

SALESFORCE.COM

HEALTH AND WELFARE PLAN

WRAP SUMMARY PLAN DESCRIPTION

Dated: January 1, 2020

VERY IMPORTANT: This Wrap Summary Plan Description (the “Wrap SPD”), together with the certificates of insurance, evidence-of-coverage booklets, summary plan descriptions and/or other descriptions of benefits that have been prepared by insurance companies and/or salesforce.com, inc. with respect to the Salesforce.com Health and Welfare Plan, constitute the Plan’s “summary plan description,” as required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”)

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1. Definitions

Capitalized terms used in this Wrap SPD have the following meanings:

“AD&D” means accidental death and dismemberment insurance.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as amended.

“Company” means salesforce.com, inc. or any successor thereto.

“DCAP” means the dependent care assistance program established by the Company under a separate document. It allows a covered Employee to use pre-tax dollars to pay for the qualifying care of his or her eligible dependents while the Employee and, if applicable, his or her spouse, are working. Please note that this Wrap SPD includes DCAP information for reference only; the DCAP program is not subject to ERISA and is not part of the Plan.

“EAP” means employee assistance program.

“Employee” means any common-law employee of the Company or any affiliate of the Company that participates in the Plan with the approval of the Company who satisfies the eligibility provisions of Section 4 and who is not excluded from participation by the terms of an applicable component benefit program. An “Employee” does not include, however, any individuals classified or treated by the Company or its affiliate as a temporary employee, independent contractor, consultant, leased employee, or employee of an employment agency or entity other than the Company or its affiliate for any period of time, even if he or she is later determined to have been a common-law employee of the Company or its affiliate during that time.

“HDHP” means high deductible health plan.

“Health FSA” collectively means the health care flexible spending account programs (that is, the “Health Care FSA” and “Limited Purpose FSA” programs) established by the Company under a separate document. The Health FSA is a component benefit program under the Plan. It allows a covered Employee to use pre-tax dollars to pay for qualifying health care expenses not reimbursed or paid under other programs.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“HMO” means health maintenance organization.

“Plan” means the salesforce.com Health and Welfare Plan, as amended from time to time. The Plan provides benefits through various component benefit programs.

“Plan Administrator” means the Company.

“PPO” means preferred provider option.

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

2. Introduction

The Company maintains the Plan to provide certain health and welfare benefits to eligible Employees and their eligible dependents, if applicable. These benefits are provided through various component benefit programs that comprise the Plan. The component benefit programs in effect as of January 1, 2020 are listed in the chart below. The component benefit programs may be updated from time to time.

Component Benefit Program	Insured or Self-Funded	Insurance Company or Third-Party Administrator (TPA)
Health FSA and DCAP*	Self-Funded	Connect Your Care 307 International Circle, Suite 200 Hunt Valley, Maryland 21030
Medical (HDHP Standard and HDHP Premium), Medical (PPO), Medical (HMO) and Medical (Indemnity)	Self-Funded	Aetna Life Insurance Company (TPA) 151 Farmington Avenue Harford, CT 06156
Medical (HDHP Standard and HDHP Premium), Medical (PPO), Medical (HMO)	Self-Funded	United Healthcare Services, Inc. (TPA) 9900 Bren Road East Minnetonka, MN 55343
Medical (HMO)	Insured	Kaiser Foundation Health Plan, Inc. - Northern California Region 1 Kaiser Plaza Oakland, CA 94612
Medical (HMO)	Insured	Kaiser Foundation Health Plan of the North West 500 NE Multnomah St., Suite 100 Portland, OR 97232
Medical (PPO)	Insured	Hawaii Medical Service Association, an independent licensee of the Blue Cross and Blue Shield Association P.O. Box 860, Honolulu, Hawaii 96808

Component Benefit Program	Insured or Self-Funded	Insurance Company or Third-Party Administrator (TPA)
Dental (PPO)	Self-Funded	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7339
Vision	Self-Funded	Vision Service Plan (TPA) 3333 Quality Drive Rancho Cordova, CA 95670
Group-Term Life Insurance	Insured	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166
AD&D Insurance	Insured	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166
Short Term Disability for eligible non-California employees only**	Self-Funded	<u>For claims filed on or after January 1, 2020:</u> Matrix Absence Management (TPA) 5225 Hellyer Avenue, #210 San Jose, California 95138
Long Term Disability Insurance	Insured	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166
Employee Assistance Program	Insured	CONCERN: Employee Assistance Program 2400 Grant Road, Suite 100 Mountain View, CA 94020
Business Travel Accident Insurance	Insured	Federal Insurance Company, a Chubb subsidiary 202 Hall's Mill Road, P.O. Box 1600 Whitehouse Station, New Jersey 08889-1600

Component Benefit Program	Insured or Self-Funded	Insurance Company or Third-Party Administrator (TPA)
Expatriate Benefit Plan <ul style="list-style-type: none"> • Global Medical Plan • Global Dental Care • Global Vision Care • International EAP 	Insured	Cigna Health and Life Insurance Company P.O. Box 15050 Wilmington, DE 19850
Inpatriate Benefit Plan <ul style="list-style-type: none"> • Medical • Dental • Vision • EAP 	Insured	Cigna Health and Life Insurance Company P.O. Box 15050 Wilmington, DE 19850
Medical Benefits Abroad Policy <ul style="list-style-type: none"> • Urgent and Emergency Medical • Emergency Dental 	Insured	Cigna Health and Life Insurance Company P.O. Box 15050 Wilmington, DE 19850

* Although this Wrap SPD includes DCAP information for your reference, the DCAP program is not subject to ERISA and is not part of the Plan.

** Note, California employees may be eligible to receive short-term disability benefits through the Company's Voluntary Disability Insurance Plan (the "VDI Plan"). The VDI Plan is not subject to ERISA and is not part of the Plan.

Each component benefit program is summarized in a certificate of insurance or evidence-of-coverage booklet issued by the applicable insurance company or a summary plan description or other description of benefits prepared specifically for that component benefit program by the Company (each, a "Benefit Booklet"). The Benefit Booklets are incorporated into this Wrap SPD by reference, which means that the information set forth in the Benefit Booklets is considered to be part of this Wrap SPD.

The Benefit Booklets that are currently in effect are listed in Section 13 and may be updated from time to time. Upon your enrollment in a component benefit program, a copy of the Benefit Booklet for that program will be distributed to you electronically or, in some cases, by mail. If you don't receive the Benefit Booklets for the component benefit programs in which you are enrolled or need duplicate copies at no charge, please contact the Plan Administrator (see Section 3 for the contact information). The latest Benefit Booklets are available for review at any time at www.getsalesforcebenefits.com.

IMPORTANT: Please note that you must read a component benefit program's Benefit Booklet for more details on specific items such as the program's eligibility requirements for participation, benefit coverage, definitions, coordination of benefit rules, reimbursement/subrogation rules, procedures that must be followed in order to make a claim for benefits and/or appeal a denied claim, exclusions and limitations on benefits, and other terms and conditions and/or restrictions.

When you are first eligible to enroll in the Plan, the Plan Administrator will provide you with enrollment and benefit information, as well as applicable enrollment instructions (collectively, the "Enrollment Materials"). You must complete the specified enrollment process within 30 calendar days of the date you first become eligible.

Purpose of This Wrap SPD

You are being provided this Wrap SPD to give you an overview of the Plan as in effect on January 1, 2020 (except as otherwise specified in the Wrap SPD) and to address certain information that may not be addressed in the Benefit Booklets. As noted earlier, this Wrap SPD, together with the Benefit Booklets, constitute the Plan's "summary plan description," as required by ERISA (the "Summary Plan Description"). This Wrap SPD is not intended to give you any substantive rights to benefits that are not already provided in the Benefit Booklets. You must read the Summary Plan Description (that is, this Wrap SPD and the applicable Benefit Booklets) to understand your benefits!

Application Forms

Some of the component benefit programs require completion of application forms, annual elections, and/or other administrative forms (which may be in electronic form). The details of these administrative requirements are described in the applicable Benefit Booklets and/or in the Enrollment Materials provided by the Plan Administrator.

3. General Information About the Plan

Plan Name

salesforce.com Health and Welfare Plan

Type of Plan

The Plan is a health and welfare benefit plan that provides the coverages listed in Section 2. The Plan also includes a cafeteria plan under Code §125 (the “Cafeteria Plan”) and DCAP under Code §129. The Cafeteria Plan and DCAP, however, are not subject to ERISA.

