Culinary Health Fund™

CO-PAYMENT BOOK

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702-733-9938
www.culinaryhealthfund.org

Revised December 2016 (Replaces Co-Payment Book dated July 2016)

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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. (Includes medical and prescription copays/excludes dental copays)						
Preventive Services	Immunizations for adults (Age appropriate) & children (Birth to age 18)	$0	No coinsurance	100% of allowable charges	No maximum benefit	For a complete list of preventive services covered by the Affordable Care Act please visit **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/** You can also contact the Customer Service Office at **702-733-9938** if you have any questions.
	Well Baby/Child Exams (Birth to age 21)					
	Annual Physical Exams					
	Nutritional Counseling					
	Osteoporosis Screening (Women age 65 and older)					
	Mammography (Women age 35 and older)					
	Women's well check (Ages 21 to 64)					
	Colonoscopy & Sigmoidoscopy (Ages 50 to 74)					
Physician Office Services	Primary Doctor	$15	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	Specialist	$30				
	In-Patient Services	$0	No coinsurance	100% of allowable charges		
	Injection					
	IV Treatment					
	Pulmonary Treatment					
	Pulmonary Test					
	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/Ultrasound	$30	No coinsurance	100% of allowable charges after copay	No maximum benefit	Copay applies only in select physician offices.
	Radiology-PET/PET CT	$225 per visit				
	Radiology-CT/MRA/MRI	$125 per visit				

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Physician Office Services (continued)	Lab	$0	No coinsurance	100% of allowable charges	No maximum benefit	No other information.
	Ophthalmologist/ Optometrist (Vision Exam)	$20	No coinsurance	100% of allowable charges after copay	No maximum benefit	Lenses and frames are covered under the vision category.
	Chemotherapy	$0	No coinsurance	100% of allowable charges	No maximum benefit	Services need to be provided at Comprehensive Cancer Centers of Nevada.
	Radiation Therapy					
	Hearing & Speech Exam	$0	No coinsurance	100% of allowable charges	No maximum benefit	No other information.
	Allergy Testing					
	Allergy Immunotherapy					
	Surgery in the physician's office					
	Nerve conduction studies					
	Dialysis Management					
	All other physician office procedures					
	Sleep Study performed in a doctor's office	$125/ procedure	No coinsurance	100% of allowable charges after copay		

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Prescriptions	Culinary Pharmacy (Generic medications only)	$0	No coinsurance	100%	No maximum benefit	**Tip: you can save money by asking your doctor for a generic medication** Contact the Culinary 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 **OptumRx at 1-866-611-5960.**
	Tier 2 Formulary	$30				
	Tier 3 Non-Formulary	$50				
	Specialty Exception Prescriptions	$0	25% of allowable charges	75% of allowable charges	No maximum benefit	Prior Authorization (approval) is required. The benefit for Specialty Exception Prescriptions is effective 1/1/17.
	Mail Order	$10, $20, or $35	No coinsurance	100% after copay	No maximum benefit	With one copay, you can get a **60-day** supply.
Ambulatory Surgery Center	Surgery	$150	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.

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Therapy at an Outpatient Free Standing Facility (Not at a hospital)	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 after copay	30 visits **per** therapy	No other information.
	Applied Behavior Analysis (ABA) Therapy	$10 per day of treatment, regardless of the number of hours of treatment or the number of ABA therapy providers that see the eligible dependent during the day	No coinsurance	100% of allowable charges after copay	No maximum benefit	Benefit is available for eligible dependents who are at least 2 years old and younger than 6 years old, have a valid diagnosis of autism spectrum disorder (ASD) and have a prorated mental age (PMA) of at least 11 months. Prior authorization (approval) required. Services must be provided by a PPO provider. The ABA Therapy benefit is effective 1/1/17.
Free-Standing Facility Services (Not at a hospital)	Lab	$0	No coinsurance	100% of allowable charges	No maximum benefit	**Tip:** CPL is the only lab you can use.
	X-Ray/Ultrasound	$20	No coinsurance	100% of allowable charges after copay	No maximum benefit	**Tip:** Desert Radiologists is the only free-standing radiology facility you can use.
	CT Scan, MRI, MRA	$125				
	PET	$175				

