# Comprehensive Medical Plan

## Schedule of Benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

**Prepared exclusively for:**

| | |
|---|---|
| **Employer**: | salesforce.com, Inc. |
| **Contract** number: | MSA-883528 |
| | Schedule of Benefits 2A |
| Plan effective date: | January 01, 2019 |
| Plan issue date: | January 01, 2019 |

**These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.**

# Schedule of benefits

This schedule of benefits lists the **deductibles** and **payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **payment percentage** and any limits that apply to the services.

## How to read your schedule of benefits

- The **deductibles** and **payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits 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 health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**

**Important note:**
All **covered benefits** are subject to the Calendar Year **deductible** and **payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

| Plan features | Deductible/Maximums |
|---|---|
| **Deductible** | |
| You have to meet your Calendar Year **deductible** before this plan pays for benefits. | |
| | |
| Individual | $500 per Calendar Year |
| | |
| Family | $1,500 per Calendar Year |
| | |
| **Deductible waiver** | |
| The Calendar Year **deductible** is waived for all of the following **eligible health services:**<br>• Preventive care and wellness<br>• Family planning services - female contraceptives | |
| | |

| Maximum out-of-pocket limit | |
|---|---|
| **Maximum out-of-pocket limit** per Calendar Year. | |
| Individual | $2,500 per Calendar Year |
| | |
| Family | $4,500 per Calendar Year |
| | |
| **Precertification covered benefit reduction** | |
| The booklet contains a complete description of the **precertification** program. You will find details on **precertification** requirements in the *Medical necessity and precertification requirements* section.<br><br>Failure to **precertify** your **eligible health services** when required will result in the following benefits reduction:<br>• A $400 benefit reduction will be applied separately to each type of **eligible health services** or<br>• The **eligible health services** will not be covered.<br><br>The additional percentage or dollar amount of the **recognized charge** which you may pay as a penalty for failure to obtain **precertification** is not a **covered benefit**, and will not be applied to the **deductible** amount or the **maximum out-of-pocket limit**, if any. | |
| | |

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

| | |
|---|---|
| **Eligible health services** | |
| **Preventive care and wellness** | |
| **Routine physical exams** | |
| Performed at a **physician's** office | 100% (of the **recognized charge**) per visit<br><br>No **deductible** applies. |
| Covered persons through age 21: | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.<br><br>For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card. |
| Covered persons age 22 and over but less than 65: Maximum visits per 12 months | 1 visit |
| Covered persons age 65 and over: Maximum visits per 12 months | 1 visit |
| | |
| **Preventive care immunizations** | |
| Performed in a facility or at a **physician's** office | 100% (of the **recognized charge**) per visit<br><br>No **deductible** applies |
| | Subject to any age and visit limits provided for in the comprehensive guidelines supported by 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 your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card. |
| | |
| **Well woman preventive visits routine gynecological exams (including pap smears)** | |
| Performed at a **physician's**, obstetrician (OB), gynecologist (GYN) or OB/GYN office | 100% (of the **recognized charge**) per visit<br><br>No **deductible** applies |
| Maximums | Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. |
| Maximum visits per Calendar Year | 1 visit |
| | |

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

| Preventive screening and counseling services | |
|---|---|
| Office visits<br>• Obesity and/or healthy diet counseling<br>• Misuse of alcohol and/or drugs<br>• Use of tobacco products<br>• Sexually transmitted infection counseling<br>• Genetic risk counseling for breast and ovarian cancer | 100% (of the **recognized charge**) per visit<br><br>No **deductible** applies |
| | |
| **Obesity and/or healthy diet counseling maximums:** | |
| Maximum visits per 12 months<br><br>(This maximum applies only to covered persons age 22 and 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. | |
| | |
| **Misuse of alcohol and/or drugs maximums:** | |
| Maximum visits per 12 months | 5 visits* |
| *Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit. | |
| | |
| **Use of tobacco products maximums:** | |
| Maximum visits per 12 months | 8 visits* |
| *Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit. | |
| | |
| **Sexually transmitted infection counseling maximums:** | |
| Maximum visits per 12 months | 2 visits* |
| *Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit. | |
| | |
| **Genetic risk counseling for breast and ovarian cancer maximums:** | |
| Genetic risk counseling for breast and ovarian cancer | Not subject to any age or frequency limitations |
| | |

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

| **Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)** | |
|---|---|
| Routine cancer screenings | 100% (of the **recognized charge**) per visit<br><br>No **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 your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card. |
| Lung cancer screening maximums | 1 screening every 12 months* |
| ***Important note**:<br>Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section. | |
| | |
| **Prenatal care**<br>**Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)** | |
| Preventive care services only | 100% (of the **recognized charge**) per visit<br><br>No **deductible** applies |
| **Important note:**<br>You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan. | |
| | |
| **Comprehensive lactation support and counseling services** | |
| Lactation counseling services – facility or office visits | 100% (of the **recognized charge**) per visit<br><br>No **deductible** applies |
| Lactation counseling services maximum per 12 months either in a group or individual setting | 6 visits* |
| ***Important note:**<br>Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits. | |
| | |

