COPAYMENT BOOK

Culinary Health Fund™

Revised July 2023 (Replaces Copayment Book dated April 2022)

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This booklet shows the copayments for **in-network benefits.**

The information in this Copay Book is based on the Plan Document. However, in the event of a conflict between the Copay Book and the Plan Document, **the Plan Document will govern.**

Your Out-of-Pocket Maximum

The maximum yearly amount you have to pay out of your pocket for your copays and coinsurance is **$6,350** per person or **$12,700** per family. (This includes in-network medical copays/coinsurance and prescription copays/excludes dental copays).

Preventive Services

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Immunizations for adults (Age appropriate) & children (Birth to 18 yrs. old)	$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 **https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** You can also contact the Customer Service Office at **702-733-9938** if you have any questions.
Well Baby/Child Exams (Newborn through 21 yrs. old)					
Annual Physical Exams					
Nutritional Counseling					
Osteoporosis Screening (Women age 60 and older)					
Mammography (Women age 35 and older)					
Women's well check					
Colonoscopy & Sigmoidoscopy (Adult ages 45 to age 75)					
Preventive Prescriptions as recommended by the USPSTF					

Culinary Health Centers

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Primary Doctor	$0	No coinsurance	100% of allowable charges after copay	No maximum benefit	Culinary Health Center locations: **Culinary Health Center - Nellis** 650 North Nellis Blvd. Las Vegas, NV 89110 702-790-8000 **Culinary Health Center - Durango** 6350 S. Durango Dr. Las Vegas, NV 89113 702-790-8000
Pediatrician					
Culinary Pharmacy					
Mental Health Counseling					
Chiropractic Care					
Acupuncture					
Physical Therapy					
Dental Care	Same copays as a dentist in the network. Refer to Dental Book for more info.				
Eye Care	$20 copay for eye exams				

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

In-Network Doctor Office Services (Part 1 of 2)

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
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	$15	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	No other information.
X-Ray/Ultrasound	$30	No coinsurance	100% of allowable charges after copay	No maximum benefit	Copay applies only in select doctors' offices. Some services require prior authorization.
Radiology-PET/PET CT	$225 per visit				
Radiology-CT/MRA/MRI	$125 per visit				
Lab	$0	No coinsurance	100% of allowable charges	No maximum benefit	Some services require prior authorization.
Ophthalmologist	$20	No coinsurance	100% of allowable charges after copay	No maximum benefit	Lenses and frames are covered under the vision benefits.
Chemotherapy	$0	No coinsurance	100% of allowable charges	No maximum benefit	Services need to be provided at Comprehensive Cancer Centers of Nevada.
Radiation Therapy					

In-Network Doctor Office Services (Part 2 of 2)

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Hearing & Speech Exam	$0	No coinsurance	100% of allowable charges	No maximum benefit	No other information.
Allergy Testing					
Allergy Immunotherapy					
Surgery in the doctor's office					
Nerve conduction studies					
Dialysis Management					
All other doctor office procedures					
Sleep Study performed in a doctor's office	$125/ procedure	No coinsurance	100% of allowable charges after copay		
Acupuncture performed in a doctor's office	$15 per visit	No coinsurance	100% of allowable charges after copay	Limited to 12 visits per calendar year; for pain management of certain conditions	For a list of conditions and PPO providers, please call Customer Service at **702-733-9938**.

Prescriptions

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Culinary Pharmacy (Generic medications only)	$0	No coinsurance	100%	No maximum benefit	Contact the Culinary Pharmacy at the following locations: **Culinary Health Fund - St. Louis Square** **702-650-4417** 1945 S. Las Vegas Blvd. Las Vegas, NV 89104 **Culinary Health Center - Nellis** **702-963-9400** 650 North Nellis Blvd. Las Vegas, NV 89110 **Culinary Health Center - Durango** **725-223-2100** 6350 S. Durango Dr. Las Vegas, NV 89113 **Tip:** You can save money by asking your doctor for a generic medication.
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.** **Quantity limits, prior authorization requirements and other cost-containment programs may apply.**
Tier 2 Formulary	$20				
Tier 3 Non-Formulary	$35				
Specialty Drugs	$0	25% of allowable charges	75% of allowable charges	No maximum benefit	Prior authorization is required.
Mail Order	$10, $20, or $35	No coinsurance	100% after copay	No maximum benefit	With one copay, you can get a **60-day** supply. To sign up, please call OptumRx Home Delivery at **866-611-5960** or visit **culinaryhealthfund.org/prescriptions-by-mail/**.

