# Schedule of Benefits

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| **Employer:** | **salesforce.com, Inc.** |
| **MSA:** | 883528 |
| **Issue Date:** | January 01, 2018 |
| **Effective Date:** | January 01, 2018 |
| **Schedule:** | 2A |
| **Booklet Base:** | 2 |

For: Traditional Choice

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

## Comprehensive Medical Plan

| PLAN FEATURES | |
|---|---|
| Calendar Year **Deductible*** | $500 |
| **Family Deductible*** | $1,500 |

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

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

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

**Individual Maximum Out of Pocket Limit:** $2,500

**Family Maximum Out of Pocket Limit:** $4,500

| PLAN FEATURES | |
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| **Lifetime Maximum Benefit per person** | Unlimited |

***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 | |
|---|---|
| ***Preventive Care Benefits*** | |
| ***Routine Physical Exams*** | |
| ***Office Visits***. | 100% per visit<br><br>No deductible applies. |
| *Covered Persons through age 21*:<br>Maximum Age & Visit Limits | 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.<br><br>*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.* |
| *Covered Persons ages 22 but less than 65*:<br>Maximum Visits per 12 consecutive months | 1 visit |
| *Covered Persons age 65 and over*:<br>Maximum Visits per 12 consecutive months | 1 visit |
| ***Preventive Care Immunizations***<br>*Performed in a facility or* ***physician's*** *office* | 100% per visit<br><br>No **copay** or **deductible** applies.<br><br>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.<br><br>*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.* |
| ***Screening & Counseling Services***<br><br>***Office Visits***<br>***Obesity and/or Healthy Diet***<br><br>***Misuse of Alcohol and/or Drugs & Use of Tobacco Products***<br><br>***Sexually Transmitted Infections***<br><br>***Genetic Risk for Breast and Ovarian Cancer*** | 100% per visit<br><br>No **copay** or **deductible** applies. |

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| *Obesity and/or Healthy Diet*<br>Maximum Visits per 12 consecutive months<br>*(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)* ***** |

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

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| *Misuse of Alcohol and/or Drugs*<br>Maximum Visits per 12 consecutive months | 5 visits ***** |

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

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| *Use of Tobacco Products*<br>Maximum Visits per 12 consecutive months | 8 visits ***** |

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

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| *Sexually Transmitted Infections Benefit Maximums*<br>Maximum Visits per Calendar Year | 2 visits***** |

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

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| ***Well Woman Preventive Visits***<br>***Office Visits***<br><br>Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations | 100% per visit<br><br>No Calendar Year deductible applies. |
| Maximum Visits per Calendar Year | 1 visit |
| ***Hearing Exam*** | 90% per exam after Calendar Year **deductible** |
| Maximum Exam per 24 month period | 1 exam |
| ***Hearing Aids*** | 90% per exam after Calendar Year **deductible** |
| Hearing Supply Maximum per Calendar Year | $5,000 |

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| ***Routine Cancer Screenings***<br>***Outpatient*** | 100% per visit<br><br>No Calendar Year **deductible** applies. |
| Maximums | Subject to any age; family history and frequency guidelines as set forth in the most current:<br>• 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<br>• the comprehensive guidelines supported by the Health Resources and Services Administration.<br><br>*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***** |
| ***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***<br>***Office Visits*** | 100% per visit<br><br>No **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<br><br>No Calendar Year **deductible** applies. |
| Lactation Counseling Services Maximum Visits either in a group or individual setting | 6* visits per 12 months |
| ***Important Note**: Visits in excess of the Lactation Counseling Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*. | |

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| **Breast Pumps & Supplies** | 100% per item<br><br>No 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 Contraceptives*** | |
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| ***Female Contraceptive Counseling Services - Office Visits***. | 100% per visit<br><br>No Calendar Year **deductible** applies. |

