

Vision Plan

Booklet-Certificate

Prepared exclusively for

Policyholder:	**Brookhaven Science Associates**
Group policy number:	**499953**
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Underwritten by Aetna Life Insurance Company in the state of Delaware

Welcome

Thank you for choosing **Aetna®**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the **group policy**, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for **eligible vision services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the **group policy** between **Aetna Life Insurance Company** (**Aetna**) and your **policyholder**. Ask the **policyholder** if you have any questions about the **group policy**.

Sometimes, these documents have amendments, inserts or riders which we will send you. These change or add to the documents they're part of. When you receive these, they are considered part of your **Aetna** plan for coverage.

Where to next? Try the *Let's get started!* section. *Let's get started!* gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

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Schedule of benefits Issued with your booklet-certificate

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Aetna**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical vision language that is familiar to **vision providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible vision services**. Your plan has an obligation to pay for **eligible vision services**.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered

Your plan provides **covered benefits**. These are **eligible vision services**. Your plan has an obligation to pay for **eligible vision services**.

Eligible vision services

So what are **eligible vision services**? They are vision care services that meet these three requirements:

- They appear in the *Eligible vision services under your plan* section.
- They are not listed in the *What your plan doesn't cover – eligible vision service exclusions* section.
- They are not beyond any limits in the schedule of benefits.

Providers

You may choose any **vision provider** for the care you need.

For more information about the role of your **vision provider**, see the *Who provides the care* section.

Paying for eligible vision services– sharing the expense

Generally your plan and you will share the expense of your **eligible vision services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

How to contact us for help

We are here to answer your questions. You can contact us by:

- Logging in to your member website at https://www.aetna.com/
- Registering for our Internet access to reliable vision information, tools and resources

Online tools will make it easier for you to make informed decisions about your vision care, view claims, research care and treatment options, and access information.

You can also contact us by:

- Calling **Aetna** Member Services
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

Your **policyholder** decides and tells us who is eligible for vision care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At any time
- Once each **calendar year** during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself and your dependents when you first qualify for vision benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets any **policyholder** rules and requirements under state law
- Your dependent children – yours or your spouse's or partner's
  - Dependent children must be:
    - Under age 26
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody

Effective date of coverage

Your coverage will be in effect as of the date you become eligible for vision benefits.

Important note: You may continue coverage for a disabled child past the age limit shown above. See *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

You can't have coverage as an employee and a dependent and you can't be covered as a dependent of more than one employee on the plan.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your **policyholder** when benefits for your spouse will begin:
    - If we receive your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month.
    - If we receive your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan. See *Who can be on your plan (who can be your dependent)* section for more information.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your **policyholder**.
  - Ask your **policyholder** when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.
- A newborn child or grandchild - Your newborn child or grandchild is covered on your vision plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information within 60 days of birth.
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have vision benefits after the first 31 days.
- An adopted child - See *Who can be on your plan (who can be your dependent)* section for more information. An adopted child is covered on your plan for the first 31 days after the adoption is complete or the date the child is placed for adoption. “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
  - To keep your adopted child covered, we must receive your completed enrollment information within 60 days after the adoption or the date the child was placed for adoption.
  - If you miss this deadline, your adopted child will not have vision benefits after the first 31 days.
- A foster child - A foster child is covered on your plan for the first 31 days after obtaining legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents.
  - To keep your foster child covered, we must receive your completed enrollment information within 60 days after the date the child is placed with you.
  - If you miss this deadline, your foster child will not have vision benefits after the first 31 days.
- A stepchild – You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or Declaration of Domestic Partnership with your stepchild’s parent.
  - Ask your **policyholder** when benefits for your stepchild will begin. It is the date of your marriage, Declaration of Domestic Partnership or the first day of the month following the qualifying event date.

Inform us of any changes

It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other group vision plan

Special times you and your dependents can join the plan

You can enroll in these situations:

- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- You did not enroll in this plan before because:
  - You were covered by another group vision plan, and now that other coverage has ended
  - You had COBRA, and now that coverage has ended
- A court orders that you cover a current spouse, domestic partner, or a child on your vision plan.

We must receive your completed enrollment information from you within 31 days of the event or the date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage will be in effect on the first date of the month based on when we receive your completed enrollment application.

Eligible vision services under your plan

Eligible vision services include services provided by an ophthalmologist or optometrist.

You may get vision services and supplies from any **vision providers**. Refer to your schedule of benefits for more information.