Plan Year

The Plan year is January 1 to December 31.

Plan Number

The Plan number is 501.

Funding Method and Type of Plan Administration

As described in the chart in Section 2, some of the component benefit programs that comprise the Plan are self-funded (that is, they are funded from the general assets of the Company), and other component benefit programs are insured (that is, they are funded entirely through group insurance contracts entered into between the Company and the applicable insurance companies (“Insurance Contracts”)). The Company is solely responsible for paying qualifying claims for benefits under the self-funded component benefit programs. The insurance companies, not the Company, are solely responsible for paying qualifying claims for benefits under the insured component benefit programs.

As discussed below in Section 7, the Company, as the Plan Administrator, and its authorized delegates, as well as the insurance companies listed in Section 2, share responsibility for administering the component benefit programs under the Plan.

Source of Premiums/Contributions

Insurance premiums and/or contributions for coverage under the Plan are paid by the Company out of its general assets and, when required by the Company, by Plan participants, on a pre-tax basis and/or after-tax basis, as applicable.

If eligible, Plan participants may pay for certain component benefit program coverage on a pre-tax basis through the Cafeteria Plan.

The Plan Administrator will provide a schedule of the applicable premiums or contributions during the Plan's enrollment period(s) and upon request for each of the component benefit programs, as applicable.

Neither the Plan nor any of the component benefit programs offered through it have a trust.

Plan Sponsor

salesforce.com, inc.
415 Mission St
3rd Floor
San Francisco, CA 94105
1-415-901-7000

Plan Sponsor's Employer Identification Number

94-3320693

Insurance Companies

See the chart in Section 2 for a list of the insurance companies with respect to the insured component benefit programs in effect as of January 1, 2020.

Plan Administrator

salesforce.com, inc.
Attn: Human Resources VP
415 Mission St
3rd Floor
San Francisco, CA 94105
1-415-901-7000

Agent for Service of Legal Process

General Counsel of salesforce.com, inc., on behalf of the Plan Administrator
salesforce.com, inc.
415 Mission St
3rd Floor
San Francisco, CA 94105
1-415-901-7000

COBRA Administrator

Individual Billing Administration & COBRA Services
P.O. Box 14391
Lexington, KY 40512-4391
1-800-429-9526
www.MemberIBA.com

Important Disclaimer: Official Plan Documents Control

Plan benefits are provided pursuant to Insurance Contracts and pursuant to other governing written Plan documents adopted by the Company from time to time (the "Plan Documents"). The Summary Plan Description does not contain all of the terms and conditions of the Insurance Contracts and the Plan Documents (together, the "Official Plan Documents"). To the extent that the terms and conditions of the Plan as described in the Summary Plan Description or in any oral descriptions provided about your benefits conflict with the provisions of the Official Plan Documents (or are missing from the Summary Plan Description), the wording of the Official Plan Documents will control, rather than the Summary Plan Description, unless otherwise required by applicable law.

The Official Plan Documents are available for your review during normal business hours in the Company's Benefits Department.

No Vested Rights to Plan Benefits

You have no vested rights to any benefits under the Plan. The Company may amend or terminate the Plan or any part of the Plan at any time and for any reason, subject to applicable law (see Section 8 for more information).

4. Eligibility and Participation Requirements

Eligibility and Participation

Eligible Employees:

An eligible Employee with respect to the Plan is any Employee who is eligible to participate in and receive covered benefits under one or more of the component benefit programs.

You generally are an eligible Employee if you are a U.S. full-time or part-time Employee (including intern) who is regularly scheduled to work 20 hours or more per week.

Important: Please note, however, that the eligibility and participation requirements may vary depending on the particular component benefit program. Certain component benefit programs may not be available to all Employees and their family members. For example, the Aetna Comprehensive Medical Plan (Indemnity) (“Aetna Indemnity”) option currently offered under the Plan is available only to otherwise eligible Employees who live in areas where the applicable Aetna provider network is not available, as determined by the Employees’ home zip codes. To determine whether you or your family members are eligible to participate in a particular component benefit program, please read the eligibility information contained in the related Benefit Booklet and/or contact the Plan Administrator. The Plan Administrator has the discretionary authority to determine whether an individual meets the eligibility requirements for participation in any particular component benefit program and such determination will be final and binding. You must satisfy the eligibility, enrollment and participation requirements under a particular component benefit program in order to receive any covered benefits under that program.

The Company reserves the right to change the Plan’s eligibility rules at any time and for any reason, subject to applicable law.

Notwithstanding any contrary provision in the Summary Plan Description, you are not eligible to participate in the Plan if you are classified or treated by the Company or its affiliate as a temporary employee, independent contractor, employee of an employment agency or entity other than the Company or its affiliate, leased employee or other non-employee for any period of time, even if you are later determined to have been a common-law employee of the Company or its affiliate during that time.

Eligible Dependents:

If you are an eligible Employee, you generally can enroll the following individuals as your dependents in a component benefit program that offers dependent coverage:

- your spouse or qualifying domestic partner;
- your child(ren) and/or your spouse's/qualifying domestic partner's child(ren) who are under age 26; and
- your child(ren) and/or your spouse's/qualifying domestic partner's child(ren) who are age 26 or older and solely dependent on you for support due to a mental or physical disability.

(Note: you may enroll your eligible dependents only if you are enrolled.)

For purposes of the Plan, your "spouse" generally means the spouse to whom you are legally married.

Your "qualifying domestic partner," for purposes of the Plan, generally means a person who has been in an ongoing and committed spouse-like relationship with you that has existed for at least 6 months, is at least 18 years of age, and meets certain other criteria as specified in the Company's Declaration of Domestic Partnership form (which must be timely completed by you and your qualifying domestic partner and provided to the Plan Administrator or its delegate, as set forth on the form, in order for any applicable Plan coverage to become effective for your qualifying domestic partner). To request a copy of the Company's Declaration of Domestic Partnership form, please contact the Plan Administrator.

Your "children," for purposes of the Plan, generally means your biological children, your stepchildren, legally-adopted children, your foster children, including any children placed with you for legal adoption, and children for whom you are responsible under court order.

Important: Please note, however, that the eligibility and participation requirements may vary depending on the particular component benefit program. Certain component benefit programs may not be available to all Employees and their family members. For example, the dependent eligibility requirements under a self-funded medical plan option under the Plan may differ from the dependent eligibility requirements under an insured medical plan option. To determine whether you or your family members are eligible to participate in a particular component benefit program, please be sure to review the eligibility information set forth in the related Benefit Booklet carefully and/or contact the Plan Administrator. The Plan Administrator will determine whether an individual meets the eligibility

requirements for participation in any particular component benefit program and such determination will be final and binding.

You and any covered dependent(s) must satisfy the eligibility, enrollment and participation requirements under a particular component benefit program in order to receive any covered benefits under that program.

No Duplicate Coverage

No person may be covered as both an Employee and a dependent under the Plan, and no person may be covered as a dependent of more than one Employee. This means that you may not cover your dependent under the Plan if that dependent also is an eligible Employee who has elected his or her own coverage under the Plan.

Need for Enrollment: Time Limits

While coverage under some of the Plan's component benefit programs are provided automatically to eligible Employees, other component benefit programs require eligible Employees to complete the enrollment process specified in the applicable Benefit Booklets and Enrollment Materials, in order to enroll themselves and their eligible dependents, if applicable. For component benefit programs that require enrollment action, newly-hired eligible Employees generally must enroll within certain time periods after being hired (generally 30 calendar days), as described in the related Benefit Booklet and Enrollment Materials. Thereafter, you generally will not be allowed to change your enrollment status and/or coverage levels until the annual open enrollment period that occurs during the fourth quarter of each year, except as described in the "*HIPAA Special Enrollment Rights for Medical Plan Coverage*" section below and in the applicable Benefit Booklets and Enrollment Materials.

HIPAA Special Enrollment Rights For Medical Plan Coverage

HIPAA requires that you be notified of your right to enroll in medical plan coverage offered under the Plan (the "Medical Plan") pursuant to its "special enrollment provision" if you acquire a new qualifying dependent, or if you decline enrollment in the Medical Plan for yourself or a qualifying dependent while other coverage is in effect and that other coverage is later lost due to certain qualifying reasons.