Therapy at an Outpatient Free-Standing Facility (Not at a hospital)

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
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 doctor.
Occupational and Speech Therapy (age 18 or older)	$20	No coinsurance	100% of allowable charges after copay	Annual limit of 30 visits per therapy type	No other information.
Occupational and Speech Therapy (under age 18)	$10	No coinsurance	100% of allowable charges after copay	Annual limit of 80 visits per therapy type	
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	Not to exceed 30 hours of ABA Therapy per week	Benefit is available for eligible dependents who are at least 2 years old and younger than 21 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 required. Services must be provided by a PPO provider.

Free-Standing Facility Services (Not at a hospital)

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Lab	$0	No coinsurance	100% of allowable charges	No maximum benefit	Some services require prior authorization. **Tip:** CPL is the only lab you can use.
X-Ray/Ultrasound	$20	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization. **Tip:** Steinberg Diagnostic Medical Imaging, SimonMed Imaging, and Pueblo Medical Imaging are the only free-standing radiology facilities you can use.
CT Scan, MRI, MRA	$125				
PET	$175				
Interventional Radiology Services (procedures done under anesthesia that are image-based)	$150				
Dialysis	$0	No coinsurance	100% of allowable charges	No maximum benefit	Some services require prior authorization.
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 each year	
Preventive Mammogram	$0	No coinsurance	100% of allowable charges	No maximum benefit	**Tip:** Steinberg Diagnostic Medical Imaging, SimonMed Imaging, and Pueblo Medical Imaging are the only free-standing radiology facilities you can use.
Diagnostic Colonoscopy (for eligible persons until age 75)	$0	No coinsurance	100% of allowable charges	No maximum benefit	No other information.

Outpatient Services in a Hospital

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
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. **Tip:** If your doctor refers you to a hospital to have these tests, ask your doctor to send you to Steinberg Diagnostic Medical Imaging, SimonMed Imaging, Pueblo Medical Imaging, or CPL.
X-Ray/Ultrasound	$45				
MRI, MRA, CAT 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	No other information.
Physical Therapy (after discharge from inpatient hospital admission)	$30	No coinsurance	100% of allowable charges after copay	30 visits per therapy type each year	
Occupational & Speech Therapy (after discharge from inpatient hospital admission)					
Cardio/Pulmonary Rehab (after discharge from inpatient hospital admission)	$40	No coinsurance	100% of allowable charges after copay	30 visits each year	Some services require prior authorization.
Outpatient Surgery	$250	No coinsurance	100% of allowable charges after copay	No maximum benefit	
Diabetes Education	$0	No coinsurance	100% of allowable charges		
Sleep Study	$0	25% of allowable charges	75% of allowable charges		
All other outpatient hospital services	$0	25% of allowable charges (Not to exceed $250 per day)			

Emergency Room vs. Urgent Care

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Emergency Room in a PPO hospital	$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.
Emergency Room in a Non-PPO hospital in the Las Vegas geographic area	For an Emergency - $350 per visit	No coinsurance	100% of the Fund's median contracted rates for PPO hospitals in the Las Vegas geographic area	No maximum benefit	No coverage for non-emergency care in a Non-PPO emergency room in the Las Vegas geographic area.
Emergency Room in a Non-PPO hospital outside of the Las Vegas geographic area	$350 per visit	No coinsurance	100% of the Fund's median contracted rates for PPO hospitals in the Las Vegas geographic area	No maximum benefit	No other information.
Urgent Care	$40 per visit	No coinsurance	100% of allowable charges after copay	No maximum benefit	Copay includes all covered services related to the visit. No coverage for services at Non-PPO Urgent Care in the Las Vegas geographic area.