You may use **vision providers** of your choice for **eligible vision services** and supplies under this plan.

Vision care services and supplies

Eligible vision services and supplies include:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses that are prescribed by a **vision provider**
- Aphakic lenses prescribed after cataract surgery
- Contact lenses required to correct visual acuity to 20/40 or better in the better eye if such correction cannot be made with conventional lenses

What your plan doesn't cover –eligible vision service exclusions

We already told you about the many vision care services and supplies that are eligible for coverage under your plan in the *Eligible vision services under your plan* section. In that section we also told you that some vision care services and supplies have exclusions. For example, **cosmetic** surgery is never covered. This is an exclusion.

In this section we tell you about the exclusions that apply to your plan.

And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

Exclusions

The following are not **eligible vision services** under your plan except as described in the *Eligible vision services under your plan* section of this booklet-certificate, or by a rider or amendment included with this booklet-certificate:

Cornea transplants

- Cornea (corneal graft with amniotic membrane)

Cosmetic services and plastic surgery

- Any treatment, surgery (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body

Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Examinations

Any vision examinations needed:

- During your stay in a hospital or other facility for medical care
- For the purpose of the fitting of contact lenses
- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Laser in-situ keratomileusis (LASIK)

- Including related procedures designed to surgically correct refractive errors

Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision)

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Services provided by a family member

- Services provided by a spouse, civil union partner, domestic partner, parent, child, step-child, brother, sister, in-law, or any household member

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, unless coverage is required by applicable laws

Vision care services and supplies

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Aniseikonic lenses
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Any vision examination, or any corrective eyewear required by a **policyholder** as a condition of employment, and safety eyewear
- Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (non-prescription) lenses
- Non-prescription sunglasses
- Services provided after the date you're no longer covered under the plan, except for vision materials that:
  - Were ordered before coverage ended
  - Are delivered and **eligible vision services** are provided to you for the ordered materials within 31 days from the date of the order
- Services or materials provided by any other group benefit plan providing vision care

Who provides the care

Vision providers

When you need vision services or supplies, you can go to any **vision provider**.

You may have to pay for services at the time that they are provided. You are responsible for completing and submitting claim forms for reimbursement of **eligible vision services** that you paid directly to a **vision provider**.

We will tell you what we have paid for **eligible vision services** and supplies. Our notice will tell you if you owe any amounts or if any services or supplies are not covered. You can receive this notice from us by e-mail or through the mail.

What the plan pays and what you pay

Who pays for your **eligible vision services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains the vision supply maximums listed in your schedule of benefits.

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an **eligible vision service**.

Special financial responsibility

You are responsible for the entire expense of cancelled or missed appointments.

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of any maximum

Where your schedule of benefits fits in

How your vision supply maximum works

The maximum is the most your plan will pay for **eligible vision services** incurred by a covered person per 12 consecutive month period. You are responsible for any amounts above the maximum.

Important note:
See the schedule of benefits for maximums that apply.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible vision services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

You or your **vision provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **vision provider** or to you as appropriate.

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from us • The claim form will provide instructions on how to complete and where to send the form(s)	• You must send us notice and proof within 90 days. • If you are unable to complete a claim form, you may send us: – A description of services – Bill of charges • Any vision documentation you received from your **vision provider**
Proof of claim When you have received a service from an eligible **vision provider**, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us	• You must send us notice and proof within 90 days
Benefit payment	• Written proof must be provided for all benefits • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits will be paid as soon as the necessary proof to support the claim is received

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if it is filed as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Communicating our claim decisions

The amount of time that we have to tell you about our decision on a claim is shown below.

Post-service claim

A post service claim is a claim that involves vision care services you have already received.

Type of notice	Post-service claim
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

Adverse benefit determinations

Sometimes we pay only some of your claim. And sometimes we deny payment entirely. Any time we deny even part of the claim, that is an “adverse benefit determination” or “adverse decision”. If we make an adverse benefit determination, we will tell you in writing

.

The difference between a complaint and an appeal

A complaint

You may not be happy about a provider or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An appeal

You can ask us to review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination. Or you can call Member Services. You need to include:

- Your name
- The **policyholder's** name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **vision provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **vision provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for deciding appeals

The chart below shows a timetable view of the type of notice and how much time we have to tell you about our decision.

Type of notice	**Post-service appeal**
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

Exhaustion of appeals process

In most situations you must complete the one level of appeal with us before you can take these other actions:

- Contact the Delaware Department of Insurance to request an investigation of a complaint or appeal.
- File a complaint or appeal with the Delaware Department of Insurance.
- Pursue arbitration, litigation or other type of administrative proceeding.

