

11 NCAC 12 .1803 GENERAL REQUIREMENTS

No insurer shall provide any PPO benefit plan unless it complies with the following:

- (1) Where the covered benefits of a PPO benefit plan include coinsurance, the difference in coinsurance rates between in-network covered services and out-of-network covered services shall not exceed 30 percentage points.
- (2) If the schedule of benefits for a PPO benefit plan imposes a deductible for in-network covered services, the amount of any separate annual deductible per enrollee or per family for out-of-network covered services may not exceed two times the amount of the annual per enrollee or per family deductible applied to in-network covered services.
- (3) If the schedule of benefits for a PPO benefit plan does not include an annual deductible for in-network covered services, the annual deductibles for out-of-network covered services shall not exceed two hundred and fifty dollars (\$250.00) per enrollee and the family deductible may not exceed seven hundred and fifty dollars (\$750.00).
- (4) The portion of any charge for out-of-network covered services to be applied to an annual deductible may be based on actual charges or the insurer's usual and customary charges.
- (5) If there are benefit maximums for in-network covered services, the amount of any annual and lifetime maximum limits for out-of-network covered services shall not be less than one-half of the amount of any annual and lifetime maximum limits for in-network covered services.
- (6) If a PPO benefit plan includes copayments for both in-network covered services and out-of-network covered services, the amount of the copayment for an out-of-network covered service shall not exceed the copayment for an in-network covered service by more than twenty dollars (\$20.00) or 100%, whichever is greater.
- (7) If the schedule of benefits for a PPO benefit plan limits the annual out-of-pocket expenses of enrollees to a maximum amount for in-network covered services, the amount of any separate annual out-of-pocket maximum for out-of-network covered services may not exceed two times the maximum amount for in-network covered services.
- (8) If the schedule of benefits for a PPO benefit plan does not include an annual maximum limit on out-of-pocket expenses for in-network covered services, the maximum limit on out-of-pocket expenses for out-of-network covered services shall not exceed one thousand two hundred and fifty dollars (\$1,250) per enrollee or three thousand seven hundred and fifty dollars (\$3,750) per family.
- (9) An insurer offering a PPO benefit plan may limit coverage for annual physicals and health screenings performed for preventative purposes to those services provided on an in-network basis, except that services provided in connection with mandated benefits must be available on both an in-network and out-of-network basis. An insurer shall provide coverage on both an in-network and out-of-network basis for all other covered services.
- (10) PPO benefit plans shall give enrollees the option to choose in-network covered services or out-of-network covered services each time those covered services are authorized, obtained, or rendered; and shall not require enrollees to obtain insurer approval to exercise that option.
- (11) An insurer offering a PPO benefit plan shall not impose different medical management requirements, including utilization review criteria or prior approval requirements, for out-of-network covered services than are imposed on in-network covered services. Those medical management requirements shall not restrict enrollees' abilities to seek covered services on out-of-network bases.

*History Note: Authority G.S. 58-2-40; 58-50-56;
Temporary Adoption Eff. January 1, 1998;
Eff. August 1, 1998;
Readopted Eff. May 1, 2020.*