Ambulance

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Ground	$0	25%	75%	No maximum benefit	No other information.
Air	$500 per person per incident	No coinsurance	100% after copay		

Ambulatory Surgery Center

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Surgery	$150	No coinsurance	100% of allowable charges after copay	No maximum benefit	Prior authorization is required.

In-Network Hospital (in-patient)

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Inpatient Stay	$250	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization. **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 days/cal. yr.	
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		

Breast Care at a Free-Standing Facility

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Preventive (annual mammogram)	$0	No coinsurance	100% of allowable charges	No maximum benefit	**Tip:** Steinberg Diagnostic Medical Imaging, SimonMed Imaging, and Pueblo Medical Imaging are the only free-standing radiology facilities you can use.
Mammogram-Additional Views					
Diagnostic Mammogram	$20	No coinsurance	100% of allowable charges after copay	No maximum benefit	
Breast Ultrasound	$20				
Breast MRI	$125				
Needle-guided breast biopsy under ultrasound	$20				
Needle-guided breast biopsy under ultrasound when performed in a doctor's office	$30				
Needle-guided breast biopsy under CT Scan	$125				

Mental Health and Addictions

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
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 require prior authorization. Call Harmony Healthcare at **702-251-8000** or Human Behavior Institute (HBI) at **702-248-8866** for additional information.
Inpatient	$250 per admission				
Residential Treatment					
Partial Hospital Admission	$150 per treatment plan				
Intensive Outpatient Program	$0				

Other Services (Part 1 of 2)

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Home Health Care	$0	No coinsurance	100% of allowable charges	Maximum benefit of 60 days per calendar year	Prior authorization is required.
Home Infusion Therapy	$0	No coinsurance	100% of allowable charges	No maximum benefit	
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	$2,000 per lifetime	$2,000 per lifetime	Hearing aid benefit is not per ear.
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.
Orthotic Shoe Inserts	$10 per pair	No coinsurance	100% of allowable charges after copay	1 pair or 2 inserts every 3 years	They must be prescribed by a PPO doctor, PPO podiatrist, PPO orthopedic doctor or a PPO orthotic provider. You can get changes to your shoe inserts (called orthotic refurbishments) with no copay. You can do this anytime during the 3-year benefit period.
Durable Medical Equipment & Medical Supplies	$0	10% of allowable charges	90% of allowable charges	No maximum benefit	Prior authorization is required for items over $500.

Other Services (Part 2 of 2)

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
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	No maximum benefit	Prior authorization is required.
Prosthetic & Orthotic Appliances	$0	10% of allowable charges	90% of allowable charges		
Glasses following cataract surgery	$0	No coinsurance	$300 per lifetime	$300 per lifetime	**Tip:** If you have surgery on both eyes, wait until both surgeries are performed before using this benefit.

Vision Benefits
EyeMed

Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Vision Exam	$20	No coinsurance	100% after copay	Adult - every calendar year Children under 19 - twice every calendar year	No other information.
Frames	$0	No coinsurance	Up to $300 allowance (20% off balance over $300) **PLUS Provider** up to $350 allowance (20% off balance over $350)	Every two calendar years	
Lenses (instead of contacts)	$25 for single vision, bifocal, trifocal, and lenticular lenses	No coinsurance	100% after copay	Every calendar year	$80 - $200 copay for progressive lenses.
Elective Contact Lenses (instead of glasses)	$0	No coinsurance	Up to $300 allowance (15% off balance over $300; does not apply to disposable contacts)	Every calendar year	Up to $40 for standard contact lenses. 10% of retail price for premium contact lenses. Contact lens fit and two follow-up visits available, after eye exam is completed.

Culinary Health Fund™

1901 Las Vegas Blvd. South, Suite 107
Las Vegas, NV 89104
702-733-9938
www.culinaryhealthfund.org

@CulinaryHealthFund