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

| Breast feeding durable medical equipment | |
|---|---|
| Breast pump supplies and accessories | 100% (of the **recognized charge**) per item<br><br>No **deductible** applies |
| **Important note:**<br>See the *Breast feeding durable medical equipment* section of the booklet for limitations on breast pump and supplies. | |
| | |
| **Family planning services – female contraceptives** | |
| **Counseling services** | |
| Female contraceptive counseling services office visit | 100% (of the **recognized charge**) per visit<br><br>No **deductible** applies |
| Contraceptive counseling services maximum visits per 12 months either in a group or individual setting | 2 visits* |
| ***Important note:**<br>Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits. | |
| | |
| **Devices** | |
| Female contraceptive device provided, administered, or removed, by a **physician** during an office visit | 100% (of the **recognized charge**) per item<br><br>No **deductible** applies |
| | |
| **Female voluntary sterilization** | |
| Inpatient | 100% (of the **recognized charge**) per admission<br><br>No **deductible** applies |
| Outpatient | 100% (of the **recognized charge**) per visit<br><br>No **deductible** applies |
| | |

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| **Eligible health services** | |
|---|---|
| **Physicians and other health professionals** | |
| **Eligible health services** | **Cost share/Deductible/Maximums** |
| **Physicians and other health professionals** | |
| **Physicians** and **specialists** office visits (non-surgical) | |
| **Physician services** | |
| Office hours visits (non-surgical) non preventive care | 90% (of the **recognized charge**) per visit |
| | |
| **Immunizations that are not considered preventive care** | |
| Immunizations that are not considered preventive care | Covered according to the type of benefit and the place where the service is received. |
| | |
| **Physician surgical services** | |
| **Physicians** and **specialists** office visits | |
| Performed at a **physician's** office | 90% (of the **recognized charge**) per visit |
| Performed at a **specialist's** office | 90% (of the **recognized charge**) per visit |
| | |

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| | |
|---|---|
| **Eligible health services** | |
| **Hospital and other facility care** | |
| **Hospital care** | |
| Inpatient **hospital** | 90% (of the **recognized charge**) per admission |
| | |
| **Alternatives to hospital stays** | |
| **Outpatient surgery and physician surgical services** | |
| **Home health care** | |
| Outpatient | 90% (of the **recognized charge**) per visit |
| Maximum visits per Calendar Year | 120<br><br>Limited to: 1 intermittent visit per day provided by a participating **home health care agency**; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care<br><br>The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge |
| | |
| **Hospice care** | |
| Inpatient facility | 90% (of the **recognized charge**) per admission |
| Maximum days per lifetime | Unlimited |
| | |
| **Hospice care** | |
| Outpatient | 90% (of the **recognized charge**) per visit |
| | Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours a day<br><br>Part-time or intermittent home health aide services to care for you up to 8 hours a day |
| | |
| **Outpatient private duty nursing** | |
| Outpatient private duty nursing | 90% (of the **recognized charge**) per visit |
| Maximum visits/shifts per Calendar Year | 180 shifts<br><br>Up to eight hours equal one shift. |
| | |

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|---|---|
| **Skilled nursing facility** | |
| Inpatient facility | 90% (of the **recognized charge**) per admission |
| Maximum Days per Calendar Year | 60 |
| | |
| **Eligible health services** | |
| **Emergency services and urgent care** | |
| | |
| **Emergency services** | |
| **Hospital** emergency room | 90% (of the **recognized charge**) per visit |
| | |
| Non-emergency care in a **hospital** emergency room | 50% (of the **recognized charge** ) per visit after the **deductible** |
| | |
| **Urgent Care** | |
| Urgent medical care (at a non-**hospital** free standing facility) | 90% (of the **recognized charge**) per visit |
| | |

