§ 58-3-190. Coverage required for emergency care.

(a) Every insurer shall provide 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.

(b) With respect to emergency services provided by a health care provider who is not under contract with the insurer, the services shall be covered if:

(1) A prudent layperson acting reasonably would have believed that a delay would worsen the emergency, or

(2) The covered person did not seek services from a provider under contract with the insurer because of circumstances beyond the control of the covered person.

(c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the provider of the emergency services or the covered person.

(d) Coverage of emergency services shall be subject to coinsurance, co-payments, and deductibles applicable under the health benefit plan. An insurer shall not impose cost-sharing for emergency services provided under this section that differs from the cost-sharing that would have been imposed if the physician or provider furnishing the services were a provider contracting with the insurer.

(e) Both the emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition within a reasonable clinical confidence, or with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

(f) Insurers shall provide information to their covered persons on all of the following:

(1) Coverage of emergency medical services.

(2) The appropriate use of emergency services, including the use of the "911" system and other telephone access systems utilized to access prehospital emergency services.

(3) Any cost-sharing provisions for emergency medical services.

(4) The process and procedures for obtaining emergency services, so that covered persons are familiar with the location of in-plan emergency departments and with the location and availability of other in-plan settings at which covered persons may receive medical care.

(g) As used in this section, the term:

(1) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

a. Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

(2) "Emergency services" means health care items and services furnished or required to screen for or treat an emergency medical condition until the

condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

(3) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also 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 insurance.
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.

(4) "Insurer" means an entity that writes a health benefit plan and that is an insurance company subject to this Chapter, a service corporation under Article 65 of this Chapter, a health maintenance organization under Article 67 of this Chapter, or a multiple employer welfare arrangement under Article 50A of this Chapter.

(5) "To stabilize" means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred. (1997-443, s. 11A.122; 1997-474, s. 2; 2019-202, s. 8)