Schedule of Benefits

Employer: **salesforce.com, Inc.**

MSA: 883528

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For: Aetna Select Medical Plan

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

Aetna Select Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$200	Not applicable
Family Deductible*	$400	Not applicable

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

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

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $2,200

Family Maximum Out of Pocket Limit:

- For **network** expenses: $4,400

Lifetime Maximum Benefit per person	Unlimited	Not applicable

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.

PLAN FEATURES	NETWORK	OUT OF NETWORK
Preventive Care Benefits		
Routine Physical Exams		
Office Visits -	100% per visit. No copay or **deductible** applies.	Not Covered
Covered Persons through age 21: Maximum Age & Visit Limits per 12 consecutive months	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. *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.*	Not Covered
Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months	1 visit	Not Covered
Covered Persons age 65 and over: Maximum Visits per 12 consecutive months	1 visit	Not Covered.
Preventive Care Immunizations *Performed in a facility or **physician's** office*	100% per visit. No **copay** or **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. *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.*	Not Covered

Screening & Counseling Services ***Office Visits*** ***Obesity and/or Healthy Diet*** ***Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** ***Sexually Transmitted Infections*** ***Genetic Risk for Breast and Ovarian Cancer***	100% per visit. No **copay** or **deductible** applies.	Not Covered

Obesity and/or Healthy Diet 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)* *****	Not Covered.

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Misuse of Alcohol and/or Drugs Maximum Visits per 12 consecutive months	5 visits *****	Not Covered.

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Use of Tobacco Products Maximum Visits per 12 consecutive months	8 visits *****	Not Covered.

Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Sexually Transmitted Infections Benefit Maximums		
Maximum Visits per Calendar Year	2 visits*****	Not Covered

Note:** ***In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.

Well Woman Preventive Visits Office Visits Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	100% No Calendar Year **deductible** applies	Not Covered
Maximum Visits per Calendar Year	1 visit	Not Covered
Hearing Exam	$15 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Maximum exams per 24 month period	1 exam	Not Covered
Hearing Aids	100% after Calendar Year **deductible**	Not Covered
Hearing Supply Maximum per Calendar Year	$5,000	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Routine Cancer Screenings		
Routine Cancer Screening Outpatient	100% per visit No Calendar Year **deductible** applies.	Not Covered
Maximums	Subject to any age; family history and frequency guidelines as set forth in the most current: • 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.	Not Covered *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.*	
Lung Cancer Screening Maximum	One screening every 12 months*	Not Covered
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 No **copay** or **deductible** applies.	Not Covered
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 No **copay** or **deductible** applies.	Not Covered.
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	Not Covered
***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. No **copay** or **deductible** applies.	Not Covered
Family Planning - Other		
Voluntary Termination of Pregnancy Outpatient	100% per visit after Calendar Year **deductible.**	Not Covered.
Voluntary Sterilization for Males		
Outpatient	100% per visit after Calendar Year **deductible.**	Not Covered.

Family Planning Services		
Female Contraceptive Counseling Services -Office Visits.	100% per visit No Calendar Year **deductible** applies.	Not Covered.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Covered.
*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*.		

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item No **copay** or **deductible** applies.	Not Covered.
Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit No **copay** or **deductible** applies.	Not Covered
Outpatient	100% per visit No **copay** or **deductible** applies.	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Specialist Office Visits	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered

Walk-In Clinic Visit (Non-Emergency)		
Preventive Care Services*		
Immunizations	100% per visit No **copay** or **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.	Not Covered
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or **deductible** applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
Individual Screening and Counseling Services for Obesity	100% per visit No **copay** or **deductible** applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
***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**.		
All Other Services	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Physician Office Visits-Surgery	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Physician Services for Inpatient Facility and Hospital Visits	100% per visit after Calendar Year **deductible**	Not Covered
Administration of Anesthesia	100% after Calendar Year **deductible**	Not Covered

Allergy Testing and Treatment	$15 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered.
Allergy Injections	100% per visit No Calendar Year **deductible** applies.	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
Hospital Emergency Facility and Physician	$75 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	Paid the same as the Network level of benefits. **See Important note below*

***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 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 **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered

Important Notice:
A separate **hospital** emergency room **copay** or **deductible** 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 **copay** or **deductible** is waived.