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| **Eligible health services*** | |
|---|---|
| **Specific conditions** | |
| **Autism spectrum disorder** | |
| Autism spectrum disorder treatment | Covered according to the type of benefit and the place where the service is received |
| | |
| Applied behavior analysis | Covered according to the type of benefit and the place where the service is received |
| | |
| All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other **illness** under this plan | |
| | |
| **Birthing Center** | |
| Inpatient | 90% (of the **recognized charge**) per admission |
| | |
| **Diabetic equipment, supplies and education** | |
| Diabetic equipment, supplies and education | 100% (of the **recognized charge**) per item/visit |
| | |
| **Family planning services - other** | |
| **Voluntary sterilization for males** | |
| Outpatient | 90% (of the **recognized charge**) per visit |
| | |
| **Abortion** | |
| Outpatient | 90% (of the **recognized charge**) per visit |
| | |
| **Jaw joint disorder treatment** | |
| **Jaw joint disorder** treatment | 90% (of the **recognized charge**) per visit |
| | |
| **Maternity and related newborn care** | |
| Inpatient | 90% (of the **recognized charge**) per admission |
| | |
| **Delivery services and postpartum care services** | |
| Performed in a facility or at a **physician's** office | 90% (of the **recognized charge**) per visit |
| Other prenatal care services | Covered according to the type of benefit and the place where the service is received. |
| | |

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| **Mental health treatment - inpatient** | |
|---|---|
| Inpatient mental health treatment<br><br>Inpatient **residential treatment facility**<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | 90% (of the **recognized charge**) per admission |
| | |
| **Mental health treatment - outpatient** | |
| Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | 90% (of the **recognized charge**) per visit |
| | |
| Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultation | 90% (of the **recognized charge**) per visit |
| | |
| Other outpatient mental health treatment (includes skilled behavioral health services in the home)<br><br>**Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment)<br><br>**Intensive outpatient program** (at least 2 | 90% (of the **recognized charge**) per visit |

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| | |
|---|---|
| hours per day and at least 6 hours per week of clinical treatment) | |
| | |
| **Substance related disorders treatment - inpatient** | |
| Inpatient **substance abuse detoxification** during a **hospital** confinement<br><br>Inpatient **substance abuse** rehabilitation during a **hospital** confinement<br><br>Inpatient **residential treatment facility** during a **hospital** confinement<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | 90% (of the **recognized charge**) per admission |
| | |
| **Substance related disorders treatment - outpatient: detoxification and rehabilitation** | |
| Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** (includes **telemedicine** consultation)<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | 90% (of the **recognized charge**) per visit |
| | |
| Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | 90% (of the **recognized charge**) per visit |

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| | |
|---|---|
| Other outpatient **substance abuse** services (includes skilled behavioral health services in the home)<br><br>**Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment)<br><br>**Intensive outpatient program** (at least 2 hours per day and at least 6 hours per week of clinical treatment) | 90% (of the **recognized** charge) per visit |
| | |
| **Obesity surgery** | |
| Inpatient **hospital** (includes surgical procedure and acute **hospital** services) | 90% (of the **recognized charge**) per admission |
| | |
| **Outpatient obesity surgery** | |
| | 90% (of the **recognized charge**) per visit |
| | |

| | |
|---|---|
| **Oral and maxillofacial treatment (mouth, jaws and teeth)** | |
| Oral and maxillofacial treatment (mouth, jaws and teeth) | 90% (of the **recognized charge**) per visit |
| | |
| **Reconstructive breast surgery** | |
| Reconstructive breast **surgery** | Covered according to the type of benefit and the place where the service is received |
| | |
| **Reconstructive surgery and supplies** | |
| Reconstructive **surgery** | Covered according to the type of benefit and the place where the service is received |
| | |

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| | |
|---|---|
| **Eligible health services*** | |

| | |
|---|---|
| **Transplant services facility and non-facility** | |
| Inpatient **hospital** transplant services | 90% (of the **recognized charge**) per transplant |
| **Physician** services including office visits | Covered according to the type of benefit and the place where the service is received. |
| | |
| **Eligible health services*** | |
| **Treatment of infertility** | |
| **Basic infertility** | |
| Basic **infertility** | Covered according to the type of benefit and the place where the service is received |
| | |
| **Contact Progyny for covered infertility benefits that are above the basic infertility. Progyny 1-888-461-5067.** | |
| | |
| **Eligible health services** | |
| **Specific therapies and tests** | |
| **Outpatient diagnostic testing** | |

| | |
|---|---|
| **Diagnostic complex imaging services** | |
| | 90% (of the **recognized** charge) per visit |
| | |
| **Diagnostic lab work** | |
| | 90% (of the **recognized** charge) per visit. |
| | |
| **Diagnostic radiological services** | |
| | 90% (of the **recognized** charge) per visit. |
| | |
| **Chemotherapy** | |
| | Covered according to the type of benefit and the place where the service is received. |
| | |

| | |
|---|---|
| **Outpatient infusion therapy** | |
| | 90% (of the **recognized charge**) per visit |
| | |