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal.

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is no longer available
- The **group policy** ends
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employment ends
- You do not pay any required **premium** payment
- We end your coverage
- You become covered under another vision plan offered by your **policyholder**

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by the **policyholder** and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue, until stopped by the **policyholder**, but not beyond 30 months from the start of your absence.
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the **policyholder** and us.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the p**olicyholder** and we agree to do so and as described below: • Your coverage will not continue after the month in which your absence started.
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage.	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by the **policyholder** but not beyond 30 months from the start of the absence.

Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage will not continue after the month in which your absence started.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by the **policyholder** but not beyond 18 months from the start of the absence.

It is your **policyholder's** responsibility to let us know when your employment ends. The limits above may be extended only if we and the **policyholder** agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- The **group policy** ends
- You do not make the required **premium** contribution toward the cost of dependents' coverage
- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners
- The date the domestic partnership ends. For domestic partnerships, you should provide the **policyholder** a completed and signed Declaration of Termination of Domestic Partnership.

What happens to your insured dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end your coverage?

We will give you 31 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on loss of coverage.

On the date your coverage ends, we will refund to the **policyholder** any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

The federal COBRA law usually applies to employers of group sizes of 20 or more. It gives employees and most of their covered dependents the right to keep their vision coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage.

The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy.

Talk with your employer if you have questions about COBRA or to enroll.

Continuation of coverage for other reasons

To request an extension of coverage, just call Member Services.

How can you extend coverage for vision care services and supplies when coverage ends?

If your coverage ends while you are not totally disabled**,** your plan will cover vision services and supplies for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in **prescription**

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond the plan age limits if your disabled child:

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly (more than 50% of income) on you for support

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet-certificate when we administer your coverage, so long as we use reasonable authority.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **vision providers**. They are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the **group policy**. This document may have amendments and riders too. Under certain circumstances, we, the **policyholder** or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive requirements under the plan or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the **policyholder** or **vision provider**, can do this.

Financial sanctions exclusions:

If coverage provided under this booklet-certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible vision services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Assets Control (OFAC). Visit https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx to find out more.

Legal action

You are encouraged to complete the appeal process before you take any legal action against us for any expense or bill until you complete the appeal process. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **physicians** and **vision providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception

Honest mistakes

You or your **policyholder** may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious effects on your coverage. These include, but are not limited to:

- Loss of coverage, starting at some time in the past. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Some other money issues

Assignment of benefits

When you see a **vision provider** they will usually bill us directly. We may choose to pay you or to pay the **vision provider** directly.

Recovery of overpayments

We sometimes pay too much for **eligible vision services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid – you or your **vision provider** – to return what we paid. If we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

Premium contribution

This plan requires the **policyholder** to make **premium** contribution payments. If payments are made through a payroll deduction with the **policyholder**, the **policyholder** will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** contributions are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Payment of premiums

The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium** due date"). Each **premium** payment is to be paid to us on or before the **premium** due date.

Your vision information

We will protect your vision information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call Member Services. When you accept coverage under this plan, you agree to let your **vision providers** share your information with us. We will need information about your physical and mental condition and care.

Glossary

Aetna®
Aetna Life Insurance Company, an affiliate, or a third-party vendor under contract with **Aetna**.

Calendar Year
A period of 12 months that begins on January 1st and ends on December 31st.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible vision services that meet the requirements for coverage under the terms of this plan.

Effective date of coverage
The date your coverage begins under this booklet-certificate as noted in our records.

Eligible vision services
The vision care services and supplies listed in the *Eligible vision services under your plan* section and not listed or limited in the *What your plan doesn't cover – eligible vision service exclusions* section or in the schedule of benefits**.**

Group policy
The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any amendments to the **group policy**, the booklet-certificate, and the schedule of benefits

Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Policyholder
An employer or organization who agrees to remit the **premiums** for coverage under the **group policy** payable to **Aetna**. The **policyholder** shall act only as an agent of **Aetna** members in the employer group, and shall not be the agent of **Aetna** for any purpose.

Premium
The amount you or your **policyholder** are required to pay to **Aetna** for your coverage.

Prescription
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Vision provider

Any individual legally licensed to provide vision services or supplies.

