

Cornell University



EYE CARE PLAN

For Student Health Insurance
Plan (SHIP) Members
2010 - 2011

Cornell University students and dependents who are members of the Student Health Insurance Plan may enroll in an optional eye care insurance plan that has been tailored to fit their needs. This plan, offered through First Ameritas Life Insurance Corp. of New York, provides exam and materials coverage and access to the EyeMed eye doctor network, with more than 38,000 providers nationwide at over 25,000 locations.

Insurance Provided By:



See the Benefits of Eye Care Insurance

Good vision health is important to overall health, academic success, and your quality of life. Cornell University is pleased to offer students and dependents the option of enrolling in this eye care insurance plan.

The First Ameritas ViewPointeSM eye care insurance plan provides benefits for annual exam and vision care materials, such as glasses and contacts. In addition, the plan offers access to EyeMed's eye doctor network (visit www.eyemedvisioncare.com). Regular eye exam can detect eye health problems and medical conditions such as high blood pressure, diabetes, kidney problems and certain cancers. Many new blindness cases each year can be cured or prevented with early detection. Statistics show that having eye care insurance, like this affordable plan from First Ameritas, encourages regular eye exams and preventive care.

Eligibility

You must be enrolled in the Cornell University Student Health Insurance Plan (SHIP) to enroll in this eye care plan. To enroll dependents (spouse, same-sex partner (SSP), children), you and they must be enrolled in the SHIP. Students who were registered in the fall semester may not purchase coverage for the spring semester.

Enroll Today!

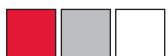
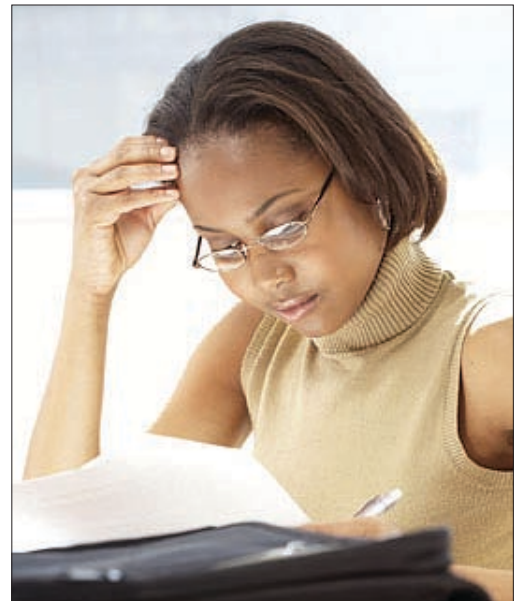
Just complete the attached application and return it to the Cornell University Office of Student Health Insurance.

After returning the application form, please allow at least ten days for First Ameritas' enrollment systems to update before scheduling an eye care appointment. Prior to this time, you may not appear as an insured member of the plan.

Fall deadline: September 30, 2010

New Spring entrants only deadline: February 28, 2011

Late registrants: 30 days after registration



Eye Care Plan Highlights

Service	Benefits with EyeMed Doctor *	Maximum Covered Expense with Non EyeMed Doctor *
Annual Exam	100% Covered After Deductible	\$ 35.00 ****
Frame	\$100.00 **	\$ 45.00 ****
Single Lenses	100% Covered	\$ 25.00 per pair ****
Bifocal Lenses	100% Covered	\$ 40.00 per pair ****
Trifocal Lenses	100% Covered	\$ 55.00 per pair ****
Lenticular Lenses	20% Discount	No Benefit
Contact Lenses Necessary ***	100% Covered	\$ 200.00 per pair ****
Contact Lenses Elective ***	\$80.00 per pair ****	\$ 64.00 per pair ****

Frequency Allowance

Exam benefit allowed once in a 12-month period

Lens benefit allowed once in a 12-month period

Frames benefit allowed once in a 12-month period

Contact Lens benefit allowed once in a 12-month period

Please Note: Either a lens and frame benefit OR a contact lens benefit is covered once in a 12-month period.

This eye care plan provides, on average, a 15% discount off retail price or 5% off promotional price on plan approved laser assisted in-situ keratomileusis (LASIK) and photorefractive keratectomy (PRK) laser surgery when coordinated by an EyeMed panel doctor and performed at a contracted laser surgery center.

* Patient is responsible for \$10.00 annual deductible on exam and \$0.00 annual deductible on materials.

** EyeMed provides a \$100.00 allowance toward a new frame. If the Insured chooses a frame valued at more than the plan's allowance, you will receive a 20% discount on the amount over your frame allowance.

*** When contact lenses are selected:

1. The insured is eligible for an exam and contact lenses. Other limitations and provisions of the policy will apply. The benefit for the examination will be reimbursed as shown above.
2. The exam, lens, and frame benefit will not be available for the next 12-month period following the date of service. See Limitations and Exclusions for a list of services not covered.
3. Contact lenses are defined as medically necessary if the individual is diagnosed with a medical condition that requires contacts instead of glasses to correct vision. See limitations and exclusions for specific details.

**** Patient pays remainder.

To ensure you receive the full network benefit, remember to present your Vision ID card when visiting an EyeMed provider. To find an EyeMed eye care provider in your area, please visit the Cornell University Office of Student Health Insurance web site at www.studentinsurance.cornell.edu.

Premiums

	Annual Rates	Spring Rates
Student	\$148	\$96
Spouse/Same-Sex Partner (SSP)	Additional \$133	Additional \$89
One or more children	Additional \$89	Additional \$61

Annual rates are effective for the time period 8/17/2010 – 8/16/2011.

Spring rates are effective for the time period 1/17/2011 – 8/16/2011.

Premium refund policy – Any student withdrawing from Cornell University during the first 31 days of the period for which coverage is purchased will not be considered covered under the Policy and will receive a full refund of the paid premium unless a claim is paid. Students withdrawing after 31 days will remain covered under the Policy for the full period for which premium has been billed and no refund will be allowed.

Plan Limitations and Exclusions

Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. vision examinations more than the frequency as indicated on the plan summary page.
2. lenses more than the frequency as indicated on the plan summary page.
3. frames more than the frequency as indicated on the plan definition page.
4. contact lenses more than once in any twelve month period. When chosen, contact lenses shall be in lieu of any other lens benefit during the twelve month period. When eyeglass lenses are chosen, expenses for contact lenses are not Covered Expenses during the twelve month period.
5. contacts limited to the amount shown on the plan summary page unless they are medically necessary. Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:
 - a. keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
 - b. high Ametropia exceeding -12 D or +9 D in spherical equivalent.
 - c. anisometropia of 3 D or more.
 - d. patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

If the member is diagnosed with a medically necessary condition, the Provider will submit a request for pre-authorization to EyeMed. The Medical Director reviews all requests for medically necessary contact lenses. If approved, the member will be covered for medically necessary contact lenses up to the plan allowance.

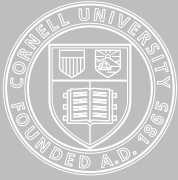
Such payment is limited to once in any twelve month period and is in lieu of lens benefits under this proposal.

6. orthoptics or eye care training and any associated testing.
7. plano non-prescription lenses and non-prescription sunglasses (except for 20% discount).
8. two pairs of glasses in lieu of bifocals (does not apply to Secondary Discounts).
9. lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
10. medical and/or surgical treatment of the eye, eyes, or supporting structures.
11. services for which a claim is filed more than 1 year after completion of the service.
12. for any procedure not listed on the Schedule of Eye Care Services.



This brochure is a benefit highlight, not a certificate of insurance. The coverage outlined here highlights the eye care benefits available through First Ameritas Life Insurance Corp. of New York.

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Cornell University Eye Care Plan Enrollment Application

Student Name: _____

Cornell ID Number: _____ Net ID: _____

Enrollment identification cards are mailed to the local address that the student has on file with Cornell University. Please be sure your address is up to date at studentcenter.cornell.edu.

Telephone Number: () _____ Date of Birth ____/____/____ Sex: M F

Spring Fall

LIST ALL FAMILY MEMBERS/DEPENDENTS TO BE COVERED BY THIS ENROLLMENT

Name (Last, First, Middle Initial)	Relationship	Date of Birth	Sex
_____	Spouse/SSP	____/____/____	M F
_____	Child	____/____/____	M F
_____	Child	____/____/____	M F
_____	Child	____/____/____	M F
_____	Child	____/____/____	M F

PREMIUM RATES (please check one)

	Annual Rates <input checked="" type="checkbox"/>	Spring Rates* <input checked="" type="checkbox"/>
Student	\$148	\$96
Spouse/Same-Sex Partner (SSP)	Additional \$133	Additional \$89
One or more children	Additional \$89	Additional \$61

*Spring rates and enrollment are available to new spring entrants only.

By signing below, I certify that this enrollment information is true and correct. I understand that in order to be enrolled in this eye care plan each member (including dependents) must also be enrolled in the SHIP. I understand that the premium amount selected will be billed to my Cornell University Student Bursar account. I also understand this plan is non-cancelable and non-refundable.

Student Signature: _____ Date: _____

Please return your completed application to:
Cornell University Office of Student Health Insurance
409 College Avenue, Suite #211
Ithaca, NY 14850
Phone: (607) 255-6363
Fax: (607) 254-5221