



OMAHA FIREFIGHTERS HEALTHCARE TRUST
COST PLUS PLAN ONE
Effective January 1, 2023
Group #870941

PLEASE CONTACT GROUP & PENSION ADMINISTRATORS OR THE PPO NETWORK AT THE PHONE NUMBER OR WEBSITE SHOWN ON YOUR PLAN I.D. CARD FOR INFORMATION ABOUT WHICH PROVIDERS ARE INCLUDED.

DEDUCTIBLE AND ANNUAL OUT-OF-POCKET MAXIMUM	FACILITY 1) PPO PHYSICIANS AND NON-PPO PHYSICIANS 2), 3), 4)	
COST PLUS PLAN – PLAN 1 Major Medical – Prescriptions with deductible	***Tier I – CHI Health Partners Providers & CHI Facilities, Children’s Physicians Networks, See The Trainer, Aerocare - CPAP Vendor	Tier II –Non CHI Health Partners Providers & Non-Contracted Facilities
Calendar Year Deductible		
- Per Individual	\$500	\$1,000
- Family Limit	\$1,000	\$2,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible, all Co-pays and Rx)		
- Per Individual	\$1,200	\$1,700
- Family Limit	\$2,200	\$3,200

LEVEL I FACILITY BENEFITS – Payment Levels:

This section applies to covered expenses for services rendered by Hospitals and other types of facilities which are not included in the **Preferred Provider Organization (PPO) network**.

BENEFIT PERCENTAGE FOR:	FACILITY BENEFIT 1)		MAXIMUM BENEFITS, LIMITS & PROVISIONS
	Tier I	Tier II	
Inpatient Hospital Services	90% after Deductible	70% after Deductible	UR Notification required, \$500 non-compliance penalty for failure to Notify.
Maternity Inpatient Hospital Services	90% after Deductible	70% after Deductible	Contact UR Company for coordination of care.
Routine Newborn Care Inpatient Hospital Services	90% after Deductible	70% after Deductible	
Rehabilitation Facility	90% after Deductible	70% after Deductible	UR Notification required.
Skilled Nursing Facility	90% after Deductible	70% after Deductible	UR Notification required.
Hospital Services for Mental/ Nervous Disorders, Chemical Dependency, Drug and Substance Abuse Inpatient/Residential Treatment Facilities	90% after Deductible	70% after Deductible	UR Notification required.
Hospital Emergency Room	90% after deductible	90% after Deductible	
Outpatient Surgical Facility	90% after Deductible	70% after Deductible	
Outpatient Therapy/Other Services Physical & Speech Therapy Occupational Therapy Pulmonary Therapy Cardiac Rehabilitation Therapy Chemotherapy, Dialysis, Radiation Therapy	90% after Deductible 90% after Deductible 90% after Deductible 90% after Deductible 90% after Deductible	70% after Deductible 70% after Deductible 70% after Deductible 70% after Deductible 70% after Deductible	CYM 60 visits CYM 36 visits CYM 18 visits UR Notification required
Outpatient Diagnostic Services Select Diagnostic Procedures (CT Scans, MRIs, PET Scans, etc.)	90% after Deductible	70% after Deductible	UR Notification required.
All Other Diagnostic Lab and X-ray	90% after Deductible	70% after Deductible	UR Notification required for MRI, MRA, CT and PET
Preventive and Wellness Lab and X-ray	100%; Deductible waived	100%; Deductible waived	



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LEVEL I PROVIDER BENEFITS – Payment Levels and Limits:

This section applies to Providers of services defined below. Benefits shown are available **based upon the Provider's participation in the Provider Group.**

BENEFIT PERCENTAGE FOR:	LEVEL I BENEFIT		MAXIMUM BENEFITS, LIMITS & PROVISIONS
	Tier I	Tier II	
We Care Providers – Initial Visit	100% Deductible Waived	Non-We Care Providers	Benefits limited to Firefighters – Active and Retirees Only
We Care Providers – Subsequent Visits	90% after Deductible	70% after Deductible	
We Care Providers – Initial Visit	90% after Deductible	Non-We Care Providers	Benefits for participating spouses and child(ren)
We Care Providers – Subsequent Visits	90% after Deductible	70% after Deductible	

LEVEL II PHYSICIAN BENEFITS – Payment Levels and Limits:

This section applies to Physicians and all other Providers of service not included as Facility Providers or Select Provider Group. Benefits shown are available **based upon the Provider's participation in the PPO network.**