Additional Information Provided by

Brookhaven Science Associates

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Refer to your Plan Administrator for this information

Employer Identification Number:
Refer to your Plan Administrator for this information

Plan Number:
Refer to your Plan Administrator for this information

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Brookhaven Science Associates
Attention: Melissa Schuchman, Supervisor, Benefits
Brookhaven National Laboratory Benefits Office - Building 400B
Upton, NY 11973
Telephone Number: (631) 344-2877

Agent For Service of Legal Process:
Brookhaven Science Associates
Attention: Melissa Schuchman, Supervisor, Benefits
Brookhaven National Laboratory Benefits Office - Building 400B
Upton, NY 11973

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan 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 and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is 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, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan 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 up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, 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 status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your 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 your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- 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.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Your Aetna International health and wellness programs

Being away from home often means being away from your friends and family support network. As your 24/7 partner in health, we help make sure you have the support you need to thrive. Whether it's our Aetna International Care team to manage chronic conditions or our Employee Assistance Program to help balance your work and personal needs, we're here for you with the all the tools, resources and programs you need – no matter where you are in the world.

24-Hour Nurse Line

Our 24-Hour Nurse Line gives members ready access to registered nurses who can answer their questions on a variety of health topics. The nurses give members the information they need and help them make smarter health care decisions. They can also help improve members' relationships with their doctors, and:

- Empower members with health information to help them use health care services appropriately
- Encourage members to give a clear medical history and ask relevant questions
- Promote healthy lifestyle habits
- Provide members with health information to help them improve and better manage chronic conditions

Nurse Access
Nurses are available through a toll-free telephone number 24 hours a day, 7 days a week. We offer foreign language translation for our non-English speaking members.

Our nurses also have access to the Healthwise® Knowledgebase video library and can relay video links to callers upon request or to provide further education/support of the health topic they discussed. It is a user-friendly decision-support tool that promotes informed health decision-making and helps members learn about their treatment options.

NOTE: Neither Aetna International ® nor **24-Hour Nurse Line** is a healthcare provider and neither shall be responsible for the availability, quantity, quality, or result of any medical treatment a member may receive, or for a member's failure to pursue or obtain medical treatment.

Emergency Assistance Services

Medical emergencies are unpredictable — but if they do happen, Aetna International is there for members and their families no matter where they are in the world. With our in-house Aetna Assistance team, we make sure you have access to necessary resources during a medical emergency 24 hours a day, seven days a week.

The following benefits, exclusions and requirements apply to you as the covered member along with any eligible dependents.

Aetna covered services and expenses – emergency services

- **Emergency or urgent medical evacuation:** Evacuation services may be necessary if you or your eligible dependent develops an emergency or urgent medical situation requiring immediate attention, and adequate medical facilities are not locally available. The plan will cover the cost of medically supervised evacuations with no benefit maximum to the closest facility capable of providing appropriate care.

- **Medical repatriation coordination:** Following an evacuation or a catastrophic medical event, depending on the circumstances, the plan will cover with no benefit maximum the one-way cost of transportation to your point of origin, your permanent residence, your original work location or the location from which you were evacuated. This may include any medically supervised transportation or medical treatment administered en route.

- **Return of mortal remains:** If you die outside your home country, we'll cover with no benefit maximum up to the reasonable costs associated with the transportation of mortal remains from the place of death to the Home Country, or approved destination. In addition, assistance will be provided by Aetna, or its designee, for organizing or obtaining the necessary clearances for the repatriation of mortal remains:

1) to transport your body or mortal remains to your home country or your country of residence as directed by your next kind or estate, **or**
2) for your burial or cremation at the place of your death as directed by your next of kin or estate
    a. In the event of your burial, we'll cover:
        i. The cost of opening or reopening a grave;
        ii. Any exclusion right of burial fee; and
        iii. Burial costs
    b. In the event of your cremation, we'll cover:
        i. The cost of any doctor's certificates; and
        ii. Cremation costs, including the removal of any medical device before the cremation
3) Services such as funeral home and mortuary care are arranged and coordinated by our designated evacuation and repatriation partner. Only their participating providers will be reimbursed through your plan benefits if applicable.

- **Return of dependent children:** If dependent child(ren) are left unattended by virtue of the evacuee's absence following a covered evacuation, a one-way economy airfare with no benefit maximum will be provided to their place of residence or that of an individual chosen by you.

- **Companion travel coordination:** Following an evacuation, if Aetna determines that you or your Dependent is expected to require hospitalization in excess of seven (7) days, we'll cover the cost with no benefit maximum of a round-trip economy airfare for one person chosen by you to travel to and from the place of hospitalization.

