student vision plan

Convenience and Value
2017 - 2018

Cornell University students and their dependents can save on eye exams, glasses, contacts and laser vision surgery by enrolling in an optional vision plan offered by Ameritas Life Insurance Corp. of New York.

Eligibility: You must be a registered Cornell University student to enroll in this vision plan. To enroll dependents (spouse, domestic partner, children), you must be enrolled on the plan. Students who were registered in the fall semester may not purchase coverage for the spring semester only.

How to Enroll: Complete the on-line application form at www.studenthealthbenefits.cornell.edu and allow at least ten days for processing before scheduling a vision care appointment. Prior to this time, you may not appear as an insured member of the plan.

Deadlines: Fall 9/30/2017, New Spring entrants only 2/28/2018, Late registrants 30 days after registration.

Insurance Provided By:

Ameritas Life Insurance Corp. of New York
### Your Ameritas of New York Vision Plan

A diverse EyeMed provider network, the ability to use your benefits online, plus discounts on additional glasses and sunglasses that are above the industry standard.

**See the Savings**

<table>
<thead>
<tr>
<th>Service</th>
<th>What your plan pays in-network</th>
<th>What your plan pays out-of-network</th>
<th>What you pay</th>
<th>Premiums</th>
<th>Annual Rates</th>
<th>Spring Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Exam</td>
<td>100% after deductible</td>
<td>$35</td>
<td>Remaining balance</td>
<td>Student</td>
<td>$142</td>
<td>$92</td>
</tr>
<tr>
<td>Frames</td>
<td>$100</td>
<td>$45</td>
<td>Remaining balance (minus 20% discount if in-network)</td>
<td>Spouse/Domestic Partner</td>
<td>Additional $128</td>
<td>Additional $85</td>
</tr>
<tr>
<td>Single Lenses</td>
<td>100%</td>
<td>$25 per pair</td>
<td></td>
<td>One or more children</td>
<td>Additional $85</td>
<td>Additional $59</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>100%</td>
<td>$40 per pair</td>
<td>Remaining balance if out-of-network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>100%</td>
<td>$55 per pair</td>
<td>Remaining balance if out-of-network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenticular Lenses</td>
<td>$0</td>
<td>$0</td>
<td>Remaining balance (minus 20% discount if in-network)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacts medically necessary</td>
<td>100%</td>
<td>$200 per pair</td>
<td>Remaining balance if out-of-network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacts elective</td>
<td>$80 per pair</td>
<td>$64 per pair</td>
<td>Remaining balance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

**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 summary 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 vision 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 Vision Services.
Things to Know

EyeMed Access Network: Choose from more than 94,000 providers, including more than 21,000 independent locations and more than 6,000 retail locations. Find a provider at eyemedvisioncare.com.

Online in-network options: Order eyewear online at glasses.com and contactsdirect.com. Both are in the EyeMed network, so when you’re ready to buy, each site will incorporate your benefit pricing and show your cost after allowances and copays. Learn more at eyemedvisioncare.com.

In-network vs out-of-network: Your vision plan provides benefits whether your doctor is in- or out-of-network. You have the freedom to visit any provider you choose, however by visiting a network provider, your out-of-pocket expenses are lower and there are no claim forms to complete. If you visit a non-network provider, you must pay the charges and submit a claim. We will reimburse you according to the non-network maximum covered expense amounts of your plan.

Benefit frequencies: Whether you visit an in- or out-of-network provider, your vision benefits can be applied to an exam and either lenses/frames OR contacts once in a 12-month period. In other words, you will not receive an allowance for contacts if you already chose to apply your vision benefits to a new pair of lenses and/or frames during the same benefit year.

Big discounts: Additional savings make it even more enticing to visit a network provider.
  • 40% off additional pairs of glasses
  • 20% off any remaining balance over the frame allowance
  • 20% off any non-covered item, such as lens cleaner or non-prescription sunglasses
  • 15% off retail or 5% off the promotional price of LASIK

Laser vision surgery: Your vision 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.

ID card: You can access your personalized ID card anytime via eyemedvisioncare.com or the EyeMed app, however, you do not need an ID card to use your vision benefits. Simply tell your provider you have EyeMed and supply your student ID (including the two leading zeroes) instead of your social security number.

Get the app: With EyeMed’s app you can receive reminders about upcoming exams, pull up your ID card, find a provider, load and save your prescription and more – all while on the go.

For additional information and resources visit www.ameritas.com/group/olbc/cornellstudents
New York Limitations and Exclusions

No coverage is available under this Policy for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Cosmetic Services.
We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Policy unless medical information is submitted.

D. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your treatment in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Policy for non-investigational treatments. See the Utilization Review and External Appeal sections of this Policy for a further explanation of Your Appeal rights.

E. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

F. Foot Care.
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

G. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

H. Medical Services.
We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

I. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

J. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

K. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

L. Services Not Listed.
We do not Cover services that are not listed in this Policy as being Covered.

M. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your Spouse.

N. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

O. Services with No Charge.
We do not Cover services for which no charge is normally made.

P. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

Q. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

For enrollment and billing:
Cornell University
Office of Student Health Benefits
312 College Ave, Suite A
Ithaca, NY 14850
Phone: (607) 255-6363
Fax: (607) 254-5221
Web: studenthealthbenefits.cornell.edu

For claims assistance:
EyeMed: (866) 939-3633
Ameritas Life Insurance Corp. of New York
1350 Broadway, Suite 2201
New York, NY 10018
Phone: (800) 628-8889
Fax: (845) 357-3612
Web: ameritas.com

1EyeMed's internal analysis of membership data compared to publicly available data from leading vision benefit companies, as reported in Freedom of Information Act requests and news stats as of 10/30/14.
This information is provided by Ameritas Life Insurance Corp. of New York (Ameritas of New York). In New York, group dental and vision products (9021 NY Ed. 11-16 S) and individual dental and vision products (Indiv. 9000 NY Ed. 07-16) are issued by Ameritas of New York. Some plan designs are not available in all areas. Most plans for groups with 26 or more enrolled lives are administered by Ameritas of New York.
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