

Schedule of Benefits

Employer: salesforce.com, Inc.
 MSA: 883528
 Issue Date: January 01, 2018
 Effective Date: January 01, 2018
 Schedule: 1B
 Booklet Base: 1

For: Choice POS II- HDHP

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$1,500	\$3,000
Family Deductible*	\$3,000	\$6,000

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: \$3,000.
- For **out-of-network** expenses: \$6,000.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$6,000.
- For **out-of-network** expenses: \$12,000.

Lifetime Maximum Benefit per person	Unlimited	Unlimited
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Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams		
Office Visits	100% per visit No copay or Calendar Year deductible applies.	70% per visit after Calendar Year deductible
<i>Covered Persons through age 21: Maximum Age & Visit Limits</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>
<i>Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months</i>	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per 12 consecutive months</i>	1 visit	1 visit
Preventive Care Immunizations		
<i>Performed in a facility or physician's office</i>	100% per visit No copay or Calendar Year deductible applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>	70% per visit after Calendar Year deductible Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>

Screening & Counseling Services	100% per visit	70% per visits after Calendar Year deductible
Office Visits Obesity and/or Healthy Diet	No copay or Calendar Year deductible applies.	
Misuse of Alcohol and/or Drugs & Use of Tobacco Products		
Sexually Transmitted Infections		
Genetic Risk for Breast and Ovarian Cancer		

<i>Obesity and/or Healthy Diet</i> Maximum Visits per 12 consecutive months (This maximum applies only to Covered Persons ages 22 & older.)	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

<i>Misuse of Alcohol and/or Drugs</i> Maximum Visits per 12 consecutive months	5 visits*	5 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

<i>Use of Tobacco Products</i> Maximum Visits per 12 consecutive months	8 visits*	8 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

<i>Sexually Transmitted Infections Benefit Maximums</i> Maximum Visits per 12 consecutive months	2 visits*	2 visits*
*Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.		

Well Woman Preventive Visits Office Visits	100% per visit	70% per visit after Calendar Year deductible
Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human	No copay or Calendar Year deductible applies.	

Resources Administrations

Well Woman Preventive Visits

Maximum Visits per Calendar Year	1 visit	1 visit
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Hearing Exam

\$15 exam copay then the plan pays 100%	70% per exam after Calendar Year deductible
No Calendar Year deductible applies.	

Maximum exams per 24 month period	1 exam	1 exam
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Hearing Aids	90% after Calendar Year deductible.	70% after Calendar Year deductible.
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Hearing Aid Maximum per Calendar Year	\$5,000	\$5,000
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PLAN FEATURES

NETWORK

OUT-OF-NETWORK

Routine Cancer Screenings

**Routine Cancer Screening
Outpatient**

100% per visit	70% per visit after Calendar Year deductible
No copay or Calendar Year deductible applies.	

Maximums

<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and the comprehensive guidelines supported by the Health Resources and Services Administration. 	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and the comprehensive guidelines supported by the Health Resources and Services Administration.
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*For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.*

*For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.*

<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	One screening every 12 months*
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***Important Note:** *Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.*

***Prenatal Care
Office Visits***

100% per visit

70% per visit after Calendar Year
deductible

No **copay** or Calendar Year
deductible applies.

Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Booklet for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services

***Lactation Counseling Services
Facility or Office Visits***

100% per visit

70% per visit after Calendar Year
deductible

No **copay** or Calendar Year
deductible applies.

Lactation Counseling Services
Maximum Visits either in a group or
individual setting

6* visits per 12 months

Not Applicable

***Important Note:** Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Breast Pumps & Supplies

100% per item

70% per item after Calendar Year
deductible

No **copay** or Calendar Year
deductible applies

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.

Family Planning Services

***Female Contraceptive Counseling
Services -Office Visits***

100% per visit.

70% per visit after Calendar Year
deductible

No **copay** or Calendar Year
deductible applies.