If you decline enrollment in Medical Plan coverage for yourself or for a qualifying dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your qualifying dependents in any Medical Plan option if you or

your qualifying dependent loses eligibility for that other coverage (or if the employer stops contributing toward your or your qualifying dependents' other coverage). However, you must request such enrollment in accordance with the Plan's enrollment procedures within 31 calendar days after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage). The Plan Administrator may request proof of the loss of the other health insurance or group health plan coverage.

If you decline enrollment in Medical Plan coverage for yourself or for a qualifying dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program ("CHIP") is in effect, you may be able to enroll yourself and your qualifying dependents in any Medical Plan option if you or your qualifying dependent loses eligibility for that other coverage. However, you must request such enrollment in accordance with the Plan's enrollment procedures within 60 calendar days after your or your dependent's coverage ends under Medicaid or CHIP. The Plan Administrator may request proof of the loss of eligibility for Medicaid or CHIP coverage.

If you have a new qualifying dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new qualifying dependent in any Medical Plan option. However, you must request such enrollment in accordance with the Plan's enrollment procedures within 31 calendar days after the marriage, birth, adoption, or placement for adoption. The Plan Administrator may request proof of your gaining a new qualifying dependent.

If you or your qualifying dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through CHIP with respect to Medical Plan coverage, you may be able to enroll yourself and your qualifying dependents in any Medical Plan option. However, you must request such enrollment in accordance with the Plan's enrollment procedures within 60 calendar days after the applicable determination of eligibility for such assistance. The Plan Administrator may request proof of the eligibility for premium assistance.

Any requests for special enrollment or to obtain more information should be directed to the Plan Administrator.

When Participation Begins

Coverage under a component benefit program generally begins once you, as an eligible Employee, have completed any necessary enrollment actions or if the program does not require any enrollment action on your part, when you become eligible for the program, if earlier. Requirements may vary

depending on the component benefit program. For information about when coverage begins, please read the eligibility and participation information contained in the applicable Benefit Booklets.

Please note that if you enroll in the Aetna PPO option but you do not live in an area where the applicable Aetna provider network is available, as determined by your home zip code, then you and any eligible dependents whom you elected to cover will instead be enrolled in the Aetna Indemnity option.

Termination of Participation

In general, your coverage under this Plan (including all component benefit programs) terminates on the last day of the month in which you terminate employment with the Company or its participating affiliate. Your participation and the participation of any covered dependents in a component benefit program also terminates if you fail to pay your share of the required premium or contribution toward the cost of coverage, if you or your covered dependents cease to meet the eligibility requirements for participation, if you submit false claims or misrepresent your or your dependents' eligibility for benefit coverage, the Plan or applicable component benefit program terminates or for any other reasons described in the related Benefit Booklet.

Coverage for your covered dependents stops when your coverage stops and for other reasons specified in the related Benefit Booklets (for example, divorce or a dependent's attaining the age limit). Note that termination of coverage under a particular component benefit program does not necessarily mean your coverage under the Plan in general terminates. You may still have coverage under another component benefit program.

You must consult the applicable Benefit Booklet for specific termination events and information.

Note, however, that federal and state laws may provide a special right to a temporary continuation of group health plan coverage offered under the Plan ("Health Care Plan Coverage") if such coverage is lost due to a qualifying event (please see the "*Continuation Coverage Under COBRA and USERRA*" section below for more details).

Supporting Documentation

When you enroll yourself and/or your eligible dependent(s) in the Plan, you are certifying that you (and your dependent, if applicable) satisfy the eligibility requirements for Plan coverage. By enrolling in the Plan, you agree to notify the Plan Administrator as soon as possible, but in no event later than 31 calendar days, after you or your covered dependent ceases to meet the eligibility requirements for

coverage under the Plan. Once any covered dependent is no longer an eligible dependent, his or her coverage under a component benefit program will continue only through the date specified in the related Benefit Booklet. In some cases, however, a temporary continuation coverage of Health Care Plan Coverage may be available through COBRA. (See the “*Continuing Coverage Under COBRA and USERA*” below for more information.)

From time to time, the Plan Administrator or its authorized delegate may ask you to provide appropriate certification(s) and/or information/documentation for any of the elections or changes that you request under the Plan, including, but not limited to, marriage certificates, verification of domestic partnership, address information, tax documentation and more, which you must provide within the time specified by the Plan Administrator or its delegate.

Very Important: If the Plan Administrator or its delegate requests that you certify your and/or your covered dependent’s eligibility or continued eligibility under the Plan and/or requests that you provide information/documentation verifying your and/or your covered dependent’s eligibility or continued eligibility under the Plan and you fail to do so within the time period specified by the Plan Administrator or its delegate, your and/or your dependent’s coverage under the Plan, as applicable, will be terminated and may not be reinstated even if you and/or your dependent may otherwise be eligible.

By enrolling in the Plan, you agree to reimburse the Company or the applicable insurance company for any and all taxes, penalties, or other losses (including, for example, repaying any benefits received) that the Company or the insurance company may incur as a result of its reliance on your certifications described above if they are untrue or incorrect in any respect, or if you fail to timely provide any required notice described above.

Termination of Coverage for Misrepresentation

As noted earlier, if you make a misrepresentation under the Plan, the Plan Administrator has the right to permanently terminate coverage for you and all of your otherwise eligible dependents. The Plan Administrator also has the right to seek reimbursement from you for any claims and expenses paid pursuant to the Plan as a result of the misrepresentation, and may pursue legal action against you. Misrepresentations include, but are not limited to, submitting falsified claims and obtaining coverage or services for an individual who is ineligible.

Please note that any Health Care Plan Coverage generally cannot be rescinded (that is, canceled or discontinued retroactively) for any individual (including any group classification in which the individual is included) once he or she becomes covered, unless the Plan Administrator (or its delegate)

determines that the individual (or a person seeking coverage on behalf of the individual) has performed an act, practice or omission that constitutes fraud with respect to such coverage, or unless the individual makes an intentional misrepresentation of a material fact with respect to such coverage (for example, if you fail to timely advise the Plan Administrator that your covered dependent no longer satisfies the eligibility rules for dependent coverage or if you fail to timely respond to the Plan Administrator's request for proof of dependent eligibility, as required under the Plan).

A cancellation or discontinuance of Health Care Plan Coverage is not a rescission, however, if (1) the cancellation or discontinuance of coverage has only a prospective effect, (2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums/contributions toward the cost of coverage, or (3) the cancellation or discontinuance is effective retroactively for continuation coverage under COBRA for which a qualified beneficiary did not make a timely election or timely payment of the applicable COBRA premium/contribution amount (see the "*Continuation Coverage Under COBRA and USERRA*" section below for more information).

If your Health Care Plan Coverage is going to be rescinded, you will receive at least 30 calendar days' advance written notice. Any such rescission under the Plan will be considered an adverse benefit determination. You will then have the opportunity to appeal the rescission as described in Section 10 below.

Continuation Coverage Under COBRA and USERRA

COBRA Coverage

This section applies to everyone with Health Care Plan Coverage. It contains important information about "COBRA Coverage," which is a temporary extension of Health Care Plan Coverage (that is, coverage under any medical (including prescription drug), dental, vision, Employee Assistance Program (but only to the extent it provides medical care) and Health FSA component benefit programs under the Plan). **This notice generally explains COBRA Coverage, when it may become available to you and your family, and what you and your family need to do to protect the right to receive it.** When you become eligible for COBRA Coverage, you also may become eligible for other coverage options that may cost less than COBRA Coverage. COBRA (and the description of COBRA Coverage set forth below) applies only to Health Care Plan Coverage and not to any other coverages offered under the Plan or by the Company.

The right to COBRA Coverage was created by a federal law called COBRA. COBRA Coverage can become available to you, your spouse, and your dependent children when Health Care Plan Coverage would otherwise end. For additional information about your rights and obligations under the Plan and under federal law, you should contact the COBRA Administrator or Plan Administrator (see Section 2 for the applicable contact information). The Plan provides no greater COBRA rights than what COBRA requires - nothing in the Summary Plan Description is intended to expand your rights beyond COBRA's requirements.

You may have other options available to you when you lose Health Care Plan Coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA Coverage?

COBRA Coverage is a temporary continuation of Health Care Plan Coverage when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator or COBRA Administrator, as specified below, COBRA Coverage must be offered to each person losing Health Care Plan Coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA Coverage if Health Care Plan Coverage is lost because of the qualifying event. Certain newborns, newly-adopted children, and alternate recipients under qualified medical child support orders also may be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the Plan, qualified beneficiaries who elect COBRA Coverage must pay for such coverage.

Who is Entitled to Elect COBRA Coverage?

If you are an employee, you will be entitled to elect COBRA Coverage if you lose Health Care Plan Coverage because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends (other than because of your gross misconduct).

If you are the spouse of an employee, you will be entitled to elect COBRA Coverage if you lose Health Care Plan Coverage because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends (other than because of his/her gross misconduct); or
- You become divorced from your spouse. Also, if your spouse (the employee) reduces or eliminates your Health Care Plan Coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your Health Care Plan Coverage was reduced or eliminated before the divorce.

If you are the dependent child of an employee, you will be entitled to elect COBRA Coverage if you lose Health Care Plan Coverage because any of the following qualifying events happens:

- Your parent-employee dies;
- Your parent-employee's hours of employment are reduced;
- Your parent-employee's employment ends (other than because of his/her gross misconduct);
- You stop being eligible for such coverage as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA Coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment (other than because of the employee's gross misconduct), reduction in hours of employment, or death of the employee, the Plan will offer COBRA Coverage to qualified beneficiaries. You do not need to notify the COBRA Administrator or Plan Administrator of any of these qualifying events.

You Must Give Notice of Certain Qualifying Events.

For all of the other qualifying events (i.e. divorce of the employee and spouse or a dependent child's losing eligibility for Health Care Plan Coverage as a "dependent child"), a COBRA Coverage election will be available to you only if you notify the Plan Administrator in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) Health Care Plan Coverage under the terms of the Plan as a result of the qualifying event. Failure to timely comply with this notice requirement will result in ALL QUALIFIED BENEFICIARIES LOSING THEIR RIGHT TO ELECT COBRA COVERAGE.

Electing COBRA Coverage.

Once any notice requirements described above are satisfied, COBRA Coverage will be offered to each of the qualified beneficiaries.

How To Elect COBRA Coverage. To elect COBRA Coverage, you must complete the Election Form that is part of the Plan's COBRA election notice and timely return it by mail according to the directions on the Election Form. (A COBRA election notice generally will be provided to qualified beneficiaries at the time of a qualifying event.)

Deadline for COBRA Coverage Election. Your properly completed Election Form must be postmarked no later than 60 calendar days after the COBRA election notice was provided to you (or, if later, 60 calendar days after the date that your Health Care Plan Coverage was lost due to the qualifying event). **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE.**

Independent Election Rights. Each qualified beneficiary will have an independent right to elect COBRA Coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA Coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA Coverage on behalf of their children. **Any qualified beneficiary for whom COBRA Coverage is not elected by the end of the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

Are There Other Coverage Options Besides COBRA Coverage?

Yes. Instead of enrolling in COBRA Coverage, there may be other options for you and your family through the Health Insurance Marketplace, Medicaid, or another group health plan. Some of these options may cost less than COBRA Coverage.

Health Insurance Marketplace. The Marketplace is intended to offer "one-stop shopping" to find and compare private health insurance options. Through the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions that lower your out-of-pocket costs for deductibles, coinsurance, and co-payments. You have a 60-day special enrollment period following the time you lose your job-based coverage in which to enroll in the Marketplace. After 60 days, your special enrollment period will end, and you may not be able to enroll until the Marketplace's next annual open enrollment period. To find out more about enrolling in the Marketplace, visit www.HealthCare.gov.

Enrollment in Another Group Health Plan. You may be eligible to enroll in coverage under another group health plan (such as your spouse's plan) if you request enrollment within 30 calendar days of the loss of coverage. If you or your dependent chooses to elect COBRA Coverage instead of enrolling in another group health plan for which you're eligible, you may have another opportunity to enroll in the other group health plan within 30 calendar days of losing your COBRA Coverage.

Length of COBRA Coverage.

As noted earlier, COBRA Coverage is a temporary continuation of Health Care Plan Coverage. The COBRA Coverage periods described below are maximum coverage periods only.

COBRA Coverage can end before the end of the maximum coverage period for several reasons, which are described in the paragraph below entitled “*Termination of COBRA Coverage Before the End of the Maximum Coverage Period.*”

Death, Divorce, or Child’s Loss of Dependent Status. When Health Care Plan Coverage is lost due to the death of the employee, the covered employee’s divorce, or a dependent child’s losing eligibility as a dependent child, COBRA Coverage can last for up to a total of 36 months.

If the Covered Employee Becomes Entitled to Medicare Within 18 Months Before His or Her Termination of Employment or Reduction of Hours. When Health Care Plan Coverage is lost due to the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA Coverage for qualified beneficiaries (other than the employee) who lose such coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his/her employment terminates, COBRA Coverage for his/her or her spouse and children who lost Health Care Plan Coverage as a result of the termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA Coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Termination of Employment or Reduction of Hours. Otherwise, when Health Care Plan Coverage is lost due to the end of employment or reduction of the employee’s hours of employment, COBRA Coverage generally can last for only up to a total of 18 months.

Note: Notwithstanding the foregoing, any COBRA Coverage under the Health FSA component benefit program can last only until the end of the Plan Year in which the qualifying event occurred (see the “*COBRA Coverage Under the Health FSA*” section below for more details).

Extension of Maximum Coverage Period (Not Applicable to the Health FSA).

If the qualifying event that resulted in your COBRA Coverage election was the covered employee’s termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator or Plan Administrator, as specified below, of a disability or a second qualifying event in order to extend the period of COBRA Coverage. Failure to provide notice of a

disability or second qualifying event will eliminate the right to extend the period of COBRA Coverage. (Note, any period of COBRA Coverage under the Health FSA cannot be extended under any circumstances. These extension opportunities also do not apply to any period of COBRA Coverage resulting from a covered employee's death, divorce or a dependent child's loss of eligibility.)

Disability Extension of COBRA Coverage. If a qualified beneficiary is determined by the Social Security Administration ("SSA") to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA Coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA Coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st calendar day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA Coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You Must Notify the COBRA Administrator of a Qualified Beneficiary's Disability by This Deadline. The disability extension is available only if you notify the COBRA Administrator in writing of the SSA's determination of disability within 60 days after the latest of:

- the date of the SSA's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) Health Care Plan Coverage as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. **If written notice of the SSA's disability determination is not provided to the COBRA Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction in hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second Qualifying Event Extension of Cobra Coverage. An extension of coverage will be available to spouses and dependent children who are receiving COBRA Coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA Coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce from the covered employee, or a dependent child's ceasing to be eligible for Health Care Plan Coverage as a

dependent. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose Health Care Plan Coverage if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

You Must Notify the Plan Administrator of a Second Qualifying Event by This Deadline. This extension due to a second qualifying event is available only if you notify the Plan Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. **If written notice of the second qualifying event is not provided to the Plan Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Note, however, that any COBRA Coverage under the Health FSA can last only until the end of the year in which the qualifying event occurred (see “COBRA Coverage Under the Health FSA” below for more details).

Termination of COBRA Coverage Before the End of the Maximum Coverage Period.

COBRA Coverage automatically will terminate before the end of the maximum period if:

- any required premium or contribution is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA Coverage, under another group health plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both) after electing COBRA coverage;
- the Company ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the SSA to be no longer disabled (in which case COBRA Coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate). For more information about the disability extension period, see the “*Extension of Maximum Coverage Period (Not Applicable to the Health FSA)*” section above.”

COBRA Coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving COBRA Coverage (such as fraud).

You Must Notify the COBRA Administrator If a Qualified Beneficiary Becomes Entitled to Medicare or Obtains Other Group Health Plan Coverage. You must notify the COBRA Administrator in writing within 30 calendar days if, after electing COBRA Coverage, a qualified beneficiary

becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other group health plan. In addition, if you were already entitled to Medicare before electing COBRA Coverage, you must notify the COBRA Administrator of the date of your Medicare entitlement.