All evacuations, returns to residence after stabilization and/or repatriations of mortal remains are coordinated by and subject to prior approval of Aetna International.

Aetna covered services and expenses – travel expenses

We will cover travel expenses incurred after your evacuation and/or release from the hospital due to illness or injury until you are fit to fly and return to your point of origin. Hotel covered up to $125/night for member and covered members under age 18. Stays over 10 days require clinical review. Taxi covered as well.

For the duration of your evacuation and period of admission, we'll cover:

- **Overnight accommodation costs** up to $125 a night, if deemed necessary
- **The fare for a taxi** to take you from your accommodations to the hospital and back once a day

Please note that arranging your own transportation or lodging may jeopardize your evacuation benefit. To remain eligible, all arrangements must be made directly through your designated evacuation vendor.

For any covered members or dependents under the age of 18, we'll pay the following costs for a parent or legal guardian:

- **Hospital accommodations** to stay with the child if receiving inpatient treatment
- **Reasonable accommodation costs at a hotel** (up to $125 a night) for them to stay with the child if they can't return to their country of residence and the child's accommodation costs are covered in this section

Aetna covered services and expenses – medical assistance services

Our Care and Response Excellence (CARE) team of clinicians can provide assistance by email, fax or phone with:

- **Pre-trip planning** — Updated information on required vaccinations, health risks, travel restrictions and weather conditions for worldwide destinations
- **Medical, dental and pharmacy referrals** — Referrals to the most appropriate, nearby medical care resources, including preferred access to our network of medical providers
- **Prescription medicine and vaccines** — Assistance with obtaining prescription medicine and/or vaccines, when not locally available and when legally permissible, upon written authorization of your primary physician

The benefits listed above are subject to overall evacuation dollar maximum limitations.

Definitions, requirements and exclusions

Definitions

- **Accident** — A sudden, violent, external, unforeseen and identifiable event
- **Emergency** — A situation that, in the professional opinion of your physician, poses a clear and significant risk of death or imminent serious injury or harm to you or your eligible dependents

- **Home country** — The country where you primarily reside and will return to when repatriated, or a country where you hold a valid passport

- **Host country** — The country you are visiting

- **Member** — Any eligible person who has enrolled in Aetna Assistance through a participating plan sponsor

- **Personal belongings** — Any items you take on, or acquire during, an insured journey that are your personal property or are property you're personally responsible for

- **Qualified medical practitioner** — A doctor or specialist who is registered or licensed to practice medicine under the laws of the country they practice in; excludes you, your partner, any members of your immediate family or any of your employees

Requirements

Contact and claims requirements

- You or someone on your behalf must contact us as soon as possible to confirm eligibility for covered expenses. Failure to do so may invalidate your eligibility for payment of transportation and other expenses.

- The evacuation method and destination chosen must meet Aetna Assistance requirements. Failure to do so may invalidate payment of subsequent transportation expenses.

- All assistance service-related bills incurred by you or your eligible dependents must be submitted to us for payment consideration.

Exclusions

General exclusions

Some of the costs you may incur during your period of convalescence from a medical emergency are not covered by this plan. These include:

- Meals

- Personal care items (e.g., shampoo, deodorant, etc.)

- Telephone calls

- Ground transportation beyond the specific covered benefits outlined in this document

- The Return of mortal remains benefit does not extend to the purchase of a burial plot, or funeral costs, including but not limited to, flowers and the funeral director's fee.

- If you die within your home country, we'll cover reasonable costs to transport your body to the place of your burial or cremation as directed by your next of kin or estate. This benefit does not extend to any costs related to your burial or cremation.

Travel assistance services exclusions

We may be able to help with travel issues and coordination when appropriate. You are responsible to pay any costs associated with the following services if they are incurred:

- 24/7 emergency travel assistance

- Translation and interpreter services

- Emergency cash advance assistance

- Replacement of lost travel documents assistance

- Lost luggage assistance

- Legal referrals

Claims exclusions

We will not be responsible for the cost of services or expenses arising from the following situations involving you or your eligible dependents:

- Abuse of drugs or alcohol

- Military or police service operations

- Successful or attempted commission of an unlawful act

- Aviation, except where you or your eligible dependents fly as a passenger in an aircraft properly licensed to carry passengers (except the Military Aircraft Command of the United States or similar air transport service of other countries)

- Travelling against a physician's advice

- Travelling for the purpose of obtaining medical treatment

- Non-emergency expenses for routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious injury or harm to you or your eligible dependents