Contraceptive Counseling Services -
Maximum Visits either in a group or
individual setting

2* visits per 12 months

Not Applicable

***Important Note:** Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Family Planning Services - Female Contraceptives

Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visits.	100% per item. No copay or Calendar Year deductible applies.	70% per item after Calendar Year deductible
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Family Planning - Other

Voluntary Termination of Pregnancy Outpatient	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Voluntary Sterilization for Males Outpatient	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Family Planning - Female Voluntary Sterilization

Inpatient	100% per visit No copay or Calendar Year deductible applies.	70% per visit after Calendar Year deductible
Outpatient	100% per visit No copay or Calendar Year deductible applies.	70% per visit after Calendar Year deductible

PLAN FEATURES

NETWORK

OUT-OF-NETWORK

Physician Services

Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Specialist Office Visits	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Physician Office Visits-Surgery	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Walk-In Clinic Visit (Non-Emergency)

Preventive Care Services*

Immunizations	100% per visit No copay or Calendar Year deductible applies. For details, contact your physician , log onto the Aetna website www.aetna.com , or call the number on the back of your ID card.	70% per visit after Calendar Year deductible
Individual Screening and Counseling Services for Tobacco Use	100% per visit No copay or Calendar Year deductible applies.	70% per visit after Calendar Year deductible
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit No copay or Calendar Year deductible applies.	70% per visit after Calendar Year deductible
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services

***Important Note:**

Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.

<i>All Other Services</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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<i>Physician Services for Inpatient Facility and Hospital Visits</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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<i>Administration of Anesthesia</i>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
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<i>Allergy Testing and Treatment</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible .
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<i>Allergy Injections</i>	90% per visit after Calendar Year deductible .	70% per visit after Calendar Year deductible .
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	90% per visit after Calendar Year deductible	Paid the same as the Network level of benefits. See Important Note Below
<p>Important Note: Please note that as these providers are not network providers and do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and payment percentage), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>		

Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered
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Important Notice:
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Urgent Medical Care <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.

Important Notice:
A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Diagnostic and Preoperative Testing</i>		
<i>Preoperative Testing (except complex imaging services)</i>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
<i>Complex Imaging Services</i>		
<i>Complex Imaging</i>	90% per test after Calendar Year deductible	70% per test after Calendar Year deductible
<i>Diagnostic Laboratory Testing</i>		
<i>Diagnostic Laboratory Testing</i>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
<i>Diagnostic X-Rays (except Complex Imaging Services)</i>		
<i>Diagnostic X-Rays</i>	90% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgery</i>		
<i>Outpatient Surgery</i>	90% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Facility Expenses</i>		
<i>Birth Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Hospital Facility Expenses</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Room and Board (including maternity)		
Other than Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Skilled Nursing Inpatient Facility</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Maximum Days per Calendar Year	60 days	60 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	120 visits	120 visits
Skilled Nursing Care (Outpatient)	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
Private Duty Nursing (Outpatient)	90% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
Maximum Visit Limit per <i>Calendar Year</i>	180 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	180 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Hospice Care - Other Expenses during a stay	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Contact Progyny for covered infertility benefits that are above the basic infertility. Progyny 1-888-461-5067.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<i>Inpatient Treatment of Mental Disorders</i>		
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<i>MENTAL DISORDERS</i>		
<i>Hospital Facility Expenses</i>		
Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Other than Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Physician Services	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

<i>Outpatient Treatment Of Mental Disorders</i>		
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<i>Outpatient Services</i>	90% per visit after Calendar Year deductible	70% per visit after the Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<i>Inpatient Treatment of Substance Abuse</i>		
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<i>Hospital Facility Expenses</i>		
Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Other than Room and Board	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Physician Services	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Outpatient Treatment of Substance Abuse			
Outpatient Treatment	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	
Obesity Treatment Non Surgical			
Outpatient Obesity Treatment (non surgical)	90% per visit after the Calendar Year deductible	Not Covered	
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	
Obesity Treatment Surgical			
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	90% per admission after the Calendar Year deductible	Not Covered	
Outpatient Morbid Obesity Surgery	90% per service after Calendar Year deductible	Not Covered	
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered	
PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	90% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	
Other Covered Health Expenses			
Acupuncture	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	
Maximum visits per Calendar Year	25 visits	25 visits	
Ground, Air or Water Ambulance	90% after Calendar Year deductible	70% after Calendar Year deductible	

