



## New FHP Co-Pay Requirements

**Beginning September 1, 2005**, all Health Plus members participating in Family Health Plus (FHP) will be subject to new co-pay requirements for the covered benefits listed below.

**FHP members who cannot afford the co-payment must not be denied a service based on their inability to pay. If a member is unable to pay the co-payment at the time of service, you are allowed (but not required) to bill the member or request payment at a later time.**

SERVICE	CO-PAY AMOUNT	CO-PAY COLLECTED BY
Brand Name Prescription Drugs	\$6 per prescription or refill	Pharmacy
Generic Prescription Drugs	\$3 per prescription or refill	Pharmacy
Clinic Visits	\$5 per visit	Clinic
Physician Visits	\$5 per visit	Facility or Physician Office
Dental Service Visits	\$5 per visit up to \$25 per year	Dental Clinic or Office
Lab Tests	\$0.50 per CPT code billed	Provider who performs test
Radiology Services (i.e diagnostic x-rays, ultrasound, nuclear medicine, radiation therapy)	\$1 per radiology service (\$1 total if billed globally; if billed separately, \$1 each for technical and professional services) <b>Co-pay waived if part of ER visit</b>	Physician and Facility
Inpatient Hospital Stays	\$25 per stay	Hospital
Non-Urgent Emergency Room Visits	\$3 per visit	Hospital
Covered Over-The-Counter (OTC) Medications (i.e. smoking cessation patches and gum, insulin)	\$0.50 per medication	Product Vendor
Covered Medical Supplies (i.e. hearing aid batteries, enteral formula, diabetes test strips, lancets)	\$1 per supply	Product Vendor

**Co-payments will NOT be required for the following services:**

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| <ol style="list-style-type: none"> <li>1. Emergency services</li> <li>2. Mental health or chemical dependence clinics</li> <li>3. Psychotropic medications</li> <li>4. Home care and DME</li> </ol> | <ol style="list-style-type: none"> <li>5. Family planning services, tests, &amp; supplies</li> <li>6. Vision care</li> <li>7. Tuberculosis medications</li> <li>8. Prescription drugs for residents of Adult Care Facilities</li> </ol> |
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**Members in the following categories are EXEMPT from all co-payments:**

- **Under age 21**
- **Pregnant, up to 60 days postpartum** (exempt for both pregnancy and non-pregnancy related services, whether provided in an outpatient or inpatient setting)
- Permanent nursing home residents
- Residents of community-based residential or intermediate care facilities licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disability. Residents of adult care facilities licensed by the State Department of Health are exempt from pharmacy co-pays only.

## **FHP Co-Pay *Fast Facts***

Here is some additional information about how co-pays are applied to certain services. More FHP co-pay information can be found on our web site: [www.healthplus-ny.org](http://www.healthplus-ny.org) (click *Providers* then *News and Notices*). If you have additional questions regarding FHP co-pays, please call our Provider Service Line at 1-800-450-8753.

### **1. Physician Office Visits**

The co-pay for a physician office visit applies to the CPT code billed for the consultation. Any lab tests or radiology services billed separately by the physician are subject to the applicable co-pay. The member is responsible for both.

### **2. Laboratory Services Involving More Than One Test**

Co-pays are charged per CPT/HCPCS code billed. If two separate tests are done (i.e. two different codes billed), then two co-pays would apply. If, however, the code description specifies that two specimen collections are part of one testing procedure, and only one code is billed, then one co-pay would apply.

### **3. Bi-lateral Radiology Services**

If one CPT code is billed, one co-payment would be collected. For example, code 73120 is used for a radiologic examination of the hand with two views. If done bilaterally, the same code is used with a modifier indicating a bilateral procedure. One code is billed and therefore one co-pay should be charged.

### **4. Radiology Services with a Technical and Professional Component**

Radiology services performed at a hospital or outpatient clinic normally generate two bills-- one each for the technical and professional components. Since two claims are generated in this example, two co-pays should be applied. The facility should bill the member for the technical co-pay, and the radiologist should bill the member for the professional co-pay.

### **5. Co-pays for Hospital Stays Related to Emergency Conditions**

There is no co-pay for ER services. However, if the ER visit results in an inpatient stay, then the member would be charged the \$25 inpatient care co-pay upon discharge.

The inpatient co-pay applies to all inpatient stays in a general hospital. There is no co-pay on Skilled Nursing Facility or Residential Health Care Facility services.

### **6. Hospital Re-admissions**

If a member is discharged from the hospital and rapidly re-admitted, then an additional co-pay would be required if the subsequent hospital stay is considered a separate admission and discharge.

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**7. Hospital Transfers**

If a member is transferred from one acute care hospital to another, then the second acute care hospital collects the co-pay.

**8. Hospital Outpatient Services**

The co-pay for outpatient surgery is for physician services only. No co-pay is required on facility charges. If a member goes to an outpatient department or clinic for laboratory or radiology testing only, then he/she is responsible only for the co-payment applicable to each test received. Other outpatient services, such as physician office visits are subject to the applicable co-pays. There is no maximum co-payment. A separate co-pay will be charged for each CPT code billed.

**9. PT/OT/Audiology**

There is no co-pay for these services.

**10. Pregnancy Verification**

A pregnancy can be verified either by the member's self-declaration or documentation from a prenatal care provider.

**FHP Vision Benefit Changes**

As of **September 1, 2005**, the Family Health Plus vision benefit will include the following routine services once every two years (twenty-four months):

- 1) One eye exam
- 2) One pair of prescription eyeglasses, or prescription contact lenses where medically necessary
- 3) One pair of medically necessary occupational eyeglasses if needed to perform job duties

FHP members will no longer be eligible for replacement eyeglasses within the 24-month benefit coverage period in cases of loss, theft, damage or a prescription change of more than .5 diopters. Vision services (whether provided by an optometrist or ophthalmologist) do not require a co-payment.