**South Carolina General Assembly**

125th Session, 2023-2024

**S. 119**

**STATUS INFORMATION**

General Bill

Sponsors: Senators Hembree and Gustafson

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Introduced in the Senate on January 10, 2023

Currently residing in the Senate Committee on **Banking and Insurance**

Summary: Hearing aids

**HISTORY OF LEGISLATIVE ACTIONS**

 Date Body Action Description with journal page number

 11/30/2022 Senate Prefiled

 11/30/2022 Senate Referred to Committee on **Banking and Insurance**

 1/10/2023 Senate Introduced and read first time (Senate Journal‑page 67)

 1/10/2023 Senate Referred to Committee on **Banking and Insurance** (Senate Journal‑page 67)

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**VERSIONS OF THIS BILL**

[12/01/2022](https://www.scstatehouse.gov/sess125_2023-2024/prever/119_20221201.docx)

A bill

to amend the South Carolina Code of Laws by adding Section 38‑71‑48 so as to PROVIDE DEFINITIONS, TO REQUIRE ALL HEALTH INSURANCE AND GROUP HEALTH BENEFIT PLANS TO COVER HEARING AIDS AND REPLACEMENT HEARING AIDS FOR INSUREDS WITH IMPAIRED HEARING, AND TO PROVIDE FOR THE SCOPE OF COVERAGE, AMONG OTHER THINGS.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Article 1, Chapter 71, Title 38 of the S.C. Code is amended by adding:

 Section 38‑71‑48. (A) As used in this section:

 (1) “Hearing aid” means any nonexperimental and wearable instrument or device designed for the ear and offered to aid or compensate for impaired human hearing, including any parts, ear molds, repair parts, and replacement parts of this instrument or device. ‘Hearing aid’ excludes batteries, cords, personal sound amplification products, and other assistive listening devices.

 (2) “Audiologist” means an individual licensed to practice audiology in this State pursuant to Chapter 67, Title 40.

 (3) “Audiologic evaluation” means an evaluation consisting of procedures to:

 (a) assess the status of the auditory system, the site of an auditory disorder, the type and degree of hearing loss, and the potential effects of hearing loss on communication; and

 (b) identify appropriate treatment and referral options. Referral options for evaluation should include linkage to state Part C Individuals with Disabilities Education Act coordinating agencies or other appropriate agencies or medical entities.

 (4) “Auditory habilitation” means intervention including the use of procedures, techniques, and technologies to facilitate the receptive and expressive communication abilities of a child with hearing loss.

 (5) “Insurer” means an insurance company, a health maintenance organization, and other entity that provides health insurance coverage as defined in Section 38‑71‑670(6), is licensed to engage in the business of insurance in this State, and is subject to state insurance regulation.

 (6) “Health maintenance organization” means an organization as defined in Section 38‑33‑20(8).

 (7) “Health insurance plan” means a group health insurance policy or group health benefit plan offered by an insurer, including the State Health Plan.

 (8) “State Health Plan” means the employee and retiree insurance program provided in Article 5, Chapter 11, Title 1.

 (9) “Practice of fitting, dispensing, servicing, and sale of hearing instruments” means the measurement of human hearing with an audiometer for the purpose of making selections, recommendations, adoptions, services, and sales of hearing instruments, including the making of ear molds, as a part of the hearing instrument. An audiometer used in this section must be calibrated to the current American National Standard Institute standards.

 (B) A health insurance plan must provide to all insureds age twenty‑six years and younger coverage for the billed charges of one hearing aid per hearing impaired ear, not to exceed two thousand five hundred dollars per hearing aid per covered individual. A health insurance plan may not deny or refuse coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on a covered individual solely because he is or has been previously diagnosed with hearing loss.

 (C) The coverage provided in this section includes the following:

 (1) fitting, dispensing, servicing, and repairs, including providing ear molds as necessary to maintain optimal fit, and prescribed and dispensed by the treating licensed audiologist of the insured;

 (2) the replacement of one hearing aid per hearing impaired ear every forty‑eight months;

 (3) the option for the covered individual to select a hearing aid or aids costing more than the amount referenced in subsection (B), so long as the covered insured pays the difference between the price of the selected hearing aids or aid and the limit in subsection (B); and

 (4) the option for the covered individual to purchase his or her hearing aids through any licensed audiologist or licensed hearing aid dealer or dispenser in this State, so long as the hearing aid or aids are purchased in accordance with federal and state laws, regulations, and rules for the sale and dispensing of hearing aids.

 (D) The hearing loss of a covered individual must be documented by a physician or audiologist licensed by this State.

 (E) A health insurance plan must replace a hearing aid or aids if it does not adequately meet the needs of the covered individual and the hearing aids cannot be repaired or adjusted. Coverage for the replacement must be offered to the covered individual within two months from the date it is determined by a licensed audiologist that the hearing aid or aids cannot be repaired or adjusted.

 (F) A health insurance plan may not impose a financial or contractual penalty to an insured or to the audiologist providing the hearing aid if a covered individual elects to purchase a hearing aid priced higher than the benefit amount by paying the difference between the benefit amount and the price of the hearing aid.

 (G) Coverage required pursuant to subsection (B) may be subject to other general exclusions and limitations of the health insurance plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, review of health care services including review of medical necessity, case management, and other managed care provisions.

 (H) The provisions of this section do not apply to any accident and sickness contract, policy, or benefit plan offered by any employer with ten or fewer employees.

SECTION 2. This act takes effect July 1, 2023, and applies to health insurance plans issued, renewed, delivered, or entered into on or after the effective date of this act.

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