OMAHA FIREFIGHTERS HEALTHCARE TRUST
COST PLUS PLAN TWO
Effective January 1, 2024
Group #870941

PLEASE CONTACT IMAGINE360 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 **COST PLUS PLAN – PLAN** 2 RX Card with co-pay	**FACILITY, CHI, PHCS and Multiplan Providers, Americare**	**Non-PPO Providers**
Calendar Year Deductible - Per Individual - Family Limit	$500 $1,000	$1,000 $2,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible and Co-pays. Excludes Rx) - Per Individual - Family Limit	$1,200 $2,200	$1,700 $3,200

LEVEL I FACILITY BENEFITS – Payment Levels:

This section applies to covered expenses for services rendered by Hospitals and other types of facilities.

BENEFIT PERCENTAGE FOR:	MAXIMUM BENEFITS, LIMITS & PROVISIONS	
Inpatient Hospital Services	90% after Deductible	UR Notification required, $500 non-compliance penalty for failure to Notify.
Maternity and Routine Newborn Care Inpatient Hospital Services	90% after Deductible	Contact UR Company for coordination of care.
Rehabilitation Facility and Skilled Nursing Facility	90% after Deductible	UR Notification required.
Hospital Services for Mental/ Nervous Disorders, Chemical Dependency, Drug and Substance Abuse Inpatient/Residential Treatment Facilities	90% after Deductible	UR Notification required.
Hospital Emergency Room	90% after deductible	
Outpatient Surgical Facility	90% 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	 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	UR Notification required.
All Other Diagnostic Lab and X-ray	90% after Deductible	UR Notification required for MRI, MRA, CT and PET
Preventive and Wellness Lab and X-ray	100%; Deductible waived	

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LEVEL II 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.**

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:	CHI, PHCS and MultiPlan Providers	Non-PHCS Providers	LIMITS & PROVISIONS
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*** *No UR Notification Required.*
Outpatient Therapy/Other Services			
Physical & Speech Therapy	90% after Deductible	70% after Deductible	CYM 60 visits
Occupational Therapy	90% after Deductible	70% after Deductible	CYM 36 Visits
Pulmonary Therapy	90% after Deductible	70% after Deductible	CYM 18 visits
Cardiac Rehabilitation Therapy	90% after Deductible	70% after Deductible	UR Notification required
Chemotherapy, Dialysis, Radiation Therapy	90% after Deductible	70% after Deductible	CYM 36 Visits
Chiropractic, Acupuncture, Massage			
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

BENEFIT PERCENTAGE FOR:	LEVEL II BENEFIT		LIMITS & PROVISIONS
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	
We Care Providers – Initial Visit **We Care Providers – Subsequent Visits**	100% Deductible Waived 90% after Deductible	Benefits limited to Firefighters – Active and Retirees Only Refer to We Care provider list at www.ofht.org	
We Care Providers – Initial Visit **We Care Providers – Subsequent Visits**	90% after Deductible 90% after Deductible	Benefits for participating spouses and child(ren) Refer to We Care provider list at www.ofht.org	

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	LIMITS & PROVISIONS
All Covered Wellness Benefits	100%; Deductible waived	

Examples of Covered Wellness Procedures to include but are not limited to:

1) Routine Physical Exam
2) Annual Well WomanExam
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.

Routine Vision (Includes Refraction)	CHI Health Partners, PHCS, MultiPlan Providers Covered 100%, Deductible Waived	Non-PHCS Providers Not Covered

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

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PRESCRIPTION DRUGS *	Network	Out of Network
Retail Non Maintenance (30 day supply)	Generic: $5 Copay Formulary Brand: $15 Copay Non-Formulary Brand: $30 Copay	Generic: $5 Copay Formulary Brand: $15 Copay Non-Formulary Brand: $30 Copay
Retail Maintenance (90 day supply required)	Generic: $10 Copay Formulary: $30 Copay Non-Formulary Brand: $60 Copay	Generic: $10 Copay Formulary: $30 Copay Non-Formulary Brand: $60 Copay
Mail Order (90 day supply required)	Generic: $10 Copay Formulary: $30 Copay Non-Formulary Brand: $60 Copay	Generic: $10 Copay Formulary: $30 Copay Non-Formulary Brand: $60 Copay
Specialty Drugs (30 day supply)**	Generic: $5 Copay Formulary Brand: $15 Copay Non-Formulary Brand: $30 Copay	Generic: $5 Copay Formulary Brand: $15 Copay Non-Formulary Brand: $30 Copay
Oral Chemotherapy Drugs with IV Equivalents	Deductible waived-$0 Coinsurance	30% Coinsurance Deductible Applies

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