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

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$50 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies	Not Applicable

Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Not Covered	Not Covered

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Preoperative Testing (except complex imaging services)	100% per procedure No Calendar Year **deductible** applies	Not Covered
Complex Imaging Services		
Complex Imaging	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Diagnostic Laboratory Testing		
	100% per procedure No Calendar Year **deductible** applies	Not Covered
Diagnostic X-Rays		
Diagnostic X-Rays (except Complex Imaging Services)	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	100% per visit/surgical procedure after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Hospital Facility Expenses Room and Board (including maternity)	100% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	100% per admission after Calendar Year **deductible**	Not Covered
Skilled Nursing Inpatient Facility	100% per admission after Calendar Year **deductible**	Not Covered
Maximum Days per Calendar Year	60 days	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care(Outpatient)	100% per visit after the Calendar Year **deductible**	Not Covered
Skilled Nursing Care (Outpatient)	100% per visit after the Calendar Year **deductible**	Not Covered
Private Duty Nursing (Outpatient)	100% per visit after the Calendar Year **deductible**	Not Covered
Maximum Visit Limit per *Calendar Year*	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)	100% per admission after Calendar Year **deductible**	Not Covered
Hospice Care – Other Expenses during a stay	100% per admission after Calendar Year **deductible**	Not Covered
Maximum Benefit per lifetime	Unlimited days	Not Covered
Hospice Outpatient Visits	100% per visit after Calendar Year **deductible**	Not Covered

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.	100% after Calendar Year **deductible** .	Not Covered
Contact Progyny for covered infertility benefits that are above the basic infertility. Progyny 1-888-461-5067.		

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	100% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	100% per admission after Calendar Year **deductible**	Not Covered
Physician Services	100% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses	100% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit after Calendar Year **deductible**	Not Covered

Outpatient Treatment Of Mental Disorders		
Outpatient Services	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	100% per admission after Calendar Year **deductible**	Not Covered
Other than Room and Board	100% per admission after Calendar Year **deductible**	Not Covered
Physician Services	100% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses	100% per admission after Calendar Year **deductible**	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit after Calendar Year **deductible**	Not Covered
Outpatient Treatment of Substance Abuse		
Outpatient Services	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	100% 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)	100% per admission after Calendar Year **deductible**	Not Covered
Outpatient Morbid Obesity Surgery	100% 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	100% per admission after Calendar Year **deductible**	Not Covered	Not Covered
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture	$15 per visit copay then the plan pays 100% No Calendar Year deductible applies	Not Covered
Maximum visits per Calendar Year	25 visits	25 visits
Ground, Air or Water Ambulance	100% after Calendar Year **deductible**	Not Covered
Diabetic Equipment, Supplies and Education	100% after Calendar Year **deductible**	Not Covered
Durable Medical and Surgical Equipment	100% per item after the Calendar Year **deductible**	Not Covered

Clinical Trial Therapies (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.
Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.
Jaw Joint Disorder Treatment	100% per visit after the Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Transgender Reassignment (Sex Change) Surgery	100% per visit/surgical procedure after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational, and Speech Therapy	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Physical, Occupational and Speech Therapy Maximum visits for each therapy per Calendar Year	60 visits	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Expenses		
Physical therapy, Occupational Therapy, Speech Therapy	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Autism - Behavioral Therapy	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Autism - Applied Behavior Analysis	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Spinal Manipulation Maximum visits per Calendar Year	25 visits	Not Covered

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

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

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Network Provider Calendar Year **Deductible**

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. 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 Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

> The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met 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.

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 **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you or your covered dependents 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 Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

> The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

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 incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

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.