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

| Outpatient infusion therapy | |
|---|---|
| | Covered according to the type of benefit and the place where the service is received. |
| | |

| Outpatient radiation therapy | |
|---|---|
| Radiation therapy | Covered according to the type of benefit and the place where the service is received. |
| | |

| Short-term cardiac and pulmonary rehabilitation services | |
|---|---|
| **Cardiac rehabilitation** | |
| Cardiac rehabilitation | Covered according to the type of benefit and the place where the service is received |
| | |
| **Pulmonary rehabilitation** | |
| Pulmonary rehabilitation | Covered according to the type of benefit and the place where the service is received |
| | |

| Short-term rehabilitation services | |
|---|---|
| **Short-term rehabilitation services (outpatient physical, occupational, speech therapies)** | |
| | 90% (of the **recognized** charge) per visit. |
| | |

| **Outpatient Physical Therapies Maximum** | |
|---|---|
| Maximum visits per Calendar Year | 60 visits |
| **Outpatient Occupational Therapies Maximum** | |
| Maximum visits per Calendar Year | 60 visits |
| **Outpatient Speech Therapy Maximum** | |
| Maximum visits per Calendar Year | 60 visits |
| | |

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| **Eligible health services*** | |
|---|---|
| **Other services** | |

| **Acupuncture** | |
|---|---|
| Acupuncture | 90% per visit |
| | |
| Maximum visits per Calendar Year | 25 |
| | |

| **Ambulance service** | |
|---|---|
| Ground, air or water **ambulance** | 90% (of the **recognized charge**) per trip |
| | |

| **Clinical trial therapies (experimental or investigational)** | |
|---|---|
| Clinical trial therapies | Covered according to the type of benefit and the place where the service is received |
| | |
| **Clinical trials (routine patient costs)** | |
| Clinical trial (routine patient costs) | Covered according to the type of benefit and the place where the service is received |
| | |

| **Durable medical equipment (DME)** | |
|---|---|
| **DME** | 100% (of the **recognized charge**) per item |
| | |
| **Hearing aids and exams** | |
| Hearing aid exams | Covered according to the type of benefit and the place where the service is received |
| | |
| Hearing aids | 90% per item |
| Maximum per calendar year | $5,000 |
| | |
| **Non-preventive hearing exams** | |
| For adults and children | 90% (of the **recognized charge**) per visit |
| | |

| Maximum | One exam in any 24 consecutive month period. |
|---|---|
| | |

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| **Nutritional supplements** | |
|---|---|
| Nutritional supplements | Covered according to the type of benefit and the place where the service is received |
| | |

| **Prosthetic devices** | |
|---|---|
| Prosthetic devices | Covered according to the type of benefit and the place where the service is received |
| | |
| **Spinal manipulation** | |
| Spinal manipulation | 90% (of the **recognized charge**) per visit |
| | |
| Maximum per Calendar Year | 25 |
| | |

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| **Eligible health services*** | |
|---|---|
| **Family planning services - female contraceptives** | |
| Female contraceptives that are **generic prescription drugs**:<br><br>• Oral drugs<br><br>• Injectable drugs<br><br>• Vaginal rings<br><br>• Transdermal contraceptive patches | 100% per **prescription** or refill<br><br>No **deductible** applies |
| Female contraceptives that are **brand-name prescription drugs**:<br><br>• Oral drugs<br><br>• Injectable drugs<br><br>• Vaginal rings<br><br>• Transdermal contraceptive patches | 100% per **prescription** or refill<br><br>No **deductible** applies |
| Female contraceptive generic devices and brand-name devices | 100% per **prescription** or refill<br><br>No **deductible** applies |
| | |
| **Preventive care drugs and supplements** | |
| Preventive care drugs and supplements filled at a **pharmacy** | 100% per **prescription** or refill<br><br>No **deductible** applies |
| | |

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| Risk reducing breast cancer prescription drugs | |
|---|---|
| Risk reducing breast cancer **prescription drugs** filled at a **pharmacy** | 100% per **prescription** or refill<br><br>No **deductible** applies |
| Maximums: | Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card. |
| | |
| **Tobacco cessation prescription and over-the-counter drugs** | |
| Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply | $0 per **prescription** or refill<br><br>No **deductible** applies |
| Maximums: | Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.<br><br>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card. |
| | |

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## General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**

that are listed in the first part of this schedule of benefits.

### Deductible provisions

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/payment percentage** for **eligible health services** to which the **deductible** does not apply.

**Individual**

This is the amount you owe for **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year. This is true even if the family **deductible** has not yet been met.

**Family**

This is the amount you and your covered dependents owe for **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reaches this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

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

- The combined **eligible health services** 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

**Copayment**

As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

### Payment percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

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## Maximum out-of-pocket limits provisions

**Eligible health services** that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **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.

**Individual**
Once the amount of the **payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

**Family**
Once the amount of the **payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

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.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

## Maximum provisions

**Eligible health services** applied to the **out-of-network** maximum will be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will be applied to satisfy the **out-of-network** maximum.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

## Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits