VMWARE, INC.
Effective Date: 01-01-2018
Aetna Choice® POS II – ASC
HSA PPO

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$1,500 Individual $3,000 Family	$1,500 Individual $3,000 Family
All covered expenses accumulate simultaneously toward both the In-Network and Out-of-Network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible.		
Member Coinsurance	10%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$2,500 Individual $5,000 Family	$6,000 Individual $12,000 Family
All covered expenses accumulate simultaneously toward both the In-Network and Out-of-Network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses apply towards the Payment Limit. There is no Individual Payment Limit to satisfy within the Family Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is a $500 penalty per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	30%; after deductible
1 exam every 12 months for members age 22 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	30%; after deductible
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	30%; after deductible
One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	30%; after deductible
Women's Health	Covered 100%; deductible waived	30%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	30%; after deductible

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Prostate-specific Antigen Test	Covered 100%; deductible waived	30%; after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	30%; after deductible
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%; deductible waived	30%; after deductible
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	10%; after deductible	30%; after deductible
Specialist Office Visits	10%; after deductible	30%; after deductible
Audiometric Hearing Exam 1 routine exam per 12 months.	Covered 100%; deductible waived	30%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	10%; after deductible	30%; after deductible
Allergy Testing	10%; after deductible	30%; after deductible
Allergy Injections	10%; after deductible	30%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	10%; after deductible	30%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	10%; after deductible	30%; after deductible
Diagnostic Complex Imaging	10%; after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	10%; after deductible	30%; after deductible
Non-Urgent Use of Urgent Care Provider	10%; after deductible	30%; after deductible
Emergency Room	10%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	30%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	10%; after deductible	30%; after deductible

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Outpatient Surgery - Hospital	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	10%; after deductible	30%; after deductible
Outpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	10%; after deductible	30%; after deductible
Limited to 120 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	Covered 100%; after deductible	30%; after deductible
Limited to 100 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing - Outpatient	Covered 100%; after deductible	30%; after deductible
Outpatient Speech Therapy	10%; after deductible	30%; after deductible
Covers all conditions.		
Outpatient Physical and Occupational Therapy	10%; after deductible	30%; after deductible
Spinal Manipulation Therapy	10%; after deductible	30%; after deductible
Limited to 20 visits per calendar year.		
Autism Behavioral Therapy	10%; after deductible	30%; after deductible
Combined with outpatient mental health visits		
Autism Applied Behavior Analysis	10%; after deductible	Not Covered
Covered same as any other Outpatient Mental Health benefit. Pre-certification and in-network providers required.		
Autism Physical Therapy	10%; after deductible	30%; after deductible
Autism Occupational Therapy	10%; after deductible	30%; after deductible
Autism Speech Therapy	10%; after deductible	30%; after deductible
Durable Medical Equipment	10%; after deductible	30%; after deductible
Therapeutic shoes and inserts covered for members with diabetes. Unlimited calendar year maximum.		
Acupuncture	10%; after deductible	30%; after deductible
Limited to 12 visits per calendar year.		
Hearing Aids	10%; after deductible	30%; after deductible
Limited to $5,000 per calendar year.		

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Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	Covered 100%; after deductible	Covered 100%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Covered 100%; after deductible	Covered 100%; after deductible
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	30%; after deductible
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	30%; after deductible
Transplants	10%; after deductible In-Network coverage is provided at an IOE contracted facility only.	30%; after deductible Out-of-Network coverage is provided at a Non-IOE facility.
Gender Reassignment Surgery	10%; after deductible	30%; after deductible
Includes transgender surgery coverage. Unlimited lifetime limit for gender reassignment surgery if deemed medically necessary and when all of the criteria requirements are met as outlined in the Aetna Clinical Policy Bulletin: Gender Reassignment Surgery (Number 0615).		
Bariatric Surgery	10%; after deductible	Not Covered
Coverage provided at an Institute of Quality (IOQ), includes Travel and Lodging benefit. Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mouth, Jaws and Teeth (oral surgery procedures that are medical in nature)	10%; after deductible	30%; after deductible
Out of Area Dependents	Coverage provided at 10%; after deductible. All Out-of-Network benefits and limitations apply.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	10%; after deductible	30%; after deductible
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	50%; after deductible	Not Covered
Coverage includes Artificial Insemination and Ovulation Induction Combined Comprehensive Infertility Services and Advanced Reproductive Technology (ART) $7,000 lifetime maximum for Medical and $3,000 lifetime maximum for Pharmacy, applies to all procedures covered by any Aetna plan except where prohibited by law. Maximum applies to all procedures covered by any Aetna plan except where prohibited by law. For information and approval contact: National Infertility Unit #1-800-575-5999.		
Advanced Reproductive Technology (ART)	50%; after deductible	Not Covered
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Also includes, Egg Retrieval for preservation of fertility to delay child bearing. Combined Comprehensive Infertility Services and Advanced Reproductive Technology (ART) $7,000 lifetime maximum for Medical and $3,000 lifetime maximum for Pharmacy, applies to all procedures covered by any Aetna plan except where prohibited by law. Maximums apply to all procedures covered by any Aetna plan except where prohibited by law. For information and approval contact: National Infertility Unit #1-800-575-5999.		
Vasectomy	10%; after deductible	30%; after deductible
Tubal Ligation	Covered 100%; deductible waived	30%; after deductible

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PHARMACY		IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.			
Pharmacy Plan Type		Aetna Premier Plus Open Formulary	
Generic Drugs			
	Retail	10% of submitted cost after combined medical/Rx plan deductible.	50% of submitted cost after combined medical/Rx plan deductible.
	Mail Order	10% of submitted cost after combined medical/Rx plan deductible.	Not Applicable
Preferred Brand-Name Drugs			
	Retail	15% of submitted cost after combined medical/Rx plan deductible.	50% of submitted cost after combined medical/Rx plan deductible.
	Mail Order	15% of submitted cost after combined medical/Rx plan deductible.	Not Applicable
Non-Preferred Brand-Name Drugs			
	Retail	20% of submitted cost after combined medical/Rx plan deductible.	50% of submitted cost after combined medical/Rx plan deductible.
	Mail Order	20% of submitted cost after combined medical/Rx plan deductible.	Not Applicable
Pharmacy Day Supply and Requirements			
	Retail	Retail In-Network: Up to a 90 day supply. Retail Out-of-Network: Up to a 30 day supply. Percentage coinsurance will not be doubled	
	Mail Order	Up to a 90 day supply from Aetna Rx Home Delivery®.	
	Premier Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred specialty pharmacy network.	
Preventive Medications - Deductible is waived for certain preventative medications. A full list of these drugs is available on Aetna Navigator.			
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Performance Enhancing Drugs limited to 6 tablets per month. Oral and injectable fertility drugs included subject to infertility maximum (physician charges for injections are not covered under RX, medical coverage is limited). Premier Plus Pre-certification for Specialty Drugs Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.			
GENERAL PROVISIONS			
Dependents Eligibility		Spouse, Domestic Partner, and children from birth to age 26 regardless of student status	

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

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Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.
• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

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Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.**

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