	Coverage for complications of pregnancy	Requires that a complication of pregnancy may not be treated any differently from any other illness or sickness under the contract. Specifically includes a non-electing cesarean section as a complication.
T11 12.0324	Coverage to treat HIV/AIDS	HIV infection and AIDS must be treated as any other illness or sickness under the contract.
T11 16.0202	Renewability standard for individual A&H coverage.	Provides that guaranteed, conditionally, or noncancellable renewability provisions are permitted; prohibits optionally renewable provisions.