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?	For in-network providers: $500/individual or $1,000/family For out-of-network providers: $1,000/individual or $2,000/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 & immunizations, office visits, emergency room visits, urgent care facility visits, and in-network prescription drugs.	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?	For in-network providers: $3,000/individual or $6,000/family For out-of-network providers: $8,000/individual or $16,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	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?	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. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	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 copay/visit Deductible does not apply	40% coinsurance	None
	Specialist visit	$30 copay/visit Deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge Deductible does not apply	40% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage	Generic drugs (Tier 1)	Retail: $10 copay Mail: $25 copay Deductible does not apply	40% coinsurance	Coverage is limited up to a 30-day supply (retail) and 90-day supply (retail or home delivery) for maintenance medications

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)	
is available at www.caremark.com	Preferred brand drugs (Tier 2)	Retail: $30 copay Mail: $75 copay Deductible does not apply	40% coinsurance	
	Non-preferred brand drugs (Tier 3)	Retail: $60 copay Mail: $150 copay Deductible does not apply	40% coinsurance	
	Specialty drugs (Tier 4)	Same as non-specialty	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit Deductible does not apply	$150 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	$50 copay/visit Deductible does not apply	$50 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit** 20% coinsurance/all other services **Deductible does not apply	20% coinsurance/office visit 40% coinsurance/all other services	50% penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.).
	Inpatient services	20% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm

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 professional services	20% coinsurance	40% coinsurance	pregnancy. 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).
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 200 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$20 copay/PCP visit** $30 copay/ Specialist visit** **Deductible does not apply	40% coinsurance/PCP visit 40% coinsurance/ Specialist visit	None
	Habilitation services	$20 copay/PCP visit** $30 copay/ Specialist visit** **Deductible does not apply	40% coinsurance/PCP visit 40% coinsurance/ Specialist visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
	Skilled nursing care	20% coinsurance	40% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 120 days annual max for Skilled Nursing, Sub-Acute Facility and 120 days annual max for Rehabilitation Hospital.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	40% coinsurance/inpatient services 40% coinsurance/outpatient services	50% penalty for failure to precertify out-of-network inpatient hospice services.

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 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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Acupuncture
- Bariatric Surgery (in-network only)
- Chiropractic care
- Hearing aids
- Infertility treatment (Lifetime max $20,000)

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, 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: California Department of Managed Health Care Help Center at (888) 466-2219.

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, kwiijigo 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** **$500**
- **Specialist copayment** **$30**
- **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	$2,950

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$30**
- **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	$4,620

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$30**
- **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$910

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: Workday, Inc. Core OAP Plan **Ben Ver:** 29 **Plan ID:** 17025864

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DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English - ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish - ATENCION: Hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Si es un cliente actual de Cigna, llame al numero que figura en el reverso de su tarjeta de identificaci6n. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese - *i.* ± (I"JilJ*1.?,1 t!Ef3'ii 1bbM.filU%*° ™m-Cigna '8JJl. F • *g)'Hi,Q:i![1 '8* ID -t- im'8 u!/fJiJI. _p f,Q:i![1.800.244.6224 〈Iffl : m 711) •

Vietnamese - XIN LLYU Y Ouy vj OLfQ'C cap djch v1,1trq giup v ngon ngfr mi n phi Danh cho khach hang hien tai cua Cigna, vui long goi so a m t sau the Hoi vien. Cac trLPang hqp khac xin goi so 1.800.244.6224 (TTY: Quay so 711)

Korean -£1: Oj§ A -§-ofAl q., '2:!0J:J::I A1l::llA§ '9-E.£ Ol-§-of qq,XH Cigna 7f :J::f'aJJIlA1 ID ;:'fC OJl 2.f .2..£ <2:! !--BH Al.2.. 71Ef q=q.on 1.800.244.6224 (TTY: qo1 Z11) º£ £l-5H Al.2..

Tagalog - PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. 0 kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian - BHVlMAHl!lE: BaM Moryr npep,ocraB1,1Tb 6ecnnaTHble ycnyr11 nepeBOAa. Ecm,1Bbl y>Ke y4acrByere B nnaHe Cigna, no3BOHl1Te no HOMepy, yKa3aHHOMy Ha o6paTHOHcropoHe BaweH11AeHTl1(pl1Kal.\110HHOHKapT04Kl1y4aCTHl1Ka nnaHa. Ec1111Bbl He f!Bm:1erecb y4aCTHl1KOM OAHOro 113 Haw11x nnaHOB, no3BOHl1Te no HOMepy 1.800.244.6224 (TTY 711).

Cigna , - -...i:... ;;,,,,; 1.Jll ..::\..o.,lai..,.:.,11*ol.;,.y,* - **Arabic** '-.-' ▮ ~oi,' li µu., _,,.Jio ._„J„ -.)J.i. .... *?3)*\.; Jl-,")11ol.;,.y,.:;,;l\,,Jl (711..,... ı:TTY) 1.800.244.6224

French Creole - ATANSYON: Gen sevis ed nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki deye kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French - ATTENTION: Des services d'aide linguistique vous sont proposes gratuitement. Si vous etes un client actuel de Cigna, veuillez appeler le numero indique au verso de votre carte d'identite. Sinon, veuillez appeler le numero 1.800.244.6224 (ATS: composez le numero 711).

Portuguese - ATENCAO: Tern ao seu dispor servicos de assistencia linguistica, totalmente gratuitos. Para clientes Cigna atuais, ligue para o numero que se encontra no verso do seu cartao de identificacao. Caso contrario, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish - UWAGA: w celu skorzystania z dost pnej, bezplatnej pomocy j zykowej, obecni klienci firmy Cigna mogc1 dzwonic pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese - 5i :B*qq q! :tl-9 ,ffl{ O) qq :ji-ij--t:'.'A cflJ ffll,\tctclt*9o!J!.ttO)CignaO)cB l;J:, ID1J- r'iriffiO)mg!Wf-ls-*"('\ sm g!1;::z;:·i!i! <tc l,\0 -fO)ft!30)J'51;J:,1.800.244.6224 (TTY: 711) *c-,smg!1;::zci!i! <tc l,\0

Italian - ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare ii numero sul retro della tessera di identificazione. In caso contrario, chiamare ii numero 1.800.244.6224 (utenti TTY: chiamare ii numero 711).

German - ACHTUNG: Die Leistungen der SprachunterstOtzung stehen Ihnen kostenlos zur VerfOgung. Wenn Sie gegenwartiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der ROckseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wahlen Sie 711).

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