Article 1G.

Health Care Liability.

§ 90-21.50. Definitions.

As used in this Article, unless the context clearly indicates otherwise, the term:

(1) "Health benefit plan" means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a self-insured indemnity program or prepaid hospital and medical benefits plan offered under the State Health Plan for Teachers and State Employees and subject to the requirements of Article 3 of Chapter 135 of the General Statutes, a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. "Health benefit plan" does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. "Health benefit plan" does not mean any of the following kinds of insurance:
   a. Accident.
   b. Credit.
   c. Disability income.
   d. Long-term or nursing home care.
   e. Medicare supplement.
   f. Specified disease.
   g. Dental or vision.
   h. Coverage issued as a supplement to liability insurance.
   i. Workers' compensation.
   j. Medical payments under automobile or homeowners.
   k. Hospital income or indemnity.
   l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
   m. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.

(2) "Health care decision" means a determination that is made by a managed care entity and is subject to external review under Part 4 of Article 50 of Chapter 58 of the General Statutes and is also a determination that:
   a. Is a noncertification, as defined in G.S. 58-50-61, of a prospective or concurrent request for health care services, and
   b. Affects the quality of the diagnosis, care, or treatment provided to an enrollee or insured of the health benefit plan.

(3) "Health care provider" means:
   a. An individual who is licensed, certified, or otherwise authorized under this Chapter to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; or
   b. A health care facility, licensed under Chapters 131E or 122C of the General Statutes, where health care services are provided to patients;

"Health care provider" includes: (i) an agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services; (ii) the officers and directors of a health care facility; and (iii) an agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(4) "Health care service" means a health or medical procedure or service rendered by a health care provider that:
   a. Provides testing, diagnosis, or treatment of a health condition, illness, injury, or disease; or
   b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a health condition, illness, injury, or disease.

(5) "Insured or enrollee" means a person that is insured by or enrolled in a health benefit plan under a policy, plan, certificate, or contract issued or delivered in this State by an insurer.

(6) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to Chapter 58 of the General Statutes, a service corporation organized under Article 65 of Chapter 58 of the General Statutes, a health maintenance organization organized under Article 67 of Chapter 58 of the General Statutes, a self-insured health maintenance organization or managed care entity operated or administered by or under contract with the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees pursuant to Article 3 of Chapter 135 of the General Statutes, a multiple employer welfare arrangement subject to Article 50A of Chapter 58 of the General Statutes, or the State Health Plan for Teachers and State Employees.

(7) "Managed care entity" means an insurer that:
   a. Delivers, administers, or undertakes to provide for, arrange for, or reimburse for health care services or assumes the risk for the delivery of health care services; and
   b. Has a system or technique to control or influence the quality, accessibility, utilization, or costs and prices of health care services delivered or to be delivered to a defined enrollee population.

   Except for the State Health Plan for Teachers and State Employees, "managed care entity" does not include: (i) an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or (ii) a health care provider.

(8) "Ordinary care" means that degree of care that, under the same or similar circumstances, a managed care entity of ordinary prudence would have used at the time the managed care entity made the health care decision.

(9) "Physician" means:
   a. An individual licensed to practice medicine in this State;
   b. A professional association or corporation organized under Chapter 55B of the General Statutes; or
   c. A person or entity wholly owned by physicians.

(10) "Successor external review process" means an external review process equivalent in all respects to G.S. 58-50-75 through G.S. 58-50-95 that is approved by the Department and implemented by a health benefit plan in the event that G.S. 58-50-75 through G.S. 58-50-95 are found by a court of competent jurisdiction to be void, unenforceable, or preempted by federal law,

in whole or in part. (2001-446, s. 4.7; 2007-323, s. 28.22A(o); 2007-345, s. 12; 2019-202, s. 8; 2021-62, ss. 4.2(a), 4.2(b).)