- Loss due to Customs or any other authority legally taking or destroying your property

- A condition not requiring emergency evacuation that would allow for treatment at a future date convenient to you or your eligible dependents

- Mountaineering or rock climbing necessitating the use of guide ropes; potholing; ballooning; motor racing; speed contests; skydiving; hang gliding; parachuting; spelunking; heli-skiing; extreme skiing; bungee cord jumping; deep sea diving utilising a hard helmet with air hose attachments; racing of any kind (other than on foot); and all professional sports

Accessing your emergency benefits

At Aetna International, we are here for you 24/7 — for medical emergencies, non-emergency needs and everything in between. Our member service representatives work closely with Aetna Assistance representatives whenever urgent or emergency situations arise.

In cases of immediate emergency

1. Go immediately to the closest physician or hospital.

2. Once it's possible, call us (or have someone on your behalf call us) using the emergency number shown on the back of your Aetna International Member ID card.

While we will do everything reasonably possible to direct you or your eligible dependents to the most appropriate care available once we receive a call, we are not responsible for the availability, quantity, quality or result of any medical treatment you may receive or your failure to obtain medical treatment.

In cases where you are able to call

Call us using the emergency number on the back of your Member ID card if you or your eligible dependents:

- Have an urgent medical concern or question
- Are hospitalized or are about to be hospitalized
- Are involved in an accident requiring medical treatment
- Are having difficulty locating urgent medical care
- Require a referral for translation services in order to receive urgent medical care

Information to provide when you call

When you or your eligible dependents call us in emergency situations, you will need to provide:

- Your policy name
- Your Member ID number (found on your Member ID card)
- Your name or the name of your eligible dependent in need of emergency assistance
- Your identification number affiliated with the group providing this coverage
- The name of the person calling on your behalf if applicable

- The nature of the illness, injury, medical problem or emergency and the type of help needed

Aetna® is a trademark of Aetna Inc. and is protected throughout the world by trademark registrations and treaties.

Plans and programs are underwritten or administered by Aetna Life & Casualty (Bermuda) Ltd. or Aetna Life Insurance Company (Aetna).

Aetna does not provide care or guarantee access to health services. Not all health services are covered. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to www.AetnaInternational.com. Whenever coverage provided by any insurance policy is in violation of any U.S, U.N or EU economic or trade sanctions, such coverage shall be null and void. For example, Aetna companies cannot pay for health care services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions.

Aetna does not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to aetnainternational.com

Employee Assistance Program (EAP)

Life is full of challenges. Our Employee Assistance Program (EAP) helps you balance the demands of work, life and personal issues. Whether it's finding balance between work and life, dealing with the loss of a loved one, managing anxiety or depression, or parenting advice, EAP offers you free, confidential support delivered by qualified counselors.

- Up to five free counselling sessions per concern, per year
- Multilingual, 24/7, worldwide support
- Telephone support from behavioral health experts
- Referral to legal and financial resources

Easy access
To reach out for EAP assistance, call our Member Service Center using the phone number located on the back of your Member ID card.

When outside the United States, you can access your international EAP through the iConnectYou app on your portable device or mobile phone. The app gives you secure, confidential access to clinical counselors and work-life experts by phone, instant message, text (SMS) or video chat.

NOTE: Aetna does not render health care services and/or treatments and, therefore, cannot guarantee any results or outcomes. All participating providers are independent contractors and are neither agents nor employees of Aetna. The availability of any provider cannot be guaranteed, and the provider network composition is subject to change

Aetna Security Assistance powered by Crisis24

We're more than just health insurance. We help protect our members by providing security advice and assistance to keep them safe from political unrest and natural disasters. To do this, we partner with global crisis management experts Crisis24 (previously called WorldAware) to make sure members have help — should their safety ever be threatened.

Aetna Security Assistance powered by Crisis24 offers valuable resources and support such as:

- 24/7 access to personalized safety advice from multilingual representatives
- Reliable information on more than 160 countries and more than 285 cities
- Travel safety briefings and security alerts tailored to your trip or assignment
- Email and text alerts providing up-to-the minute information on civil unrest, natural hazards and travel disruptions

To register, go to Crisis24Horizon.com/Aetna and register with your information and use member ID: **AETNAINTL**. Or if you prefer, you can call Crisis24's security management experts at +1-646-513-4232 to sign up.

Program is underwritten by Aetna Life & Casualty (Bermuda) Ltd