



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://www.aetna.com/sbcsearch/getpolicydocs?u=072100-120020-011798> or by calling 1-866-529-2517. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-866-529-2517 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In-network: Individual \$0 / Family \$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
<b>Are there services covered before you meet your deductible?</b>	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services.
<b>Are there other deductibles for specific services?</b>	Yes. For <u>prescription drug</u> expenses - In-network: Individual \$600 / Family \$1,200. Does not apply to in-network for preferred generic drugs. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	In-network: Individual \$7,350 / Family \$14,700.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a> or call 1-866-529-2517 for a list of in-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit	Not covered	None
	<u>Specialist</u> visit	\$75 <u>copay</u> /visit	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Lab: \$35 <u>copay</u> /visit; X-ray: \$75 <u>copay</u> /visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$350 <u>copay</u> /visit	Not covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://client.formularynavigator.com/Search.aspx?siteCode=4195839145">client.formularynavigator.com/Search.aspx?siteCode=4195839145</a>	Preferred/non-preferred generic drugs (Tier 1)	\$20 <u>copay</u> (retail), \$40 <u>copay</u> (mail order), <u>deductible</u> does not apply	Not covered	Covers up to a 30 day supply (retail prescription), 31-90 day supply (mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Precertification and step therapy for certain <u>prescription drugs</u> may be required.
	Preferred brand drugs (Tier 2)	\$75 <u>copay</u> (retail), \$150 <u>copay</u> (mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	\$100 <u>copay</u> (retail), \$200 <u>copay</u> (mail order)	Not covered	
	<u>Specialty drugs</u> (Tier 4)	50% <u>coinsurance</u> up to a \$250 maximum for up to a 30 day supply	Not covered	All specialty <u>prescription drug</u> fills on initial fill must be filled at a <u>network</u> specialty pharmacy except for urgent situations. Your <u>plan</u> may include access to CVS retail pharmacies for certain <u>specialty drugs</u> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$750 <u>copay</u> /visit for hospital facility; \$400 <u>copay</u> /visit for free standing facility	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> /visit	\$500 <u>copay</u> /visit	<u>Copay</u> waived if admitted. No coverage for non-emergency care.
	<u>Emergency medical transportation</u>	\$150 <u>copay</u> /trip	\$150 <u>copay</u> /trip	Precertification is required for certain services.
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	\$50 <u>copay</u> /visit	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 <u>copay</u> /day, days 1-5	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits and all other outpatient services: \$75 <u>copay</u> /visit	Not covered	None
	Inpatient services	\$750 <u>copay</u> /day, days 1-5	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply to <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$750 <u>copay</u> /day, days 1-5	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$35 <u>copay</u> /visit	Not covered	Coverage is limited to 100 visits/year.
	<u>Rehabilitation services</u>	\$75 <u>copay</u> /visit	Not covered	None
	<u>Habilitation services</u>	\$75 <u>copay</u> /visit	Not covered	None
	<u>Skilled nursing care</u>	\$750 <u>copay</u> /day, days 1-5	Not covered	Coverage is limited to 100 days/benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Coverage is limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	Inpatient: \$750 <u>copay</u> /day, days 1-5; Outpatient: No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If your child needs dental or eye care</b>	Children's eye exam	\$35 <u>copay</u> /visit	Not covered	Coverage is limited up to age 19.
	Children's glasses	No charge	Not covered	Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year up to age 19.
	Children's dental check-up	No charge	Not covered	Coverage is limited to 2 prophylaxis (cleanings) and 2 fluoride applications a year.

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>	
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care - Coverage is limited to 20 visits.</li> <li>• Infertility treatment - Benefit limitations may apply.</li> </ul>

**Your Rights to Continue Coverage:**

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: California Department of Managed Health Care, (888) 466-2219, 1-877-688-9891 TDD, <http://www.dmhc.ca.gov>.

