Kelsey-Seybold
GREATER HOUSTON PLAN | Cigna

2021 Plan Year: Benefits at a Glance

Kelsey-Seybold Greater Houston Plan

Medical

Description	Benefit	Limitations and exceptions
Covered Services: In order for benefits to be payable, all non-emergency and non-urgent care must be performed by or coordinated through Kelsey-Seybold.		
Annual Medical Deductible (calendar year)	**$150** person/**$300** family Does not apply to services requiring a copayment (preventive care, routine office visit, emergency room, urgent care facility or prescription drugs.) Copayments do not count toward the deductible.	After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. And, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.
Annual Medical Out-of-Pocket Maximum (calendar year)	**$2,000** person/**$4,000** family A separate out-of-pocket maximum will apply to prescription drugs.	After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses. Covered expenses that count towards the out-of-pocket maximum include the plan deductible, member paid coinsurance, and copayments.

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Cancer Coverage

Cancer Prevention, Diagnosis, and Treatment

100% coverage applies to services delivered at the **Kelsey-Seybold Cancer Center** and **The University of Texas MD Anderson Cancer Center** through the Shell Centers of Excellence program for cancer care, MD Anderson Cancer Center Direct™. With both programs, you must enroll in the provider cancer center program before you receive 100% coverage for cancer prevention, diagnosis, and treatment.

In order to receive cancer benefits at 100% coverage, you must enroll by calling the Kelsey-Seybold Concierge at **1-844-729-1219**.

100% Coverage.
Enrollment required to receive 100% coverage.

Covered Benefits: Cancer benefits apply to services delivered, authorized, and approved by Kelsey-Seybold Clinic and by The University of Texas MD Anderson Cancer Center through the Shell Center of Excellence program for cancer care, MD Anderson Cancer Center Direct™. This includes physician and provider care, diagnostic services, preventive care, outpatient and inpatient treatment, cancer care including hospitalization in acute care facilities, skilled nursing and inpatient hospice facilities, post treatment, supportive medicine, and reconstructive surgery.

Exclusions: These services are not included in the enhanced cancer coverage benefit.

1. Ambulance
2. Clinical trials approved by treating physicians (partial to full coverage based on case review)
3. Durable Medical Equipment (DME), including wheelchairs, walkers, etc.
4. Emergency room care
5. Genetic testing for breast, ovarian, and prostate cancer
6. Home healthcare
7. Hospice care at home
8. Nutrition consultation
9. Ostomy supplies
10. Prosthetic devices, including mastectomy brassieres
11. Supplies needed for feeding with formulas
12. Urgent care visits related to cancer diagnosis
13. Wigs
14. Treatment for pre-existing conditions not related to cancer
15. Feeding and nutritional supplements other than those provided during an in-patient stay

NOTE: Prescription drugs are covered separately through the prescription drug benefit program, and all applicable copays and deductibles apply.

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Physician Services Office Visits		
Preventive Care	You pay **$0**	Includes screening and diagnostic colonoscopy
Primary Care Physician (PCP) and OB/GYN	You pay a **$25** copayment/visit	Includes services performed in the office such as routine lab/X-ray and surgeries
Specialist	You pay a **$40** copayment/visit	
Allergy Injections	You pay **$25** PCP or **$40** Specialist copayment or actual charge (if less)	
Allergy Serum	You pay **$0**	
Video Visit – Primary Care Video Visit – Specialist	You pay a **$25** copayment You pay a **$40** copayment	
Outpatient Facility Services		
Physician/Surgeon/Professional Services	You pay **$0**	Includes Radiology, Pathology, and Anesthesiology
Facility Charges (operating room and related charges, etc.)	You pay **15%** coinsurance after the annual deductible	
Routine Lab & X-ray	You pay **$0**	
Advanced Radiology Imaging	You pay a **$150** copayment per scan	Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.
Short Term Rehab	You pay a **$40** copayment/visit	Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, Cardiac Rehabilitation and Chiropractic Care
Inpatient Facility Services		
Physician/Surgeon/Professional Services	You pay **$0**	Includes Radiology, Pathology, and Anesthesiology
Facility Charges (room & board, operating room and related charges, etc.)	You pay **15%** coinsurance after the annual deductible	Includes Rehabilitation Facility charges
Routine Lab & X-ray	You pay **15%** coinsurance after the annual deductible	
Advanced Radiology Imaging	You pay **15%** coinsurance after the annual deductible	Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.