You Must Notify the Plan Administrator If a Qualified Beneficiary Ceases to Be Disabled. If a disabled qualified beneficiary is determined by the SSA to no longer be disabled, you must notify the Plan Administrator of that fact in writing within 30 calendar days after the SSA's determination.

Cost of COBRA Coverage.

Except as described below, each qualified beneficiary will be required to pay the entire cost of COBRA Coverage, plus an administration charge. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA Coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions or premiums) for coverage of similarly situated participants who are not receiving COBRA Coverage. The amount of your COBRA Coverage contributions or premiums may change from time to time during your period of coverage and will most likely increase over time. You will be notified of changes in COBRA Coverage contributions or premiums.

Payment for COBRA Coverage.

How COBRA Coverage Contribution or Premium Payments Must be Made. All COBRA Coverage contributions or premiums must be paid by check. Your first payment and all monthly payments for COBRA Coverage must be mailed to the payment address specified in the Election Notice. However, if the COBRA Administrator or Plan Administrator notifies you of a new address for payment, you must mail all payments for COBRA Coverage to the address specified in that notice of a new address.

When COBRA Coverage Contribution or Premium Payments Are Considered to be Made. Your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

First Payment for COBRA Coverage. If you elect COBRA Coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA Coverage within 45 calendar days after the date of your election (that is, the date the Election Form is post-marked).

Your first payment must cover the entire cost of COBRA Coverage from the time your Health Care Plan Coverage would have otherwise terminated through the end of the month in which you

make your first payment. Your COBRA Coverage will not be effective until such payment is received in a timely manner. You are responsible for making sure that the amount of your first payment is correct. You should contact the COBRA Administrator to confirm the amount of your first payment.

If you do not make your first payment for COBRA coverage in full within that 45-day period, you will lose all COBRA Coverage rights under the Plan.

Monthly Payments for COBRA Coverage. After you make your first timely payment for COBRA Coverage, you will be required to make monthly payments for each subsequent month of COBRA Coverage. The amount due for each month for each qualified beneficiary will be disclosed in the COBRA Coverage election notice provided to you. Each of these monthly payments for COBRA Coverage will be due on the first day of the month for that month's COBRA Coverage. If your payment is received on or before the due date, your COBRA Coverage under the Plan will continue for that month without any break. All such payments must be sent to the COBRA Administrator at the address provided.

Grace Periods for Monthly COBRA Contribution or Premium Payments. Although monthly payments are due on the first day of each month of COBRA Coverage, you will be given a grace period of 30 calendar days after the first day of the month to make each monthly payment. Your COBRA Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you make a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your COBRA Coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received by the COBRA Administrator. This means that any claim you submit for covered benefits while your COBRA Coverage is suspended may be denied and may have to be resubmitted once your COBRA Coverage is reinstated.

Please remember that if you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA Coverage under the Plan.

COBRA Coverage Under the Health FSA.

Notwithstanding the foregoing, if you or your qualified beneficiary lose coverage under a Health FSA due to a qualifying event, you or the qualified beneficiary may be able to elect to temporarily continue such coverage on an after-tax basis, but only if the cost of coverage for the remainder of the Plan Year does not exceed the amount you or the qualified beneficiary could recover in benefits for the remainder of the Plan Year. If you or your qualified beneficiaries are entitled to such COBRA Coverage, it will end as of the end of the Plan Year in which the qualifying event occurred (unless the coverage is cut short as permitted by COBRA). However, qualified beneficiaries who continue

COBRA Coverage under the Health FSA through the end of that Plan Year may carry over up to \$500 of unused Health FSA amounts remaining at the end of that Plan Year in accordance with the carryover provisions of the Health FSA component benefit program, until the end of the applicable maximum COBRA Coverage period that applies to the qualifying event or, if earlier, until the amounts are used up.

Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for any COBRA Coverage under the Health FSA. However, each qualified beneficiary could alternatively elect separate COBRA Coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate COBRA contribution. If you are interested in this alternative, if available, contact the COBRA Administrator for more information.

Note: Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

More Information About Individuals Who May Be Qualified Beneficiaries.

Children Born to or Placed for Adoption With the Covered Employee During a Period of COBRA Coverage. A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA Coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA Coverage for himself/herself. The child's COBRA Coverage begins when the child is enrolled in the group health plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA Coverage lasts for other family members of the employee. To be enrolled in the group health plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

Alternate Recipients Under QMCSOs. A child of the covered employee who is receiving benefits under the group health plan pursuant to a qualified medical child support order (a "QMCSO") received by the Plan Administrator during the covered employee's period of employment with the Company is entitled to the same rights to elect COBRA Coverage as an eligible dependent child of the covered employee.

State Continuation Coverage.

If you exhaust federal COBRA Coverage under an insured group health plan, you may be eligible for additional months of continuation coverage under applicable state continuation coverage laws. For details about any additional state continuation coverage that may be available and related requirements, see the applicable Benefit Booklet for the insured group health plan or contact the applicable insurance company.

USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about any coverage available under a particular component benefit program pursuant to USERRA is included in the related Benefit Booklet.

5. Summary of Plan Benefits

Available Benefits and Contributions

The Plan provides you (and, in some cases, your eligible dependents) with the coverages listed in Section 2. A summary of each component benefit program provided under the Plan is set forth in the related Benefit Booklets.

In general, the cost of the benefits provided through the component benefit programs will be funded in part by Company contributions and in part by employee contributions (which may be pre-tax or after-tax, subject to the terms of the Cafeteria Plan and applicable component benefit program). The Company will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

With respect to the insured component benefit programs, the Company will pay its contribution and your contributions to the applicable insurance company. With respect to benefits that are self-funded, the Company will use its contribution and your contributions to pay covered benefits directly to (or on behalf of) you or your covered dependents from the Company's general assets. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

Health benefits under the Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, caps, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limits on coverage for certain services, drugs, medical tests, medical devices or medical procedures. These limitations are set forth in the Plan Documents and are explained in your Benefit Booklet(s).

Please note that the Company reserves the right to change the level of benefits provided under the Plan at any time and for any reason, to the extent permitted by applicable law.

Qualified Medical Child Support Orders

With respect to Health Care Plan Coverage, the Plan will extend coverage to an eligible Employee's non-custodial child, as required by any QMCSO, pursuant to ERISA. You will be responsible for paying the cost of any such child's Health Care Plan Coverage. The Plan has procedures for

determining whether an order qualifies as a QMSCO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator. All correspondence and questions concerning a QMCSO should be directed to the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please keep in mind, however, that pre-certification may be required for a hospital stay of more than 48 or 96 hours, as applicable, in connection with childbirth. The laws of your state related to hospital stays in connection with childbirth may differ from these Federal requirements. Consult the applicable Plan Documents or Benefit Booklets for more information.

Women's Health and Cancer Rights Act of 1998 ("WHCRA")

If you or your covered dependents have had or are going to have a mastectomy, you may be entitled to certain rights under the WHCRA. For individuals receiving mastectomy-related benefits under a Medical Plan option, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable Medical Plan option.

Mental Health Parity

The Mental Health Parity Act and Mental Health Parity and Addiction Equity Act contain certain requirements for group health plans and health insurance issuers concerning certain mental health and substance use disorder benefits. Any component benefit program that is subject to these requirements will provide for applicable parity of any aggregate dollar limits with respect to any mental health and substance use disorder benefits that may be provided. In addition, each such component benefit program will provide for applicable parity between any medical/surgical benefits offered by the program, on the one hand, and any mental health/substance use disorder benefits, on the other, as to any financial requirements (such as deductibles, co-payments, co-insurance and out-of-pocket maximums) and quantitative treatment limitations (such as number of treatments, visits or days of coverage). Such component benefit program also must comply with other parity-related requirements for nonquantitative treatment limitations (such as medical management standards).

However, the above should not be construed to require the Company to provide any coverage for any mental health or substance use disorder benefits under any component benefit program, except as required by applicable law. Please refer to the applicable Benefit Booklets for additional information.

Genetic Information Nondiscrimination Act of 2008 (“GINA”)

GINA contains certain requirements for group health plans and health insurance issuers prohibiting genetic discrimination, required genetic testing, purchasing or collecting genetic information and disclosure of genetic information except in limited circumstances. In the unlikely event that any genetic information is received by the Company, it will be maintained confidentially in accordance with the requirements of GINA. Please refer to the applicable Benefit Booklets for additional information.