BENEFIT PERCENTAGE FOR:	LEVEL II BENEFIT 2), 3), 4)		MAXIMUM BENEFITS, LIMITS & PROVISIONS
	Tier I	Tier II	
Physician Hospital Visits/Surgeon/Anesthesia	90% after Deductible	70% after Deductible	
Physician Hospital Visit for Mental & Nervous Disorders/Chemical Dependency, Drug and Substance Abuse	90% after Deductible	70% after Deductible	
Maternity (Including Prenatal delivery and Postnatal care) Lab and X-Ray Benefit Applies	90% after Deductible	70% after Deductible	Contact UR Company for coordination of care.
Routine Newborn Care (Pediatric care to date of mother's discharge.)	90% after Deductible	70% after Deductible	
Office Visit (includes Exam, Treatment, X-ray includes select diagnostic medical procedures, Allergy Injections, Testing & Serum, Office Surgery)	90% after Deductible	70% after Deductible	
TMJ Services	90% after Deductible	70% after Deductible	Limited to \$2,500 per Lifetime
Mental/Nervous Disorders and Substance Abuse Office Visits	90% after Deductible	70% after Deductible	
Urgent Care Facility	90% after Deductible	70% after Deductible	
Infertility Services (Includes Diagnostic Testing and Treatment)	90% after Deductible	70% after Deductible	
Select Diagnostic Medical Procedures CT Scans, MRIs, PET Scans, etc.(Physician's Office or Freestanding Facility)	90% after Deductible	70% after Deductible	UR Notification required.
Diagnostic Lab/X-ray (Freestanding Facility, Independent Lab or Physician's Office)	90% after Deductible	70% after Deductible	
KIS Imaging Radiological Benefit (CT scans, PET scans, MRIs)	100% of KIS Imaging negotiated rate Deductible waived	100% of KIS Imaging negotiated rate Deductible waived	Call 888-458-8746 to schedule appointment <i>No UR Notification Required.</i>
Outpatient Therapy/Other Services Physical & Speech Therapy Occupational Therapy *Chiropractic and Acupuncture Pulmonary Therapy Cardiac Rehabilitation Therapy Chemotherapy, Dialysis, Radiation Therapy	90% after Deductible 90% after Deductible 90% after Deductible 90% after Deductible 90% after Deductible 90% after Deductible	70% after Deductible 70% after Deductible 70% after Deductible 70% after Deductible 70% after Deductible 70% after Deductible	CYM 60 visits CYM 30 Visits CYM 36 visits CYM 18 visits UR Notification required



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Vision Correction Surgery	90% after Deductible	70% after Deductible	Benefits for employee only
Home Health Services	90% after Deductible	70% after Deductible	Contact UR Company for coordination of care. CYM 60 visits
Hospice (Inpatient Hospice and Home Hospice)	90% after Deductible	70% after Deductible	UR Notification required for Inpatient Hospice. 180 day limit.
Durable Medical Equipment	90% after Deductible	70% after Deductible	UR Notification Required
Prosthetic Devices and Orthotics	90% after Deductible	70% after Deductible	UR Notification Required
Ambulance Services	90% after Deductible	90% after Deductible	Non-Emergency use N/C
All Other Provider Covered Physician Services	90% after Deductible	70% after Deductible	



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Preventive and Wellness Care Benefits

This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed illness or Injury. Services must be identified and billed as routine or part of a routine physical exam/or as specified below.

BENEFIT PERCENTAGE FOR:	LEVEL II BENEFIT 2), 3), 4)		LIMITS & PROVISIONS
	Tier I	Tier II	
All Covered Wellness Benefits	100%; Deductible waived		See age and frequency limits and other special provisions below
Examples of Covered Wellness Procedures to include but are not limited to: <ol style="list-style-type: none"> 1) Routine Physical Exam 2) Annual Well Woman Exam 3) *Annual Pap smear and other routine lab 4) *Annual Routine Mammogram 5) *Bone Density test 6) Annual PSA test 7) Well Baby Care Exam/Well Child Care Exam 8) Hearing Screenings for newborns 9) Routine Immunizations 10) Flu vaccine/pneumonia vaccine 11) *Routine lab, x-ray, diagnostic testing and other medical screenings 12) Smoking/Tobacco Use Cessation 13) *All FDA-approved Women's Contraceptive methods/Sterilization procedures 14) *Routine Colonoscopy (includes polyp removal) 			

* If these services are rendered by providers billing as a Facility, please refer to the appropriate category under Level 1 for the benefit.

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Routine Vision (Includes Refraction)	CHI Health Partners, PHCS, MultiPlan Providers Covered 100%, Deductible Waived	Any Other Provider Not Covered
*Chiropractic Services	PHCS or Multiplan Providers Covered under Tier 1	Any Other Provider Covered under Tier 2



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PRESCRIPTION DRUGS *	Network	Out of Network
Retail: Pass through; Member Pays 100% at the Pharmacy (30 Day Supply) Mail Order Excluded	10% after Deductible	30% after PPO Deductible
Note: Specialty Drugs are limited to two (2) refills at Retail. For additional fills, Keenan Specialty must be used.		
Medication required as part of preventive care services (detailed information is available at www.healthcare.gov) are covered at 100% with no copayment or deductible.		
Oral Chemotherapy Drugs with IV Equivalents	Deductible waived-\$0 Coinsurance	30% Coinsurance PPO Deductible Applies

**Specialty Drugs must be obtained through the Prescription Drug Plan's Specialty Pharmacy. However, two (2) retail fills will be allowed before filling will be required at the Specialty Pharmacy.

***Tier I: CHI Health Partners Providers/CHI Facilities/Children's Physician Network/See The Trainer/Americare

-Contracted Facilities- CHI Hospitals, The Urology Center and Omaha Surgical Center