Hospice/Bereavement Counseling – Facility Charge	You pay **15%** coinsurance after the annual deductible	Service provided as part of Hospice Care Program
Emergency & Urgent Care		
Emergency Room/Emergency Care	You pay a **$200** copayment/visit	Note: Emergency & Urgent Care copayments waived if admitted
Urgent Care	You pay a **$50** copayment/visit	
Emergency Ambulance	You pay **$0**	
Maternity		
Initial Visit to Confirm Pregnancy	You pay a **$25** copayment	
Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges	You pay **$0**	
Delivery-Professional Services (inpatient hospital, birthing center)	You pay **$0**	
Delivery-Facility (inpatient hospital, birthing center)	You pay **15%** coinsurance after the annual deductible	
Breast-Feeding Equipment and Supplies	Plan pays **100%**	• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies.
Other Covered Services (benefits based on service location)		
Home Health Care	You pay **$0**	(Includes outpatient private duty nursing subject to medical necessity) • 60 days maximum per Calendar Year • 16 hour maximum per day
Outpatient Hospice/Bereavement Counseling	You pay **$0**	
Durable Medical Equipment	You pay **15%** coinsurance after the annual deductible	Unlimited maximum per Calendar Year
External Prosthetic Appliances	You pay **15%** coinsurance after the annual deductible	

Infertility (diagnosis and treatment of underlying medical condition)		Services covered as any other illness	Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed.
Family Planning - Women's Services (Includes surgical service, such as tubal ligation (excludes reversals)		You pay **$0**	
Family Planning - Men's Services (Includes surgical service, such as vasectomy (excludes reversals)		You pay a **$25** PCP or **$40** Specialist copayment/visit	
• Abortion (non-elective) • TMJ • Bariatric Surgery (clinically severe (morbid) obesity)		Services covered as any other illness	
Mental Health and Substance Use Disorder Services (administered by Cigna Behavioral Advantage)			
Inpatient Mental Health & Substance Abuse (including Residential Treatment)		You pay **15%** coinsurance after the annual deductible	• Inpatient includes Residential Treatment • Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy
Outpatient Mental Health & Substance Abuse Office Visit		You pay a **$25** copayment/visit	
Outpatient Mental Health & Substance Abuse – all other services		You pay **$0** after deductible	
Prescription Drugs (administered by CVS/Caremark)			
Prescription Drug Annual Deductible		**$0**	
Prescription Drug Annual Out-of-Pocket Maximum (calendar year) (separate)		For prescription drugs - **$2,950** person/**$5,900** family	Prescription drug copayments apply to a separate out-of-pocket maximum.
Retail			
34-day supply at participating pharmacy	Generic	You pay a **$7** copayment	• Self Administered injectable drugs • Oral contraceptive drugs and prescription appliances for contraception – with specific products covered 100% • Insulin, glucose test strips, lancets, insulin needles and syringes, insulin pens and cartridges included • Retail and Home Delivery copayments apply to the Pharmacy Out-of-Pocket
	Preferred Brand	You pay a **$55** copayment	
	Non-Preferred Brand	You pay a **$80** copayment	
Home Delivery			
90-day supply through home delivery	Generic	You pay a **$15** copayment	
	Preferred Brand	You pay a **$100** copayment	
	Non-Preferred Brand	You pay a **$125** copayment	

What's Not Covered:

Your plan provides for most medically necessary services. Examples of things your plan does not cover include:

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational, or unproven services.
- Any services and supplies for or in connection with experimental, investigational, or unproven services. Experimental, investigational, and unproven services do not include routine patient care costs related to qualified clinical trials. Experimental, investigational, and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder, or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined to be not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or the subject of review or approval by an Institutional Review Board for the proposed use.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums, or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints, and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bone support and are functional in the arch.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and dentures.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable/injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone and e-mail consultations.
- Massage therapy.
- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.
- Nutritional supplements.
- Drugs used for cosmetic purposes or to aid in weight loss or certain items for smoking cessation including gums, inhalers, patches, and sprays.