- For more information on your rights to continue coverage, contact the plan at 1-866-529-2517.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

## Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-866-529-2517.
- California Department of Managed Health Care, (888) 466-2219, 1-877-688-9891 TDD, <http://www.dmhca.gov>.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
- Additionally, a consumer assistance program can help you file your appeal. Contact California Department of Managed Health Care, California Help Center, 980 9th Street, Suite #500, Sacramento, CA 95814, (888) 466-2219, <http://www.healthhelp.ca.gov>, [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov)

## Does this plan Provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan Meet Minimum Value Standard? Yes.

If your plan doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a plan through the **Marketplace**.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

**About these Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$0**
- Specialist copayment **\$75**
- Hospital (facility) copayment **\$750**
- Other copayment **\$0**

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,860</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$0**
- Specialist copayment **\$75**
- Hospital (facility) copayment **\$750**
- Other copayment **\$0**

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles*	\$600
Copayments	\$2,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,020</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$0**
- Specialist copayment **\$75**
- Hospital (facility) copayment **\$750**
- Other copayment **\$0**

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-529-2517.

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

### Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-529-2517.

### Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

### Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-866-529-2517.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 24030 Fresno CA, 93779

1-800-648-7817, TTY: 711, Fax: 1-860-262-7705

Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.**

TTY: 711

**Language Assistance:**

For language assistance in your language call 1-866-529-2517 at no cost.

- Arabic - للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-866-529-2517
- Armenian - Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-529-2517 առանց գնով:
- Chinese - 欲取得繁體中文語言協助，請撥打 1-866-529-2517，無需付費。
- Hindi - हन्दि में भाषा सहायता के लएि, 1-866-529-2517 पर मुफ्त कॉल करें।
- Hmong - Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-529-2517.
- Japanese - 日本語で援助をご希望の方は、1-866-529-2517 まで無料でお電話ください。
- Korean - 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-866-529-2517 번으로 전화해 주십시오.
- Mon-Khmer, Cambodian - សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-866-529-2517 ដោយឥតគិតថ្លៃ។
- Navajo - T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-529-2517
- Panjabi - ਪੰਜਾਬੀ ਵੀਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-529-2517 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
- Persian - برای راهنمایی به زبان فارسی با شماره 1-866-529-2517 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
- Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-866-529-2517.
- Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-866-529-2517.
- Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-529-2517 nang walang bayad.
- Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-529-2517 ฟรีไม่มีค่าใช้จ่าย
- Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-866-529-2517.



**Supplemental Information**

**Coverage for: Employee + Family | Plan Type: HMO**

<p><b>How is the overall <u>deductible</u> or <u>out-of-pocket limit</u> met?</b></p>	<p>Individual <u>deductible</u> and <u>out-of-pocket limit</u> payments apply to the family <u>deductible</u> and <u>out-of-pocket limit</u>.</p>	<p>The family <u>deductible</u> and family <u>out-of-pocket limit</u> are cumulative for all family members. The family <u>deductible</u> and <u>out-of-pocket limit</u> can be met by a combination of family members; however no single individual within the family will be subject to more than the individual <u>deductible</u> or <u>out-of-pocket limit</u> amount.</p>
---------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**How your out-of-network care is reimbursed:**

Your plan does not cover care you get outside of our network. Generally, we will not pay anything for that care. But your plan will pay for emergency services you receive from health care providers not in our network. Your cost sharing – deductibles, coinsurance, copayments – will be the same as if you got the care in-network. You are not responsible for paying anything else. If you get a bill for anything more, contact us.

**Other important information about your plan:**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent.

Additional information regarding your plan is available in the Disclosure Document on [www.aetna.com](http://www.aetna.com).

Information includes:

- “Knowing what is covered” which describes how we review a request for coverage for a service or supply
- “Prescription drug benefit” which describes procedures we use to manage prescription drug benefits. These procedures include how to obtain a list of covered drugs and the exception policy for receiving coverage of a drug that is not on a closed formulary

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products. While this material is believed to be accurate as of the production date, it is subject to change.

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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. We do not provide care or guarantee access to health services.

## Supplemental Information

**Coverage for:** Employee + Family | **Plan Type:** HMO

The following is a partial 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 you or your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your **plan** documents
- 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 with respect to the treatment of cancer or other life-threatening disease or condition
- Home births
- Immunizations for travel or work except where **medically necessary** or indicated
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Long-term rehabilitation therapy
- Non-**medically necessary** services or supplies
- Orthotics except diabetic orthotics
- 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 or inadequacies, including therapy, supplies, counseling or **prescription drugs**
- Therapy or rehabilitation other than those listed as covered

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.

We consider your personal information to be private. We have policies and procedures in place to protect your personal information from unlawful use and disclosure. For a summary of our policy, go to [www.aetna.com](http://www.aetna.com). You'll find the Privacy Notices link at the bottom of the page.

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

© 2014 Aetna Inc.