<i>Diabetic Equipment, Supplies and Education</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Durable Medical and Surgical Equipment</i>	90% per visit after Calendar Year deductible	70% per item after the Calendar Year deductible
<i>Clinical Trial Therapies</i> (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Routine Patient Costs</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Jaw Joint Disorder Treatment</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Prosthetic Devices</i>	90% per item after Calendar Year deductible	70% per item after Calendar Year deductible
<i>Wigs</i>	90% after Calendar Year deductible	90% after Calendar Year deductible
<i>Transgender Reassignment (Sex Change) Surgery</i>	90% per visit after the Calendar Year deductible.	70% per visit after the Calendar Year deductible.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		
<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical, Occupational and Speech Therapy</i>	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Physical, Occupational and Speech Therapy Maximum visits for each therapy per Calendar Year	60 visits	60 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Autism Expenses</i>		
<i>Physical therapy, Occupational Therapy, Speech Therapy</i>	90% per visit after the Calendar Year deductible.	70% per visit after the Calendar Year deductible.

<i>Autism - Behavioral Therapy</i>	90% per visit after Calendar Year deductible	70% per visit after the Calendar Year deductible.
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<i>Autism - Applied Behavior Analysis</i>	90% per visit after Calendar Year deductible	70% per visit after the Calendar Year deductible.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>		
	90% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Spinal Manipulation Maximum visits per Calendar Year	25 visits	25 visits
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Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

Covered expenses that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable.

This Plan has individual and family calendar year **deductibles**.

For purposes of calendar year deductible provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.

Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you incur each calendar year from a **network provider** for which no benefits will be paid. After **covered expenses** reach this individual calendar year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the calendar year.

Family

This is the amount of **covered expenses** that you and your covered dependents incur each calendar year from a **network provider** for which no benefits will be paid. After **covered expenses** reach this family calendar year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur from a **network provider** for the rest of the calendar year.

Out-of-Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you incur each calendar year from an **out-of-network provider** for which no benefits will be paid. This individual calendar year **deductible** applies separately to you. After **covered expenses** reach this individual calendar year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the calendar year.

Family

This is the amount of **covered expenses** that you and your covered dependents incur each calendar year from an **out-of-network provider** for which no benefits will be paid. After **covered expenses** reach this family calendar year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur from an **out-of-network provider** for the rest of the calendar year.

Copayments and Benefit Deductible Provisions

Copayment, Copay

This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

For purposes of the following coinsurance provisions, an individual means an employee enrolled for self only coverage with no dependents coverage and a family means an employee enrolled with one or more dependents.

Maximum Out-of-Pocket Limit

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **covered expenses** during the calendar year. This Plan has an individual and family **maximum out-of-pocket limit**.

Certain **covered expenses** do not apply toward the **maximum out-of-pocket limit**. See list below.

The **maximum out-of-pocket limit** applies to **network provider** and **out-of-network provider** benefits.

You have a separate **maximum out-of-pocket limit** for **network provider** and **out-of-network provider** benefits. **Covered expenses** applied to the out-of-network **maximum out-of-pocket limit** will be applied to satisfy the in-network **maximum out-of-pocket limit** and **covered expenses** applied to the in-network **maximum out-of-pocket limit** will be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you have paid during the calendar year meets the individual **maximum out-of-pocket limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the calendar year for that person.

Family

The Family **maximum out-of-pocket limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **network provider** expenses paid during the calendar year meets this family **maximum out-of-pocket limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the calendar year for all covered family members.

Out-of Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you have paid during the calendar year meets the individual **maximum out-of-pocket limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the calendar year for that person.

Family

The Family **maximum out-of-pocket limit** can be met by a combination of family members or by any single individual within the family. Once the amount of eligible **out-of-network provider** expenses paid during the calendar year meets this family **maximum out-of-pocket limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the calendar year for all covered family members.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses that are not paid or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the “Understanding Precertification” section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A \$400 benefit reduction will be applied separately to each type of expense.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.