Physician Designation Notice

The Medical Plan option in which you are enrolled, if applicable, may require or allow for the designation of a primary care provider for you and your covered dependents. You have the right to designate any primary care provider who participates in the Medical Plan option's network and who is available to accept you or your family members, including a pediatrician (in the case of children), as the primary care provider. Until you make this designation, the Medical Plan option may designate a primary care provider for you or your covered dependents.

You do not need prior authorization from the Medical Plan option or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Medical Plan option's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

To determine if these rules apply to your Medical Plan option or to the Medical Plan option that you are considering, or for information on how to select a primary care provider, or for a list of participating primary care providers or health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator or the applicable insurance company.

Mandatory Medicare Secondary Payer Program Reporting Requirements

Under the Medicare, Medicaid and SCHIP Extension Act of 2007 ("MMSEA"), the group health component benefit programs are required to report specified information about participants and their covered dependents, including (for example) Social Security numbers, to the Centers for Medicare and Medicaid Services (the "CMS"), the federal agency that oversees the Medicare program, to enable CMS to properly coordinate any Medicare payments with other employer-sponsored health care benefits. The Plan Administrator (or its delegate) has the right to release or obtain any information about Plan participants it considers necessary in order to satisfy the Plan's mandatory reporting requirements under the MMSEA.

Administrative Requirements and Timelines

As described in the Benefit Booklets, there may be reasons that a claim for benefits is not paid, or is not paid in full. For example, claims must generally be submitted for payment within a certain period of time, and failure to submit within that time period may result in the claim being denied. In this regard, please consult Section 10 and the applicable Benefit Booklets.

6. How the Plan Is Administered

Because benefits under the Plan are provided both through Insurance Contracts and on a self-funded basis, the Plan is administered by the Company (and its authorized delegates) and the applicable insurance companies, as described below.

General

The Company is the official “administrator” of the Plan, as such term is defined in ERISA (the “Plan Administrator”). As the Plan Administrator, the Company is responsible for satisfying certain legal requirements under ERISA with respect to the Plan. The Human Resources VP of the Company is the person who acts on behalf of the Plan Administrator. The Company has agreed to indemnify the Human Resources VP for any liability that he or she incurs as a result of acting on behalf of the Plan Administrator, unless such liability is due to his or her gross negligence or willful misconduct.

The principal duty of the Plan Administrator is to see that the Plan functions according to its terms and for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator (and its authorized delegates) have the discretionary authority to interpret the Plan and to make eligibility and benefit determinations under the Plan as they may determine in their sole discretion, to the fullest extent permitted by law. The Plan Administrator (and its authorized delegates) also have the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The Plan Administrator will bear its incidental costs of administering the Plan.

All actions, interpretations and decisions of the Plan Administrator and its authorized delegates will be conclusive and binding on all persons and entities, and will be given the maximum possible deference permitted by law.

Any interpretation, determination or other action of the Plan Administrator or its delegates will be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator or its delegates will be based only on such evidence presented to or considered by the Plan Administrator or its delegates, respectively, at the time of the applicable decision or action.

Important: Accepting any benefits or making any claim for benefits under the Plan constitutes agreement with and consent to any decisions that the Plan Administrator and its delegates make, in their sole discretion, and, further, constitutes agreement to the limited standard and scope of review described above.

Named Fiduciary

Pursuant to ERISA and except as otherwise described below, the Plan Administrator is the named fiduciary of the Plan.

For each of the insured component benefit programs, the applicable insurance company listed in Section 2 is the named fiduciary pursuant to ERISA with respect to decisions regarding whether any claim for benefits will be paid under the respective Insurance Contract.

For each of the self-funded component benefit programs, the Plan Administrator generally has engaged a third party administrator ("TPA") to provide day-to-day administration of such programs, including deciding claims for benefits and appeals of any denied claims. Except as otherwise may be specified in the applicable Benefit Booklets, the TPAs are named fiduciaries pursuant to ERISA solely for purposes of deciding such claims and appeals. See Section 10 and the applicable Benefit Booklets for more details.

Your Questions

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan or a particular component benefit program offered through the Plan), please contact the Plan Administrator.

If you have any question regarding your eligibility for, or the amount of, any benefit payable under the insured component benefit programs, please contact the applicable insurance company.

7. Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits

Your benefits (and the benefits of your covered family members) will cease when your participation in the applicable component benefit program terminates. See Section 4 for more details.

Plan benefits will also cease upon termination of the Plan.

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. See the Benefit Booklets and other governing Plan Documents for additional information.

Reimbursement and Subrogation

The component benefit programs may have the right of reimbursement - that is, the programs may have the right to recover benefits or expenses paid for services relating to an accident, injuries, illnesses or conditions that were caused by the act or omission of another individual or organization ("third party expenses"), and for which you or your covered dependents recover from any other source (for example, from a lawsuit or legal settlement, or from insurance proceeds). The benefit programs also may have the right of subrogation - that is, the benefit programs may have the right to be subrogated to (or take on as its own) any claim that you or your covered dependents may have against any individual or organization for such third party expenses. Refer to the applicable Benefit Booklet for further information regarding the particular component benefit program's rights of reimbursement and/or subrogation.

In the event you or your representative fails to cooperate with the Plan and the Plan Administrator (or its delegate), or insurance company, as applicable, with respect to a component benefit program's right of reimbursement and/or subrogation provisions, you and/or your covered dependent(s) may be responsible for all benefits paid under the Plan in addition to costs and attorney's fees incurred by the Plan and the Plan Administrator (or its delegate), and/or the insurance company, in obtaining repayment. Component benefit program coverage also may be permanently terminated for you and your covered dependents for failure to comply with such provisions.

8. Amendment or Termination of the Plan

Amendment or Termination

The Company, as the sponsor of the Plan, has the right, in its absolute and unlimited discretion, to amend or terminate the Plan or any component thereof, at any time and for any reason, to the extent permitted by applicable law, by a written instrument signed by the Company's President or Human Resources VP, or any other authorized person. For example, the Company may, among other things, reduce the level of benefits provided under any component benefit plan, increase the amount participants must pay for coverage under any component benefit plan, and/or change any component benefit plan's eligibility provisions so that you, your spouse or domestic partner, or your other dependents or family members are no longer eligible for coverage under the Plan. No rights are vested under the Plan.

The Company's President or Human Resources VP, or other authorized person are also authorized to sign Insurance Contracts with the insurance companies, including amendments to those contracts.

Any statement or representation, whether oral, written, electronic or otherwise, made by the Plan Administrator (or an authorized delegate), a TPA or other Plan service provider, an insurance company or any other individual or entity that alters, modifies, amends, or is inconsistent with the Summary Plan Description (including the Benefit Booklets) will be invalid and unenforceable and may not be relied upon by any individual or entity.

9. No Contract of Employment

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Company (or any affiliate of the Company) to the effect that you will be employed for any specific period of time.

10. Claims Procedures

VERY IMPORTANT: Notwithstanding any contrary provision of any Plan Document or Benefit Booklet, no lawsuit or other legal action may be brought by or on behalf of any claimant with respect to any claim for benefits under a component benefit program unless and until the applicable claims and appeal procedures of such program have been exhausted for every issue that the claimant deems relevant with respect to the claim. That is, each and every issue that supports the claimant's position or argument with respect to his or her claim under a component benefit program must be raised during such program's claims and appeal process in order for this exhaustion requirement to be satisfied and later pursue any such issue in court. Any such lawsuit or other legal action may not be brought if more than one calendar year has passed since the date the claims administrator or insurance company rendered its final decision upon appeal or, if earlier, the date specified in the Plan Document (or related Benefit Booklet).

The claims and appeal procedures for each specific component benefit program will be furnished automatically to you without charge as part of the applicable Benefit Booklets. If you do not have copies of the Benefit Booklets for the component benefit programs in which you are enrolled, contact the applicable insurance company or the Plan Administrator.

What is a Claim?

A "claim" is a request for a benefit under a component benefit program that is made by a claimant or his or her authorized representative in accordance with such program's procedure for filing benefit claims. For information on how to file a claim under a particular component benefit program, please see the related Benefit Booklet.

Claims for Insured Component Benefit Program Benefits

As noted earlier, for purposes of determining the amount of, and entitlement to, any covered benefits under an insured component benefit program, the respective insurance company listed in Section 2 is the named fiduciary under such program, with the full power to interpret and apply the terms of the component benefit program as they relate to the benefits provided under the applicable Insurance Contract.

