# OMAHA FIREFIGHTERS HEALTHCARETRUST
## COST PLUS PLAN TWO
**Effective January 1, 2026**
**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<br>**COST PLUS PLAN – PLAN 2**<br>RX Card with co-pay | **FACILITY, CHI, PHCS and Multiplan Providers, Americare** | **Non-PPO Providers** |
|---|---|---|
| **Calendar Year Deductible**<br>- Per Individual<br>- Family Limit | $500<br>$1,000 | $1,000<br>$2,000 |
| **Calendar Year Out-of-Pocket Maximum**<br>(Includes Deductible and Co-pays. Excludes Rx)<br>- Per Individual<br>- Family Limit | $1,200<br>$2,200 | $1,700<br>$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,<br>$500 non-compliance<br>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**<br>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**<br>Physical& Speech Therapy<br>Occupational Therapy<br>Pulmonary Therapy<br>Cardiac Rehabilitation Therapy Chemotherapy, Dialysis, Radiation Therapy | <br>90% after Deductible<br>90% after Deductible<br>90% after Deductible<br>90% after Deductible<br>90% after Deductible | <br><br>CYM 60 visits<br>CYM 36 visits<br>CYM 18 visits<br>UR Notification required |
| **Outpatient Diagnostic Services**<br>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%;<br>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 30 Visits |
| Chiropractic, Acupuncture, Massage | 90% after Deductible | 70% after Deductible | |
| **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**<br>**We Care Providers – Subsequent Visits** | 100% Deductible Waived<br>90% after Deductible | Benefits limited to<br>Firefighters – Active and Retirees Only<br>Refer to We Care provider list at www.ofht.org | |
| **We Care Providers – Initial Visit**<br>**We Care Providers – Subsequent Visits** | 90% after Deductible<br>90% after Deductible | Benefits for participating spouses and child(ren)<br>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 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.

| | | |
|---|---|---|
| **Routine Vision** (Includes Refraction) | CHI Health Partners, PHCS, Multiplan Providers<br><br>Covered 100%, Deductible Waived | Non Network Providers<br><br>Not Covered |

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

| PRESCRIPTION DRUGS | Network | Out of Network |
|---|---|---|
| Retail Non Maintenance (30 day supply) | Generic: $5 Copay<br>Formulary Brand: $15Copay<br>Non-Formulary Brand: $30 Copay | Generic: $5 Copay<br>Formulary Brand: $15Copay<br>Non-Formulary Brand: $30 Copay |
| *Retail Maintenance (90 day supply required) | Generic: $10 Copay<br>Formulary: $30 Copay<br>Non-Formulary Brand: $60 Copay | Generic: $10 Copay<br>Formulary: $30 Copay<br>Non-Formulary Brand: $60 Copay |
| Mail Order (90 day supply required) at Amazon Pharmacy 855-206-3605<br>Website: amazon.com/ServeYouRx<br><br>Or<br><br>Rx Valet if medication qualifies.<br>855-798-2530 or dmp@myrxvalet.com | Generic: $10 Copay<br>Formulary: $30 Copay<br>Non-Formulary Brand: $60 Copay<br><br>$0 copay | Generic: $10 Copay<br>Formulary: $30 Copay<br>Non-Formulary Brand: $60 Copay<br><br>N/A |
| **Specialty Drugs (30 day supply)<br><br>Oral Chemotherapy Drugs with IV Equivalents | Generic: $5 Copay<br>Formulary: $15 Copay<br>Non-Formulary Brand: $30 Copay<br><br>Deductible waived-$0 Coinsurance | Generic: $5 Copay<br>Formulary: $15 Copay<br>Non-Formulary Brand: $30 Copay<br><br>30% Coinsurance Deductible Applies |

**Specialty Drug must be obtained through Bolero Specialty Pharmacy 877-220-8181. Fax 708-967-7343. Bolero-Serveyourx.com. However, two (2) retails fills will be allowed at retail before filling will be required at Bolero Specialty Pharmacy.

**After the Prescription Copayments and/or Coinsurance have reached an Out-of-Pocket Maximum of $5,600 for an individual or $11,200 for a Family, your plan pays 100% of covered prescription drugs for the remainder of the benefit year.**