



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Salary Under \$100,000: For in-network providers \$450 person / \$900 family Salary \$100,000 to \$250,000: For in-network providers \$800 person / \$1,600 family Salary Over \$250,000: For in-network providers \$1,100 person / \$2,200 family All Salaries: For out-of-network providers \$2,500 person / \$5,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. In-network preventive care & preventive RX are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Salary under \$100,000: For in-network providers \$3,450 person / \$6,900 family Salary \$100,000 to \$250,000: For in-network providers \$4,100 person / \$8,200 family Salary Over \$250,000: For in-network providers \$4,400 person / \$8,800 family All Salaries: For out-of-network providers \$5,000 person / \$10,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Cost of certain non-EHB specialty drugs, penalties for failure to obtain pre-authorization for services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. For a list of participating providers, see www.cigna.com/accenture or call 1-855-611-8131	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance /visit	40% coinsurance	None
	Specialist visit	20% coinsurance /visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit No charge/ screening No charge/immunizations Deductible does not apply	Not covered/visit Not covered/ screening Not covered/immunizations	None None None You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	For out-of-network providers \$500 penalty for no precertification.

¹ For more information about limitations and exceptions, including the benefits that are only available in-network, see the plan or policy document at <https://accenture.cigna.com/>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>Prescription Drug coverage is administered by CVS Caremark</p> <p>Mail Order: CVS Caremark Mail Order</p> <p>More information about <u>prescription drug coverage</u> is available at https://info.caremark.com/oe/accenture or by calling 800-932-7515</p>	Generic drugs	Retail: Standard Therapeutics 25% \$10 min/\$20 max Targeted Therapeutics* 25% \$50min/\$100 max Mail order** Standard Therapeutics 25% \$25 min/\$50 max Targeted Therapeutics* 25% \$125min/\$250 max	Retail: 40% coinsurance Mail Order: Not covered	ACA qualifying items including certain contraceptives for \$0 Preventive Rx is not subject to the deductible. *Impotence Agents, Fertility Regulators, Anti-Obesity Agents, Cosmetic Agents. **Maintenance drugs must be filled through CVS Caremark Mail Service Pharmacy or Walgreens/CVS 90 Day at Retail after two initial fills; if you fill a maintenance drug for a 30-day supply for the third or subsequent fills, you will be responsible for 100% of the cost of the medication.
	Preferred brand drugs	Retail: Standard Therapeutics 25% \$40 min/\$60 max Targeted Therapeutics* 25% \$200min/\$300 max Mail order** Standard Therapeutics 25% \$100 min/\$150 max Targeted Therapeutics* 25% \$500min/\$750 max	Retail: 40% coinsurance Mail Order: Not covered	You will need to fill your specialty medications at a select participating pharmacy in your plan's network. Otherwise, your medications will not be covered.
	Non-preferred brand drugs	Retail: Standard Therapeutics 25% \$60 min/\$80 max Targeted Therapeutics* 25% \$300min/\$400 max Mail order** Standard Therapeutics 25% \$150 min/\$200 max Targeted Therapeutics* 25% \$750min/\$1000 max	Retail: 40% coinsurance Mail Order: Not covered	There is no Out-of-Network coverage for Specialty Drugs.
	Specialty drugs	30% coinsurance. However, if enrolled in PrudentRX , the plan pays 100%.	Not Covered	Specialty drugs not covered by the PrudentRx program are subject to the applicable generic, preferred, non-preferred cost rules.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	For out-of-network providers \$500 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	For out-of-network providers \$500 penalty for no precertification.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network services are paid at the in-network cost share and deductible .
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible . Out-of-network non-emergency transportation: 40% coinsurance
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	For out-of-network providers \$500 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	For out-of-network providers \$500 penalty for no precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance /office visit 20% coinsurance /all other services	40% coinsurance /office visit 40% coinsurance /all other services	\$500 penalty if no precert of out-of-network non-routine services. Includes medical services for MH/SA diagnoses.
	Inpatient services	20% coinsurance	40% coinsurance	\$500 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	For out-of-network providers \$500 penalty for no precertification. 16 hour maximum per day
	Rehabilitation services	20% coinsurance / Primary care physician visit 20% coinsurance / Specialist visit	40% coinsurance	For out-of-network providers \$500 penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: unlimited days for Rehabilitation and 20 days for Chiropractic care services; 36 days for Cardiac rehab services Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	20% coinsurance / Primary care physician visit 20% coinsurance / Specialist visit	40% coinsurance	\$500 penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

1 For more information about limitations and exceptions, including the benefits that are only available in-network, see the plan or policy document at <https://accenture.cigna.com/>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance	40% coinsurance	For out-of-network providers \$500 penalty for no precertification. Coverage is limited to 120 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	For out-of-network providers \$500 penalty for no precertification.
	Hospice services	20% coinsurance /inpatient; 20% coinsurance /outpatient services	40% coinsurance /inpatient; 40% coinsurance /outpatient services	For out-of-network providers \$500 penalty for no precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Hearing Aids
- Fertility Treatment (WinFertility enrollment required)
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the program for this [plan's](#) situs state: Illinois Department of Insurance at (866) 445-5364. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-244-6224.

-----To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$450
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$450
Copayments	\$0
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$2,870

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$450
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$450
Copayments	\$0
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$40
The total Joe would pay is	\$1,690

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$450
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$450
Copayments	\$0
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$950

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Cigna PPO Plan **Ben Ver:** 35 **Plan ID:** 37358531

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