GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

H **D**

HOUSE DRH10056-LN-43 (2/21)

Short Title:	State Employees' Health Plan/Emergency Svces.	(Public)
Sponsors:	Representative Frye.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT PROVIDING FOR COVERAGE OF EMERGENCY SERVICES IN CERTAIN SITUATIONS UNDER THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 135-40.8 reads as rewritten:

"**§ 135-40.8. Out-of-pocket expenditures.**

(a) For the balance of any fiscal year after each eligible employee, retired employee, or dependent satisfies the cash deductible, the Plan pays eighty percent (80%) of the eligible expenses outlined in G.S. 135-40.6. The remaining twenty percent (20%) is paid by the covered individual until one thousand five hundred dollars ($1,500) per covered individual up to an aggregate of four thousand five hundred dollars ($4,500) per employee and child(ren) or employee and family coverage contract per fiscal year in excess of the deductible has been paid out of pocket. The Plan then pays one hundred percent (100%) of the remaining covered expenses.

(b) Repealed by Session Laws 2001-253, s. 1(m).

(c) Notwithstanding any other provision of this Article, on the first day of each confinement the Plan does not pay the first one hundred dollars ($100.00) of the room accommodation charge allowable under G.S. 135-40.6(1). Any readmission within 60 days after discharge for the same reason shall be considered the same confinement for the purpose of this subsection. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c1) Notwithstanding any other provision of this Article, the Plan does not pay the first fifty dollars ($50.00) of the facility fees and ancillary charges for allowable charges exceeding five hundred dollars ($500.00) per episode of care for hospital outpatient departments and ambulatory surgical facilities under G.S. 135-40.6(4). Readmission

within 30 days after discharge for the same reason shall be considered the same episode of care for the purpose of this subsection. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c2) Notwithstanding any other provision of this Article, the Plan does not pay the first one hundred dollars ($100.00) of allowable emergency room charges when admission to a hospital pursuant to the emergency room use does not immediately follow. This subsection shall apply only when less costly alternative means of emergency medical care are reasonably available as determined by the Executive Administrator and Board of Trustees. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(c3) Notwithstanding any other provision of this Article, the Plan does not pay for the first fifteen dollars ($15.00) of allowable charges for each home, office, or skilled nursing facility visit under the provisions of G.S. 135-40.6(7)a. and b., G.S. 135-40.6(4), G.S. 135-40.6(8)i., j., k., n., r., and s., and G.S. 135-40.5(e). The co-payment assessed by this subsection shall be assessed only once per person per provider per day and shall not apply to laboratory, pathology, and radiology services, or to charges for injected medications. The exclusion made under this subsection shall not count toward the deductible nor toward the maximum amount of coinsurance out-of-pocket costs.

(d) Where a network of qualified preferred providers of inpatient and outpatient hospital care is reasonably available for use by those individuals covered by the Plan, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year per covered individual up to an aggregate of fifteen thousand dollars ($15,000) per employee and child(ren) or employee and family coverage contract per fiscal year in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6. The Plan then pays one hundred percent (100%) of the remaining covered expenses.

(e) Notwithstanding subsection (d) of this section, where qualified preferred providers of medical care are not reasonably available in medical emergencies, the Plan pays the amounts covered by subsection (a) of this section. Any amount of charges for services under this section that exceeds the amount allowed by the Plan for the services of qualified preferred providers under this section shall be negotiated between the Plan and the provider of medical services so that the Plan member is not held financially responsible for the amount of excess charges. As used in this section, a 'medical emergency' is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical care, could imminently result in injury or danger to self or others."

SECTION 2. This act is effective when it becomes law and applies to medical emergency services received on and after January 1, 2000.