To obtain covered benefits from the insurance company under an insured component benefit program, you must follow the claims procedures for that program, which may require you to complete, sign, and submit a written claim on the applicable insurance company's claim form and

within a specified time period. (See the applicable Benefit Booklets for more information.) In that case, the form is available from the insurance company or the Plan Administrator.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. **The claims procedures under any insured component benefit program are set forth in the related Benefit Booklet.**

The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial, as well as other information required by ERISA and other applicable law.

You may appeal any adverse benefit determination under an insured component benefit program to the respective insurance company for a review of the denied claim. You must follow the claim appeal procedures under such program, including any filing deadlines, which are set forth in the related Benefit Booklet. The insurance company will decide your appeal in accordance with its reasonable appeal procedures, as required by ERISA and other applicable law. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan). (See the applicable Benefit Booklets for more information.) If the insurance company denies your appeal, you will receive a written notification setting forth the reason(s) for the denial, as well as other information required by ERISA and other applicable law.

Claims for Self-Funded Component Benefit Program Benefits

As noted earlier, for purposes of determining the amount of, and entitlement to, any covered benefits under the self-funded component benefit programs, the Plan Administrator or the respective TPA of such program, is the named fiduciary under such program, as specified therein, with the full power to make factual determinations and to interpret and apply the terms of the component benefit program as they relate to the benefits provided under the program.

To obtain covered benefits under a self-funded component benefit program, you must follow the claims procedures under such program, which may require you to complete, execute, and submit to the applicable TPA a written claim on the TPA's claim form. You may also request the applicable

claim form from the Plan Administrator. The TPA or Plan Administrator, as applicable, will decide your claim in accordance with such program's reasonable claims procedures, as required by ERISA. **The claims procedures under any self-funded component benefit program are set forth in the Benefit Booklet for that program.**

The TPA and/or Plan Administrator, as applicable, has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the TPA or Plan Administrator, as applicable, denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial, as well as other information required by ERISA.

You may appeal any adverse benefit determination to the TPA or Plan Administrator, as applicable, for a review of the denied claim. You must follow the claim appeal procedures under the applicable self-funded component benefit program, including any filing deadlines, which are set forth in the related Benefit Booklet. The TPA or Plan Administrator, as applicable, will decide your appeal in accordance with the program's reasonable appeals procedures, as required by ERISA. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). If your appeal is denied, then you will receive a written notification setting forth the reason(s) for the denial, as well as other information required by ERISA.

VERY IMPORTANT: For details about the claims and/or appeal procedures that you must follow in order to file a claim for a covered benefit under a self-funded component benefit program under the Plan and/or appeal any denial of such claim, you must read the Benefit Booklet for that program and follow the procedures set forth in such booklet.

Claims Deadline

Unless specifically provided otherwise in a component benefit program or pursuant to applicable law, any claim for benefits under the Plan (including the component benefit programs) must be made within one calendar year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Plan participant or other covered dependent, or his or her authorized designee, to make sure this deadline is met.

Claims Related to Rescissions

As noted earlier, any rescission of Health Care Plan Coverage will be considered an adverse benefit determination. You will then have the opportunity to appeal the rescission as described above. (For

more information about rescissions, see the “*Termination of Coverage for Misrepresentation*” section above.)

Limitations Period for Filing Suit

The exhaustion of the applicable claims and appeal procedures (with the exception of any external claim review process, if available) is mandatory for resolving every claim and dispute under a component benefit program before initiating any legal action. As noted earlier, any such legal action may not be brought if more than one calendar year has passed since the date the insurance company, TPA or Plan Administrator, as applicable, rendered its final decision upon appeal or, if earlier, the date specified in the Plan Document (or related Benefit Booklet).

In any legal or other action brought after you have exhausted the applicable claims and appeal procedures under a component benefit program, all determinations made by any fiduciary in connection with the claim will be afforded the maximum possible deference permitted by law.

Required Venue for Any Legal Action

Except as otherwise provided in the Official Plan Documents, any legal action, if available, filed with respect to the Plan must be filed in the federal court for California located in San Francisco County.

11. Other Important Information

No Right to Assets

No participant, dependent, or beneficiary has any right to, interests in or claim for any particular assets of the Company or its affiliates, the Plan, any component benefit program or any underlying Insurance Contract or any other funding vehicle.

Company's Use of Funds

To the maximum extent permitted by applicable law, the Company may retain any policy dividend or refund, or portion thereof, it receives from any insurance company, administrative services organization, health maintenance organization, service program or any other organizations or individuals.

Plan's Use of Funds

Any amounts paid to and held by the Plan, as well as any policy dividends and/or refunds not belonging to the Company (as described above), will be available to fund the benefits provided by any component benefit program under the Plan and to pay the benefit program's administrative expenses. To the maximum extent permitted by applicable law, the Plan Administrator, in its sole and unlimited discretion, may use any funds accumulated under the Plan for any component benefit program (whether they are funds accumulated from Insurance Contract reserves, insurance company refunds or dividends, participant or Company contributions, administrative fees or any other source) to reduce the level of contributions that the Company would otherwise make under the Plan for any component benefit program.

No Transfer of Rights

Any attempt to assign, alienate, sell, transfer, pledge or encumber the rights of any Plan participant or other covered dependent, if any, under the Plan, will be void.

HIPAA Privacy

The group health component benefit programs are subject to the provisions of HIPAA affecting the maintenance, creation or use of protected health information (as that term is defined under HIPAA). Please refer to the Notice of Privacy Practices issued by the group health component benefit

programs (or applicable insurance companies) for a description of how your PHI may be used and disclosed, and how you can get access to such information, as required by HIPAA.

Insurance Company Rebates

In the event that the Company qualifies and receives a return of premium (“Rebate”) as a result of an insurance company’s failure to meet the “medical loss ratio” requirements under the Affordable Care Act (the “ACA”), the Company, at its option, will:

- Reimburse participants through a payroll adjustment in the amount determined under the ACA regulations;
- Reduce participant contributions (current or future) by an amount determined under ACA regulations to reflect participants’ share of the Rebate;
- Use the Rebate to enhance benefits under the Plan by an amount determined under ACA regulations; or
- Otherwise use the Rebate as permitted by applicable law.

12. Statement of ERISA Rights

Your Rights

Note that the Cafeteria Plan and the DCAP component benefit programs are not covered by ERISA and this Statement of ERISA Rights does not apply to these programs.

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including Insurance Contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including Insurance Contracts and copies of the Plan's latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's latest annual report (Form 5500 series), (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report).

COBRA Rights

Temporarily continue Health Care Plan Coverage for yourself and/or other qualified beneficiaries if there is a loss of such coverage as a result of a qualifying event as defined by law. You and/or other qualified beneficiaries will have to pay for such coverage. Review the Summary Plan Description (including the applicable Benefit Booklets) on the rules governing any COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and

beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA. However, this rule neither guarantees your employment with the Company or any of its affiliates, nor affects the Company's or the affiliate's or your right to terminate your employment for other reasons.

Enforce Your Rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500) from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied in whole or in part, and you have exhausted the applicable claims and appeal procedures under the Plan, or if you have a claim for benefits which is ignored, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a QMSCO, you may file suit in federal court.

If you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

13. Benefit Booklets

The component benefit programs and related Benefit Booklets listed below are in effect as of the date of this Wrap SPD, and may be updated from time to time.

The applicable Benefit Booklets will be provided to you free of charge electronically or by mail, in some cases. If you don't receive these documents or need duplicate copies free of charge, please contact the Plan Administrator. The latest Benefit Booklets are available for review at any time at www.getsalesforcebenefits.com.

Important: As noted earlier, the Benefit Booklets, together with this Wrap SPD, collectively constitute the Plan's Summary Plan Description, as required by ERISA. So, please read them together carefully.