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Free-Standing Facility Services (Not at a hospital) **(continued)**	Interventional Radiology Services (procedures done under anesthesia that are image-based)	$150	No coinsurance	100% of allowable charges after copay	No maximum benefit	**Tip:** Desert Radiologists is the only free-standing radiology facility you can use.
	Dialysis	$0	No coinsurance	100% of allowable charges	No maximum benefit	Some services require prior authorization (approval).
	Sleep Study	$125	No coinsurance	100% of allowable charges after copay		
	Cardiac/Pulmonary Rehabilitation	$30	No coinsurance	100% of allowable charges after copay	30 visits annual limit	
	Mammogram	$0	No coinsurance	100% of allowable charges	No maximum benefit	**Tip:** Desert Radiologists is the only free-standing radiology facility you can use.
	3D Mammogram	$75	No coinsurance	100% of allowable charges after copay		
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 Radiologists or CPL.**
	X-Ray/Ultrasound	$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 (procedures done under anesthesia that are image-based)	$250				
	Dialysis	$0	No coinsurance	100% of allowable charges	No maximum benefit	Some services require prior authorization (approval).
	Physical Therapy (after discharge from inpatient hospital admission)	$30	No coinsurance	100% of allowable charges after copay	30 visits annual limit	
	Occupational & Speech Therapy (after discharge from inpatient hospital admission)	$30	No coinsurance	100% of allowable charges after copay	30 visits annual limit	
	Cardio/Pulmonary Rehab (after discharge from inpatient hospital admission)	$40	No coinsurance	100% of allowable charges after copay	30 visits annual limit	

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Outpatient Services in a Hospital (continued)	Outpatient Surgery	$250	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval).
	Diabetes Ed.	$0	No coinsurance	100% of allowable charges		
	All other outpatient hospital services	$0	25%	75% of allowable charges		
Ambulance	Ground	$0	25%	75%	No maximum benefit	No other information.
	Air	$500 per person per incident	No coinsurance	100% after copay		
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 maximum benefit	**Tip:** Call the Customer Service Office at 702-733-9938 to **make sure your hospital is in our Network.**
	Obstetrics					
	Skilled Nursing Facility	$250	No coinsurance	100% of allowable charges after copay	60 day maximum	
	Inpatient Rehabilitation					
	23 hr observation	$250	No coinsurance	100% of allowable charges after copay	No maximum benefit	
	Surgery/Anesthesia	$0	No coinsurance	100% of allowable charges		

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Mental Health and Addictions	Outpatient Therapy	No copay for the first 5 visits **per** issue/$15 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				
	Residential Treatment					
	Partial Hospital Admission	$150				
	Intensive Outpatient Program					
Breast Care at a Free-Standing Facility*	Preventive (annual mammogram)	$0	No coinsurance	100% of allowable charges	No maximum benefit	Services must be performed at a PPO Provider only. **Tip:** Desert Radiologists is the only free-standing radiology facility you can use.
	Mammogram-Additional Views					
	Diagnostic Mammogram	$20	No coinsurance	100% of allowable charges after copay	No maximum benefit	
	Breast Ultrasound	$20				
	3D Mammogram	$75				
	Breast MRI	$125				
	Needle-guided breast biopsy under ultrasound	$20				
	*Needle-guided breast biopsy under ultrasound when performed in a physician's office	$30				
	Needle-guided breast biopsy under CT Scan	$125				
Other Services	Home Healthcare	$0	No coinsurance	100% of allowable charges	Maximum benefit of 60 days per calendar year	No other information
	Home Infusion Therapy	$0	No coinsurance	100% of allowable charges	No maximum benefit	

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Other Services (continued)	Hospice	$0	No coinsurance	100% of allowable charges	No maximum benefit	No other information
	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	$0	No coinsurance	100% of allowable charges	No maximum benefit	
	Hearing Aids	$0	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, PPO Podiatrist, PPO Orthopedic Physician or a PPO Orthotic Provider.
	Durable Medical Equipment & Medical Supplies	$0	10% of allowable charges	90% of allowable charges	No maximum benefit	Prior Authorization (approval) is required for items over $500.
	Enteral Nutrition	$0	10% of allowable charges for supplies, including but not limited to, pumps and tubing	90% of allowable charges for supplies, including but not limited to, pumps and tubing The Plan pays 100% for formula and medical food up to a maximum of $3,000 per calendar year	For formula and medical food, there is a maximum of $3,000 per calendar year	Prior Authorization (approval) is required
	Prosthetic & Orthotic Appliances	$0	10% of allowable charges	90% of allowable charges	No maximum benefit	Prior Authorization (approval) is required.
	Glasses & Contact Lenses	$0	No coinsurance	$150 every two years	$150 every two years	Your eye exam is covered under your Physician Office Services Benefit.
	Glasses following cataract surgery	$0	No coinsurance	$150	$150 per lifetime	**Tip:** If you have surgery on both eyes, wait until both surgeries are performed before using this benefit.

NOTES

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