Office Visit Copays, Medical Copays, Coinsurance, and Deductibles

The Health Plan offers a variety of benefit plans that require the member to be responsible for a portion of the cost of services. Member responsibility may take the form of copays for office visits or other medical services, coinsurance amounts, and deductibles. As groups re-enroll annually, the member copayment may change, depending upon the plan selected by the employer.

**Office visit copay/medical copay**
Generally, copays are a fixed amount, but may be a percentage of the allowed amount that is associated with a specific service such as an office visit, therapy visit, or diagnostic service and would be the member’s responsibility. Members are expected to pay this amount at the time of service.

It is imperative that the offices ask for the member’s ID card at every visit to assure coverage and obtain correct copay information. A sample of The Health Plan ID card is shown on the Product Matrix.

Copay may not be waived, as this is in direct violation of the Providers Contract.

The copay should be collected at the time of service, unless other arrangements have been made. The copay amount should be listed as “copay” on the claim form.

Copays DO NOT apply to hospital inpatient physician visit, preventive services and/or prenatal office visit (after the initial visit), physician nursing home visits, or patient home visits when determined to be medically necessary by the plan. Members of specific employer groups may have a copay for specific outpatient procedures.

**Co-insurance**
Generally, co-insurance is an amount based upon the member being responsible for a percentage of the allowed amount for a covered service. A provider may request payment at the time of service. However, the provider must take care to determine the member’s specific benefit and apply any contract reimbursement terms to determine the amount of the co-insurance. At no time should a provider collect more than the amount that is contractually obligated to pay. The most accurate method to assure that the provider is collecting the correct amount may be to wait for the explanation of benefits (EOB) from The Health Plan showing the amount that is member responsibility. A copy of the EOB is also sent to the member letting them know the amount that is their responsibility.
Deductibles
Deductibles are an annual amount, defined by the member’s benefit plan that members must satisfy before the plan pays for any services. A provider may expect payment from the member at the time of service, if the member has not satisfied their annual deductible. However, unless, the member knows that they have not met their deductible, it is generally difficult, due to claims lag, to determine if a member has met their deductible at any given point in time. At no time should a provider collect more than the amount that is the member’s responsibility.

Collecting copays when another insurance is primary
If the primary insurance pays equal to, or more, than the office copay amount, do not collect The Health Plan office copay.

Example: Member has a $10.00 copay and his primary insurance carrier pays $11.00, do not collect the $10.00 copay.

If you have questions regarding whether or not to collect office copay, please contact The Health Plan Coordination of Benefits/Funds Recovery Department.

Determining a member’s responsibility
Member copays for physician office visits and certain other services may be found on the The Health Plan ID card, The Health Plan’s provider secure portal, or by calling The Health Plan Customer Service Department.

PLEASE NOTE: Deductible and coinsurance not applicable for preventive services

The Affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing. The Health Plan products affected by the ACA would be our Commercial, HMO, PPO, POS, and Self-Funded Employer Groups.

Under the ACA, private health plans must provide coverage for a range of preventive services and may not impose cost sharing (such as copayments, deductibles, or co-insurance) on patients receiving these services. Please remember that annual well exams and other preventive services do not require a copay or coinsurance from the member, unless the employer group to which they belong, is “grandfathered.”

View “Quick Reference Information” for preventive services from Centers for Medicare and Medicaid Services (CMS).