11 NCAC 12 .1402 DEFINITIONS

In this Section, unless the context clearly indicates otherwise:

(1) "Coinsurance" means the percentage of an allowed charge or expense for a covered health care service that an enrollee must pay.

(2) "Copayment" means a fixed dollar amount that an enrollee must pay each time a covered health care service is provided.

(3) "Deductible" means a specified amount of covered health care services, expressed in dollars, that must be incurred by an enrollee before the HMO will assume any financial liability for all or part of covered health care services.

(4) "In-plan covered services" means covered health care services that are received according to the rules of the health care plan from providers employed by, under contract with, or approved in advance by the HMO; and means emergency health care services.

(5) "Out-of-plan covered services" means non-emergency, medically necessary covered health care services that are not received according to the rules of the health care plan, including services from affiliated providers that are received without the approval of the HMO.

(6) "Out-of-pocket expense" means a specified dollar amount of coinsurance incurred and payable by an enrollee for covered health care services in a specified period; but does not include deductible amounts, copayment amounts, charges in excess of the amount allowed by the HMO, amounts exceeding the maximum benefits, nor any disallowed or noncovered expenses under the rules of the health care plan.

(7) "Point-of-service product" means a feature in a health care plan that provides benefits for both in-plan covered services and out-of-plan covered services.

(8) The definitions contained in G.S. 58-67-5 are incorporated into this Section by reference.

History Note: *Authority G.S. 58-2-40; 58-67-35; 58-67-150;*
Eff. January 1, 1994;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. May 1, 2018.