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| Contraceptive Counseling Services Maximum Visits either in a group or individual setting | 2* visits per 12 months |
| *****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*** | |
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| Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits. | 100% per item<br><br>No **copay** or **deductible** applies. |

| ***Family Planning - Female Voluntary Sterilization*** | |
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| ***Inpatient*** | 100% per visit<br><br>No **deductible** applies. |
| ***Outpatient*** | 100% per visit<br><br>No **deductible** applies. |

| ***Family Planning Services - Other*** | |
|---|---|
| Voluntary Sterilization for Males | |
| Outpatient | 90% per visit after Calendar Year **deductible** |
| Voluntary Termination of Pregnancy | |
| Outpatient | 90% per visit after Calendar Year **deductible** |

| PLAN FEATURES | |
|---|---|
| ***Physician Services*** | |
| ***Physician Office Visits*** *(non-surgical)* | 90% per visit after Calendar Year **deductible** |
| ***Specialist Office Visits*** | 90% per visit after Calendar Year **deductible** |
| ***Physician Office Visit (Surgery)*** | 90% per visit after Calendar Year **deductible** |
| ***Physician Services for Inpatient Facility and Hospital Visits*** | 90% per visit after Calendar Year **deductible** |
| ***Administration of Anesthesia*** | 90% per procedure after Calendar Year **deductible** |
| ***Allergy Testing and Treatment*** | 90% per visit after Calendar Year **deductible** |
| ***Allergy Injections*** | 90% per visit after Calendar Year **deductible** |

| PLAN FEATURES | |
|---|---|
| ***Emergency Medical Services*** | |
| ***Hospital Emergency Facility and Physician*** | 90% per visit after Calendar Year **deductible**<br><br>**See Important Note Below* |
| ***Important Note:** Please note that 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 **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*** | 50% after Calendar Year **deductible** |

| PLAN FEATURES | |
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| ***Urgent Medical Services*** | |
| ***Urgent Medical Care***<br>*(at a non-hospital free standing urgent care facility)* | 90% per visit after Calendar Year **deductible** |
| ***Urgent Medical Care***<br>*(for other than a non-hospital free standing facility)* | Refer to *Emergency Medical Services* and *Physician Services* above. |

| PLAN FEATURES | |
|---|---|
| ***Outpatient Diagnostic and Preoperative Testing*** | |
| ***Diagnostic and Preoperative Testing (except complex imaging services)*** | 90% per procedure after Calendar Year **deductible** |
| ***Complex Imaging Services*** | |
| ***Complex Imaging*** | 90% per procedure after Calendar Year **deductible** |
| ***Diagnostic Laboratory Testing*** | |
| ***Diagnostic Laboratory Testing*** | 90% per procedure after Calendar Year **deductible** |
| ***Diagnostic X-Rays (except Complex Imaging Services)*** | |
| ***Diagnostic X-Rays*** | 90% per procedure after Calendar Year **deductible** |

| PLAN FEATURES | |
|---|---|
| ***Outpatient Surgery*** | |
| ***Outpatient Surgery*** | 90% per visit/surgical procedure after Calendar Year **deductible** |

| PLAN FEATURES | |
|---|---|
| ***Inpatient Facility Expenses*** | |
| ***Birthing Center*** | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Hospital Facility Expenses***<br>Room and Board<br>(including maternity) | 90% per admission after Calendar Year **deductible** |
| Other than Room and Board | 90% per admission after Calendar Year **deductible** |

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| ***Skilled Nursing Inpatient Facility*** | 90% per admission after Calendar Year **deductible** |
| Maximum Days per Calendar Year | 60 days |
| **PLAN FEATURES** | |
| ***Specialty Benefits*** | |
| ***Home Health Care (Outpatient)*** | 90% per visit after the Calendar Year **deductible** |
| Maximum Visits per Calendar Year | 120 visits |
| ***Skilled Nursing Care (Outpatient)*** | 90% per visit after Calendar Year **deductible** |
| ***Private Duty Nursing (Outpatient)*** | 90% per visit after Calendar Year **deductible** |
| 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. |
| ***Hospice Benefits*** | |
| ***Hospice Care – Facility Expenses*** (Room & Board) | 90% per admission after Calendar Year **deductible** |
| ***Hospice Care (Other Expenses during a stay)*** | 90% per admission after Calendar Year **deductible** |
| Maximum Benefit per lifetime | Unlimited days |
| ***Hospice Outpatient Visits*** | 90% per visit after Calendar Year **deductible** |
| **PLAN FEATURES** | |
| ***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. |
| ***Contact Progyny for covered infertility benefits that are above the basic infertility. Progyny 1-888-461-5067.*** | |

| PLAN FEATURES | |
|---|---|
| ***Inpatient Treatment of Mental Disorders*** | |
| ***Mental Disorders*** | |
| Room and Board | 90% per admission after Calendar Year **deductible** |
| Other than Room and Board | 90% per admission after Calendar Year **deductible** |
| ***Inpatient Residential Treatment Facility*** | 90% per admission after Calendar Year **deductible** |
| ***Outpatient Treatment of Mental Disorders*** | |
| ***Outpatient Services*** | 90% per visit after Calendar Year **deductible** |