Component Benefit Program	Benefit Booklet
Medical (including Prescription Drug)	
Aetna HDHP Premium (MSA - 883528)	<ul style="list-style-type: none"> ▪ Aetna Choice POS II High Deductible Health Plan - Premium option booklet (effective 01/01/2020) ▪ Plan Design & Benefits Schedule for Aetna HDHP Premium - effective 01/01/2020
Aetna HDHP Standard (MSA - 883528)	<ul style="list-style-type: none"> ▪ Aetna Choice POS II High Deductible Health Plan - Standard option booklet (effective 01/01/2020) ▪ Plan Design & Benefits Schedule for Aetna HDHP Standard - effective 01/01/2020
Aetna HMO (MSA - 883528)	<ul style="list-style-type: none"> ▪ Aetna Select Medical Plan booklet (effective 01/01/2020) ▪ Plan Design & Benefits Schedule for Aetna HMO - effective 01/01/2020
Aetna PPO (MSA - 883528)*	<ul style="list-style-type: none"> ▪ Aetna Choice POS II Medical Plan booklet (effective 01/01/2020) ▪ Plan Design & Benefits Schedule for Aetna PPO - effective 01/01/2020
Aetna Indemnity (MSA - 883528)*	<ul style="list-style-type: none"> ▪ Aetna Comprehensive Medical Plan booklet (effective 01/1/2020) ▪ Plan Design & Benefits Schedule for Aetna Indemnity - effective 01/01/2020

Component Benefit Program	Benefit Booklet
United Healthcare HDHP Premium (MSA - 911585)	<ul style="list-style-type: none"> ▪ United Healthcare High Deductible Health Plan - Premium option plan description (effective 01/01/2020) ▪ Plan Design & Benefits Schedule for United Healthcare HDHP Premium - effective 01/01/2020
United Healthcare HDHP Standard (MSA - 911585)	<ul style="list-style-type: none"> ▪ United Healthcare High Deductible Health Plan – Standard option plan description (effective 01/01/2020) ▪ Plan Design & Benefits Schedule for United Healthcare HDHP Standard - effective 01/01/2020
United Healthcare EPO (MSA - 911585)	<ul style="list-style-type: none"> ▪ United Healthcare EPO Medical Plan description (effective 01/01/2020) ▪ Plan Design & Benefits Schedule for United Healthcare HMO - effective 01/01/2020
United Healthcare PPO (MSA - 911585)	<ul style="list-style-type: none"> ▪ United Healthcare Medical Plan description (effective 01/01/2020) ▪ Plan Design & Benefits Schedule for United Healthcare PPO - effective 01/01/2020
Kaiser Northern California HMO (#602162)	<ul style="list-style-type: none"> ▪ Kaiser Permanente Traditional Plan (HMO) Evidence of Coverage for salesforce.com (effective 01/01/2020) ▪ Combined Chiropractic and Acupuncture Benefit Summary (effective 01/01/2019)
Kaiser Northwest (Oregon) HMO (#19881)	<ul style="list-style-type: none"> ▪ Kaiser Foundation Health Plan of the Northwest Large Group Traditional Copayment Plan Evidence of Coverage (effective 01/01/2020)
Hawaii Medical Service Association (#29075)	<ul style="list-style-type: none"> ▪ Hawaii Medical Service Association (HMSA) Preferred Provider Plan 2010 Guide to Benefits (effective January 2017) ▪ HMSA Plan Certificate Complimentary Care Rider (effective January 2017)

Component Benefit Program	Benefit Booklet
Expatriate Benefit Plan (#02174C)	Preferred Provider Medical Benefits, Cigna Vision, Cigna Dental Preferred Provider Benefits, Prescription Drug Benefits Certificate (#02174C) (effective 01/01/2017)
Inpatriate Benefit Plan (#02174D)	Preferred Provider Medical Benefits, Cigna Vision, Cigna Dental Preferred Provider Benefits, Prescription Drug Benefits Certificate (#02174D) (effective 01/01/2017)
CIGNA Medical Benefits Abroad Policy (#02174E)	<ul style="list-style-type: none"> ▪ CIGNA Medical Benefits Abroad #02174E Certificate of Insurance (effective 06/01/2015) ▪ CIGNA Medical Benefits Abroad Policy #02174E Benefits at a Glance (effective 06/01/2017)
Dental	
Delta Dental Plan (#18842)	<ul style="list-style-type: none"> ▪ Delta Dental Plan booklet (effective 01/01/2020) ▪ Delta Dental Plan Benefits Summary (effective 01/01/2020)
Expatriate Benefit Plan (#02174C)	Cigna Preferred Provider Medical Benefits, Cigna Vision, Cigna Dental Preferred Provider Benefits, Prescription Drug Benefits Certificate (#02174C) (effective 01/01/2017)
Inpatriate Benefit Plan (#02174D)	Preferred Provider Medical Benefits, Cigna Vision, Cigna Dental Preferred Provider Benefits, Prescription Drug Benefits Certificate (#02174D) (effective 01/01/2017)

Component Benefit Program	Benefit Booklet
Medical Benefits Abroad Policy (#02174E)	<ul style="list-style-type: none"> ▪ Medical Benefits Abroad Policy #02174E Certificate of Insurance (effective 06/01/2020) ▪ Medical Benefits Abroad Policy #02174E Benefits at a Glance (effective 06/01/2017)
Vision	
Vision Service Plan (#12223472) - Basic and High Options	Group Vision Care Plan VSP Evidence of Coverage & Disclosure Form (effective 01/01/2020)
Expatriate Benefit Plan (#02174C)	Cigna Preferred Provider Medical Benefits, Cigna Vision, Cigna Dental Preferred Provider Benefits, Prescription Drug Benefits Certificate (#02174C) (effective 01/01/2017)
Inpatriate Benefit Plan (#02174D)	Preferred Provider Medical Benefits, Cigna Vision, Cigna Dental Preferred Provider Benefits, Prescription Drug Benefits Certificate (#02174D) (effective 01/01/2017)
Employee Assistance Program	
CONCERN: Employee Assistance Program (#11493)	CONCERN: Employee Assistance Program Combined Evidence of Coverage and Disclosure Form (effective 1/1/2018)
Expatriate Benefit Plan (#02174C)	Preferred Provider Medical Benefits, Cigna Vision, Cigna Dental Preferred Provider Benefits, Prescription Drug Benefits Certificate (#02174C) (effective 01/01/2017)

Component Benefit Program	Benefit Booklet
Inpatient Benefit Plan (#02174D)	Preferred Provider Medical Benefits, Cigna Vision, Cigna Dental Preferred Provider Benefits, Prescription Drug Benefits Certificate (#02174D) (effective 01/01/2017)
Group Life and Accidental Death and Dismemberment (AD&D)	
Metlife (#216000-1-G)	Salesforce.com Employee Term Life Coverage, Basic and Optional Plans, Dependents Term Life Coverage, Accidental Death and Dismemberment Coverage, Basic and Optional Plans Certificate of Coverage (effective 01/01/2019)
Group Long-Term Disability (LTD)	
Metropolitan Life Insurance Company (#216000-1-G)	Certificate and Summary Plan Description Group Long Term Disability Insurance (effective 01/01/19)
Short Term Disability (STD) (for eligible non-California employees only)	
Salesforce.com, Inc. Short Term Disability Plan	Summary Plan Description for the Salesforce.com, Inc. Short Term Disability Plan (effective for disabilities beginning on or after 01/01/20)
Business Travel Accident (BTA)	
Business Travel Accident Insurance (#9907-18-39)	<ul style="list-style-type: none"> ▪ Chubb Business Travel Accident Plan Overview (#9907-18-39) ▪ Chubb Business Travel Accident Insurance Policy (#9907-18-39) ▪ Chubb Business Travel Accident Insurance Policy (#9907-18-39) Endorsement No. 1 Renewal

Component Benefit Program	Benefit Booklet
Health FSA	
Health Care Flexible Spending Account and Limited Purpose Flexible Spending Account	Salesforce.com, Inc. Cafeteria Plan Summary Plan Description (Amended and Restated Effective 01/01/2016)
DCAP (not an ERISA Benefit)	
Dependent Care Flexible Spending Account (which is not part of the Plan)	Salesforce.com, Inc. Cafeteria Plan Summary Plan Description (Amended and Restated Effective 01/01/2017)

* Please note that if you enroll in the Aetna PPO option but you do not live in an area where the applicable Aetna provider network is available, as determined by your home zip code, then you and any eligible dependents whom you elected to cover will instead be enrolled in the Aetna Indemnity option. Please review the Benefit Booklet for the Aetna Indemnity option for more details on the coverage offered under that option..