Culinary Health Fund™

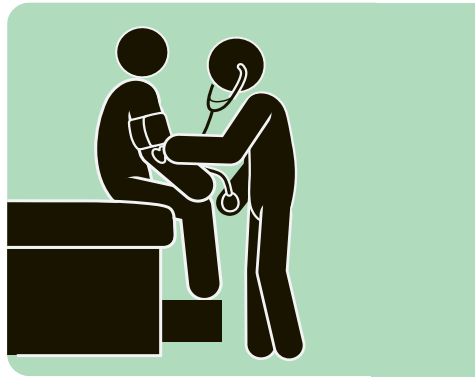
Your Culinary In-Network (PPO) Co-Payment Book

English: pg. 1-5

Ang Libro ng Co-Payment (PPO)

Sa Samahan ng Culinary

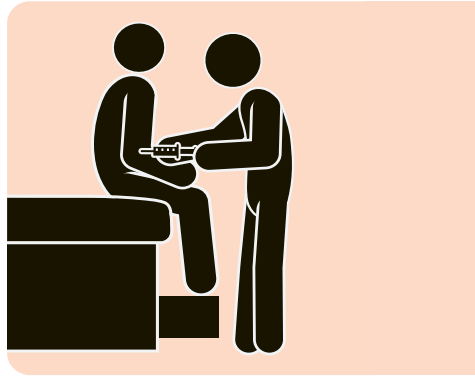
Tagalog: pg. 6-10



Su Libro de Co-pagos

dentro de la Red de la Culinaria

Español: pg. 11-15



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Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
The Maximum yearly amount you have to pay out of your pocket for your co-pays and coinsurance is **$6,350** per person or **$12,700** per family.						
Preventive Services	Immunizations for adults (Age appropriate) & children (Birth to 18 y/o)	No copay	No coinsurance	100% of allowable charges	No maximum benefit	Contact the Customer Service Office at **702-733-9938** for other services that may be covered.
	Well Baby Exams (Newborn through 21 y/o)					
	Physical Exams					
	Nutritional Counseling					
	Osteoporosis Screening (Women 60 and older)					
	Mammography (Women 35 and older)					
	Women's well check (Women 21 to 64 y/o)					
	Colonoscopy & Sigmoidoscopy (Adults ages 50-75)					
Physician Office Services	Primary Doctor	$20	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	Specialist	$30				
	In-Patient Services	No copay				
	Injection					
	IV Treatment	$7				
	Pulmonary Treatment	$5/procedure				
	Pulmonary Test	$7				
	Chiropractor	$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	Contact CACP at 702-365-5981 for Providers.
	Urgent Care	$40	No coinsurance	100% of allowable charges after copay	No maximum benefit	**Tip: Want to save money? Call Dr. Tomorrow at 702-691-5656** and get an appointment with a doctor the same day or within 24 hours.
	X-Ray	$30	No coinsurance	100% of allowable charges after copay	No maximum benefit	Copay applies only in select physician offices.
	Radiology-PET/PET CT	$225/ procedure				
	Radiology-CT/MRA/MRI	$125/ procedure				
	Lab	$10	No coinsurance	100% of allowable charges after copay	No maximum benefit	Copay applies when labs performed & processed in physician's office.

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Physician Office Services (continued)	Vision Exam	$40	No coinsurance	100% of allowable charges after copay	No maximum benefit	Lenses and frames are covered under the vision category.
	Chemotherapy	$7	No coinsurance	100% of allowable charges after copay	No maximum benefit	Services need to be provided at Comprehensive Cancer Centers of Nevada.
	Radiation Therapy					
	Hearing & Speech Exam	$40	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	Allergy Testing	$7/test type				
	Allergy Immunotherapy	$7/Injection				
	Surgery in the physician's office	$7/procedure				
	Nerve conduction studies	$7				
	All other physician office procedures	$7/procedure				
	Dialysis Managment	No copay				
Prescriptions	Culinary Pharmacy (Generic medications only)	No copay	No coinsurance	100%	No maximum benefit	**Tip: you can save money by asking your doctor for a generic medication** Contact the Culinary Free Pharmacy at 702-650-4417.
	Tier 1 Generic medications	$10	No coinsurance	100% after copay	No maximum benefit	Tier 1, 2 & 3 medications available at retail pharmacies. For a complete list of retail pharmacies included in the Network, contact **Catamaran at 1-866-611-5960.**
	Tier 2 Formulary	$30				
	Tier 3 Non-Formulary	$50				
	Mail Order	$10, $20, or $35	No coinsurance	100% after copay	No maximum benefit	With one copay, you can get a **60-day** supply.
Therapy Outpatient	Physical Therapy	$0	No coinsurance	100% of allowable charges	No maximum benefit for non-surgical Physical Therapy 30 visits per event for post-surgical Physical Therapy	Patient must have a referral from a Physician.
	Occupational and Speech Therapy	$20	No coinsurance	100% of allowable charges	30 visits per therapy	No other information.

Copays are subject to change. Call the Customer Service Office at 702-733-9938 to confirm your copay.

