OMAHA FIREFIGHTERS HEALTHCARE TRUST

COST PLUS PLAN

Effective January 1, 2019
Group #H870941

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 2 RX Card with co-pay	***Tier I – CHI Health Partners Providers & CHI Facilities	Tier II – Non CHI Health Partners Providers & Non-Contracted Facilities
Calendar Year Deductible - Per Individual - Family Limit	 $500 $1,000	 $1,000 $2,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible and all 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 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	70% 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 II PHYSICIAN BENEFITS – Payment Levels and Limits:

This section applies to Physicians and all other Providers of service not included as Facility Providers. 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	
One Call Care Radiological Benefit (CT scans, PET scans, MRIs)	100% of One Call Care negotiated rate Deductible waived	100% of One Call Care negotiated rate Deductible waived	***Call 888-458-8746 to schedule appointment*** *No UR Notification Required.*
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
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:

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) – age 50 and older or family history of colon cancer

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

Routine Vision (Includes Refraction)	CHI Health Partners, PHCS, MultiPlan Providers Covered 100%, Deductible Waived	Any Other Provider Not Covered

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PRESCRIPTION DRUGS *	Network	Out of Network
Retail (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
Mail Order (90 day supply)	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

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

NOTE: This Summary of Benefits only represents an overview of your medical benefits and are subject to change.

****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

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