2015 CULINARY HEALTH FUND COPAYS

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Deductible	NONE	NONE
Out-of-Pocket Maximum	$6,350 Single/ $12,700 Family	NONE

HOSPITAL INPATIENT FACILITY - NON MATERNITY		
Medical/Surgical	$250 copay per admit	$2,000 copay per admit, then 40% coinsurance
Skilled Nursing Facility	$250 copay per admit (60 DAY LIMIT)	NOT COVERED
LTAC & Rehabilitation	$250 copay per admit (60 DAY LIMIT)	NOT COVERED
23 Hour Observation	$250 copay per admit	$2,000 copay per admit, then 40% coinsurance

HOSPITAL INPATIENT FACILITY - MATERNITY		
Maternity	$250 copay per admit	NOT COVERED
Birthing Center	25% coinsurance	NOT COVERED

MENTAL HEALTH & ADDICTION	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Hospital Admission	$250 copay per admit	$2,000 copay per admit, then 40% coinsurance
Partial Hospital Admission	$250 copay per admit	NOT COVERED
Residential Treatment	$250 copay per admit	NOT COVERED
Intensive Outpatient Program	$250 copay per admit	NOT COVERED
Outpatient Visits	$15 copay (NO COPAY FIRST 5 VISITS)	NOT COVERED

HOSPITAL OUTPATIENT FACILITY	**IN-NETWORK**	**OUT-OF-NETWORK**
Emergency Room	$350 copay	$350 copay
Surgery	$250 copay	NOT COVERED
Cardio/Pulmonary Rehabilitation (after discharge from an inpatient hospital admission)	$40 copay (30 VISIT LIMIT)	NOT COVERED
Diabetic Education	NO COPAY	NOT COVERED
Dialysis	NO COPAY	NOT COVERED
Lab/Pathology (for hospital-based preoperative/diagnostic services only)	$15 copay	NOT COVERED

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2015 CULINARY HEALTH FUND COPAYS

PT/OT/ST (after discharge from an inpatient hospital admission)	$30 copay (30 VISIT LIMIT)	NOT COVERED
Radiology - General	$45 copay per visit	NOT COVERED
Radiology - CT/MRA/MRI	$125 copay per visit	NOT COVERED
Radiology - PET/PET CT	$225 copay per visit	NOT COVERED
Interventional and diagnostic radiology services which are performed in a surgical area or cath lab	$250 copay per visit	NOT COVERED
Other	25% coinsurance	NOT COVERED

2015 CULINARY HEALTH FUND COPAYS

NON HOSPITAL FREE STANDING FACILITY	IN-NETWORK	OUT-OF-NETWORK
Surgery	$150 copay	NOT COVERED
Cardio/Pulmonary Rehabilitation	$30 copay (30 VISIT LIMIT)	NOT COVERED
Dialysis	NO COPAY	NOT COVERED
Lab/Pathology	NO COPAY	NOT COVERED
Radiology - General	$20 copay per visit	NOT COVERED
Radiology - CT/MRA/MRI	$125 copay per visit	NOT COVERED
Radiology - PET/PET CT	$175 copay per visit	NOT COVERED
Interventional Radiology Services	$150 copay per visit	NOT COVERED
Physical Therapy - Post Surgery	$0 copay (30 VISITS PER EVENT)	NOT COVERED
Physical Therapy	$0 copay	NOT COVERED
Occupational Therapy/Speech Therapy	$20 copay (30 VISIT LIMIT)	NOT COVERED
Sleep Study	$125 copay	NOT COVERED

PROFESSIONAL SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient services	NO COPAY	NOT COVERED
Office Visit - PCP	$15 copay per visit	NOT COVERED
Office Visit - Ophthalmologist or Optometrist	$20 copay per visit	NOT COVERED
Office Visit - Specialist	$30 copay per visit	NOT COVERED
Chiropractor	$25 copay per visit	NOT COVERED
Urgent Care Visit	$40 copay per visit (includes all covered services)	NOT COVERED
Allergy Testing/Immunotherapy	NO COPAY	NOT COVERED
Chemotherapy	NO COPAY	NOT COVERED
Dialysis Management	NO COPAY	NOT COVERED
Hearing and Speech Testing	NO COPAY	NOT COVERED
Lab/Pathology	NO COPAY	NOT COVERED
Injections	NO COPAY	NOT COVERED
IV Treatment	NO COPAY	NOT COVERED
Nerve conduction studies	NO COPAY	NOT COVERED
Pulmonary Test	NO COPAY	NOT COVERED
Pulmonary Treatment	NO COPAY	NOT COVERED
Radiation Therapy	NO COPAY	NOT COVERED
Radiology - General (in select physician offices)	$30 copay per visit	NOT COVERED

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Radiology - CT/MRA/MRI (in select physician offices)	$125 copay per visit	NOT COVERED
Radiology - PET/ PET CT (in select physician offices)	$225 copay per visit	NOT COVERED
Sleep Study	$125 copay	NOT COVERED
Surgery in office	NO COPAY	NOT COVERED
All other Physician office procedures	NO COPAY	NOT COVERED

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PREVENTIVE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Immunizations for Adults & Children	NO COPAY	NOT COVERED
Well Baby/Child Exams	NO COPAY	NOT COVERED
Well Woman Exams	NO COPAY	NOT COVERED
Wellness/Physical Exams	NO COPAY	NOT COVERED
Colonoscopy/Sigmoidoscopy	NO COPAY (AGES 50-74)	NOT COVERED
Screening Mammography	NO COPAY (FEMALE, AGE 35 & OLDER)	NOT COVERED
Dexascan	NO COPAY (FEMALE, AGE 60 & OLDER)	NOT COVERED
Nutritional Counseling	NO COPAY (26 ANNUAL VISITS)	NOT COVERED

PRESCRIPTION DRUGS	IN-NETWORK	OUT-OF-NETWORK
Culinary Pharmacy (select medications available)	NO COPAY	NOT COVERED
Tier 1 - Generic	$10 copay	NOT COVERED
Tier 2 - Formulary	$30 copay	NOT COVERED
Tier 3 - Non Formulary	$50 copay	NOT COVERED

OTHER	IN-NETWORK	OUT-OF-NETWORK
Ambulance	25% Coinsurance FOR Ground Ambulance $500 COPAY FOR Air Ambulance	
Compression Stockings	$22 copay per pair (3 PAIR PER YEAR)	NOT COVERED
Diabetic Shoes	$55 copay per pair (2 PAIR PER YEAR)	NOT COVERED
Diabetic Supplies	NO COPAY	NOT COVERED
DME & Medical Supplies	10% coinsurance	NOT COVERED
Glasses/Contact Lenses	$150 maximum benefit every 2 years	NOT COVERED
Hearing Aids	$300 maximum benefit every 5 years	
Home Health	NO COPAY (60 VISIT LIMIT)	NOT COVERED
Home Infusion Therapy	NO COPAY	NOT COVERED
Hospice - Inpatient and Outpatient	NO COPAY	NOT COVERED
Mastectomy Bra	$12 copay per item ($350 MAX PER YEAR)	NOT COVERED
Orthotic Shoe Inserts - Non Diabetic	$10 per pair copay (1 PAIR OR 2 INSERTS EVERY 5 YRS)	NOT COVERED

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Prosthetic & Orthotic Appliances	10% coinsurance	NOT COVERED

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