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Cardiac/ Pulmonary Rehabilitation	Cardiac/Pulmonary Rehabilitation	$30	No coinsurance	100% of allowable charges after copay	30 visits per therapy	No other information.
Ambulatory Surgery Center	Surgery	$150	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
Free-Standing Facility Services (Not at a hospital)	Lab	No copay	No coinsurance	100% of allowable charges after copay	No maximum benefit	**Tip:** CPL is the only lab you can use.
	X-Ray	$20	No coinsurance	100% of allowable charges after copay	No maximum benefit	**Tip:** Desert Radiology is the only radiology office you can use.
	CT Scan, MRI, MRA	$125				
	PET	$175				
	Interventional Radiology Services	$150				
	Dialysis	No copay	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval).
	Sleep Center	$125				
	Cardiac/Pulmonary Rehabilitation	$30	No coinsurance	100% of allowable charges after copay	30 visits annual limit	
Outpatient Services in a Hospital	Lab for Hospital Based preoperative or diagnostic services only	$15	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval). **Tip:** If your doctor refers you to a hospital to have these tests, ask your doctor to send you to **Desert Radiology or CPL.**
	X-Ray	$45				
	MRI, MRA, CT Scan	$125				
	PET and combined PET/CT	$225				
	Interventional Radiology and Diagnostic Radiology Services only performed in a hospital outpatient setting.	$250				
	Dialysis	No copay				
	Physical Therapy (after discharge from inpatient hospital)	$0	No coinsurance	100% of allowable charges after copay	30 visits **per** event	
	Occupational & Speech Therapy (after discharge from inpatient hosp.)	$20	No coinsurance	100% of allowable charges after copay	maximum of 30 visits **per** therapy type	
	Cardio/Pulmonary Rehab (after discharge from inpatient hospital)	$40	No coinsurance	100% of allowable charges after copay	30 visits annual limit	

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Outpatient Hospital Services (continued)	Outpatient Surgery	$250	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval).
	Diabetes Ed.	No copay				
	All other outpatient hospital services	No copay	25%	75% of allowable charges		
Ambulance	Ground or Air	No copay	25%	75%	No max benefit	No other information.
Emergency Room vs. Urgent Care	Emergency Room	**$350 per visit**	No coinsurance	100% of allowable charges after copay, including all other covered ER services, as well as lab and X-ray	No maximum benefit	**Tip:** please go to the **Urgent Care** for non-life threatening issues. Take a look at the Provider Directory for **24/7 Urgent Care locations**.
	Urgent Care	**$40 per visit**	No coinsurance	100% of allowable charges after copay	No maximum benefit	**Tip: Want to save money?** Call Dr. Tomorrow at 702-691-5656 and get an appointment with a doctor the same day or within 24 hours.
In-Network Hospital (in-patient)	Inpatient Stay	$250	No coinsurance	100% of allowable charges after copay	No max benefit	**Tip:** Call the Customer Service Office at 702-733-9938 to **make sure your hospital is in our Network**.
	Obstetrics	$250				
	Skilled Nursing Facility	$250	No coinsurance	100% of allowable charges after copay	60 day max	
	Inpatient Rehabilitation	$250				
	23hr observation	$250	No coinsurance	100% of allowable charges after copay	No max benefit	
	Surgery/Anestheisia	No copay	No coinsurance	100% of allowable charges		
Mental Health and Addictions	Outpatient Therapy	No copay for the first 5 visits **per** issue/$20 copay after.	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services may require prior approval. Call Harmony Healthcare at 702-251-8000 for additional information.
	Inpatient	$250				
	Partial Hospital Admission	$250				
	Residential Treatment	$250				
	Intensive Outpatient Program	$250				

Copays are subject to change. Call the Customer Service Office at 702-733-9938 to confirm your copay.

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Other Services	Home Healthcare	$15 **per** day	No coinsurance	100% of allowable charges after copay	Maximum benefit of 60 days per calendar year	No other information
	Home Infusion Therapy	No copay	No coinsurance	100% of allowable charges		
	Hospice	No copay	No coinsurance			
	Diabetic Shoes	$55 **per** pair	No coinsurance	100% of allowable charges after copay	2 pair per calendar year	
	Mastectomy Bras	$12 **per** item	No coinsurance	100% of allowable charges after copay	$350 per calendar year	
	Diabetic Supplies	No copay	No coinsurance	100% of allowable charges	No maximum benefit	
	Hearing Aids	No copay	No coinsurance	$300 every 5 years	$300 every 5 years	
	Compression Stockings	$22 **per** pair	No coinsurance	100% of allowable charges after copay	3 pair per calendar year	Custom-made compression stockings require prior authorization (approval).
	Orthotic Shoe Inserts	$10 **per** pair	No coinsurance	100% of allowable charges after copay	1 pair or 2 inserts every 5 years	They must be prescribed by a PPO Physician, Podiatrist, Orthopedic Physician or an Orthotic Provider.
	Durable Medical Equipment & Medical Supplies	No copay	25% of allowable charges	75% of allowable charges	No maximum benefit	Prior Authorization (approval) is required for items over $500.
	Prosthetic & Orthotic Appliances	No copay	25% of allowable charges	75% of allowable charges	No maximum benefit	Prior Authorization (approval) is required.
	Glasses & Contact Lenses	No copay	No coinsurance	$150 every two years	$150 every two years	Your eye exam is covered under your Physician Office Services Benefit.

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