| PLAN FEATURES | |
|---|---|
| ***Inpatient Treatment of Substance Abuse*** | |
| ***Hospital Facility Expenses*** | |
| Room and Board | 90% per admission after Calendar Year **deductible** |
| Other than Room and Board | 90% per admission after Calendar Year **deductible** |
| ***Inpatient Residential Treatment Facility*** | 90% per admission after Calendar Year **deductible** |
| ***Outpatient Treatment of Substance Abuse*** | |
| ***Outpatient Services*** | 90% per visit after Calendar Year **deductible** |

| PLAN FEATURES | |
|---|---|
| ***Obesity Treatment Surgical and Non Surgical*** | |
| ***Outpatient Obesity Treatment (non surgical)*** | 90% per visit after Calendar Year **deductible** |
| ***Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)*** | 90% per admission after Calendar Year **deductible** |
| ***Outpatient Morbid Obesity Surgery*** | 90% per service after Calendar Year **deductible** |
| Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient) | Unlimited |

| PLAN FEATURES | |
|---|---|
| ***Transplant Expenses*** | |
| ***Transplant Facility Expenses*** | 90% per admission after Calendar Year **deductible** |
| ***Transplant Physician Services*** (including office visits) | 90% per visit after Calendar Year **deductible** |

| PLAN FEATURES | |
|---|---|
| ***Other Covered Health Expenses*** | |
| ***Acupuncture*** | 90% per visit after Calendar Year **deductible** |
| Maximum visits per Calendar Year | 25 visits |
| ***Ground, Air or Water Ambulance*** | 90% after Calendar Year **deductible** |
| ***Diabetic Equipment, Supplies and Education*** | 100% after Calendar Year **deductible** |
| ***Durable Medical and Surgical Equipment*** | 100% per item<br><br>No Calendar Year **deductible** applies. |
| ***Clinical Trial Therapies*** (Experimental or Investigational Treatment) | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Routine Patient Costs*** | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Jaw Joint Disorder Treatment*** | 90% per visit after Calendar Year **deductible** |
| ***Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)*** | 90% per visit after Calendar Year **deductible** |
| ***Orthotic and Prosthetic Devices*** | 90% per item after Calendar Year **deductible** |
| ***Transgender Reassignment (Sex Change) Surgery*** | 90% per visit after Calendar Year **deductible** |

| PLAN FEATURES | |
|---|---|
| ***Outpatient Therapies*** | |
| ***Chemotherapy*** | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Infusion Therapy*** | Payable in accordance with the type of expense incurred and the place where service is provided. |
| ***Radiation Therapy*** | Payable in accordance with the type of expense incurred and the place where service is provided. |

| PLAN FEATURES | |
|---|---|
| ***Short Term Outpatient Rehabilitation Therapies*** | |
| ***Outpatient Physical, Occupational and Speech Therapy*** | 90% per visit after Calendar Year **deductible** |
| Physical, Occupational and Speech Therapy Maximum visits for each therapy per Calendar Year | 60 visits |

| PLAN FEATURES | |
|---|---|
| ***Autism*** | |
| ***Physical therapy, Occupational Therapy, Speech Therapy*** | 90% per visit after Calendar Year **deductible** |
| ***Autism - Behavioral Therapy*** | 90% per visit after Calendar Year **deductible** |
| ***Autism - Applied Behavior Analysis*** | 90% per visit after Calendar Year **deductible** |

| PLAN FEATURES | |
|---|---|
| ***Spinal Manipulation*** | |
| ***Spinal Manipulation*** | 90% per visit after Calendar Year **deductible** |
| Spinal Manipulation Maximum visits per Calendar Year | 25 visits |

## 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 **deductibles** 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**.

**Calendar Year Deductible**

**Individual**
This is an amount of **covered expenses** incurred each Calendar Year for which no benefits will be paid. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** 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.

### Individual

Once the amount of eligible 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 the **covered expenses** that apply toward the limit for the rest 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 **Maximum Out-of-Pocket Limit,** these expenses will also count toward a family **Maximum Out-of-Pocket Limit**.

To satisfy this family **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 **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 **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 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.