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(a) Repealed by Session Laws 2015-92, s. 6, effective June 19, 2015.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(b1) Repealed by Session Laws 2015-92, s. 6, effective June 19, 2015.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