Culinary Health Fund™

Your Culinary In-Network (PPO)

CO-PAYMENT BOOK

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Ang Libro ng Co-Payment (PPO)

Sa Samahan ng Culinary

Tagalog: pg. 9-16

Su Libro de Co-pagos

dentro de la Red de la Culinaria

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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 18 y/o)	$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 (Newborn through 21 y/o)					
	Annual Physical Exams					
	Nutritional Counseling					
	Osteoporosis Screening (Women 65 and older)					
	Mammography (Women 35 and older)					
	Women's well check (Women 21 to 64 y/o)					
	Colonoscopy & Sigmoidoscopy (Adults ages 50 through 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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Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
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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Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
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 **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 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.
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	$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 radiology office 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	$150	No coinsurance	100% of allowable charges after copay	No maximum benefit	**Tip:** Desert Radiologists is the only radiology office 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	
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.	$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 **per** event	
	Occupational & Speech Therapy (after discharge from inpatient hospital admission)	$30	No coinsurance	100% of allowable charges after copay	maximum of 30 visits **per** therapy type	
	Cardio/Pulmonary Rehab (after discharge from inpatient hospital admission)	$40	No coinsurance	100% of allowable charges after copay	30 visits annual limit	
	Outpatient Surgery	$250	No coinsurance	100% of allowable charges after copay	No maximum benefit	
	Diabetes Ed.	$0	No coinsurance	100% of allowable charges		
	All other outpatient hospital services	$0	25%	75% of allowable charges		

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Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
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/Anestheisia	$0	No coinsurance	100% of allowable charges		
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					

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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	NONE, except in the case of nutritional therapy. Nutritional therapy is limited to a maximum benefit of 60 days per calendar year	
	Hospice	$0	No coinsurance	100% of allowable charges	No maximum benefit	
	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.
	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.

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