HEALTH CARE BEGINS AT THE RIT STUDENT HEALTH CENTER
Student Accident and Sickness
Insurance Program
–
2005-2006
For Students of
R I T
Rochester Institute of Technology
Rochester, New York 14623
Underwritten by:
Aetna Life Insurance Company (ALIC)
Serviced by:
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169
(800) 437-6448
Claims Administrator:
Chickering Claims Administrators, Inc.
P.O. Box 15708Boston, MA 02215-0014
(800) 466-3185
Hearing Impaired (800) 466-5996
Policy Number: 812809
(Excess Acc. Policy Number: 812809-50-555)

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Underwritten by:
Aetna Life Insurance Company

Dear Students, Parents and/or Guardians:
RIT is concerned about the health, safety and general physical and mental well-being of its students. We recognize, however, that students may encounter accidents and sickness while enrolled at RIT. The RIT Student Health Center is available for students to use when medical attention is needed. To supplement this, RIT offers a direct enrollment student insurance program. RIT requires all students to have adequate medical insurance coverage.
All domestic students must directly enroll themselves onto the Student Health Insurance Plan. Enrollment must be completed by September 30, 2005 (for students first registered in Fall quarter). International students should refer to the International Student Enrollment Process.
Part I of this Brochure provides information about the health care services and programs offered by the RIT Student Health Center. These services are funded through quarterly health fees, which all full-time undergraduate students are required to pay. The health fee is also used to support other health related services and health education on campus. Part-time and graduate matriculated students may use the Student Health Center by paying the quarterly fee, or by paying a per visit/service fee.
Parts II-V of this Brochure outline the benefits offered in RIT's Student Insurance Plans underwritten by Aetna Life Insurance Company. Part VI describes an Eyecare Discount Plan that is available to RIT students enrolled in the basic
medical insurance plan.
The 2005-06 Plans provide substantial benefits for covered medical expenses at a reasonable cost. Coverage includes the "Basic Student Accident & Sickness Plan", the optional "Enhanced Supplemental Medical Plan" and the "Excess
Accident Plan". Coverage is also available for a student's spouse and/or dependent children at an additional charge. At no charge to students, RIT maintains the Excess Accident Plan available to all RIT students for accidents occurring on campus or off-campus during an RIT sponsored activity.

Enrollment Process
RIT requires all students to have adequate medical insurance. If a student does not have coverage, this requirement may be satisfied by enrolling for Basic Accident & Sickness coverage BEFORE THE ENROLLMENT DEADLINE DATE OF SEPTEMBER 30, 2005, or later date if appropriate. Students can enroll in this Plan by either:

- Sending the Enrollment Form on the last page of this Brochure with their payment to the Plan Coordinator: University Health Plans, One Batterymarch Park, Quincy, MA 02169.
- Going Online at www.universityhealthplans.com: Students have the option to either put the charge on their RIT student account or payment can be made online with a credit card.

Students first registering at RIT in the Winter, Spring or Summer quarters must enroll within 30 days from the start of the quarter.
Note: Graduate and part-time students may voluntarily enroll in "Basic Student Accident & Sickness Plan.

International Student Enrollment Process
ALL international undergraduate and graduate students (full and part-time) on A, B, E, F, G, I, J, K, O, Q, R and V visa's will be automatically enrolled in the Basic Accident and Sickness policy on a semi-annual basis, based on registration status. Certain foreign scholars will be eligible for exemption from RIT's required insurance enrollment and will not be billed for this coverage.
For parents of entering students, we urge you to evaluate the RIT Student Insurance Plan for your student, not only based upon the absence of insurance coverage, but as an important Rochester medical community-based supplement to
existing insurance coverage.
For Student Health Center information please contact the Student Health Center at (585) 475-2255 V or (585) 475-5515 TTY. For Student Accident & Sickness Insurance information contact University Health Plans at (800) 437-6448, info@univhealthplans.com.
Sincerely,
E. Cassandra Jordan Director
RIT Student Health Center

WHERE TO FIND HELP

Got Questions? Get Answers with Chickering's Aetna Navigator™
As a Chickering student health insurance member, you have access to Aetna Navigator™, your secure member website, packed with personalized benefits and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging into Aetna Navigator, you can:
- Review who is covered under your plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Estimate the cost of common health care services and procedures to better plan your expenses.
- Research the price of a drug and learn if there are alternatives.
- Find health care professionals and facilities that participate in your plan.
- Send an e-mail to Chickering Customer Service at your convenience.
- View the latest health information and news, and more!

How do I register?
- Go to www.chickering.com
- Click on "Find Your School."
- Enter your school name and then click on "Search."
- Click on Aetna Navigator and then the "Access Navigator" link.
- Follow the instructions for First Time User by clicking on the "Register Now" link.
- Select a user name, password and security phrase.

Your registration is now complete, and you can begin accessing your personalized information!

Need help with registration?
Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at 1-800-225-3375.

For questions about:

• Insurance Benefits
• Claims Processing
• Claims Disputes
Please contact:
Chickering Claims Administrators, Inc.
P.O. Box 15708 Boston, MA 02215-0014
Telephone Number: (800) 466-3185
www.chickering.com
For questions about:
• Enrollment/Eligibility
• International Student Waiver Process
Please contact:
University Health Plans, Inc.
(800) 437-6448
www.universityhealthplans.com
For Provider Listings:
-A complete list of providers can be found by accessing Aetna's DocFindR Service at:
www.chickering.com, click on "Find Your School" enter Policy Number 812809
For questions about:
Worldwide Emergency Travel Assistance Services
Please contact:
Assist America, Inc.
(800) 872-1414 (within U.S.)
If outside the U.S., call collect by dialing the U.S. access code plus (301) 656-4152
e-mail address: medservices@assistamerica.com

PART I
SERVICES AVAILABLE AT THE RIT
STUDENT HEALTH CENTER
Access to the RIT Student Health Center is still available if students do not purchase the Student Accident and Sickness Insurance Plan.
CONFIDENTIALITY
The Student Health Center is very sensitive to the importance of confidentiality in the provider-patient relationship. Information is not
released to Institute authorities, other colleges or agencies, or parents without written authorization by the student, except as required
for insurance reimbursement or as required by law.
WHAT IS THE STUDENT HEALTH CENTER?
The Student Health Center (SHC) provides a full range of primary care, treatment and referral services, as well as related health education programs. All programs and services are aimed at maintaining the physical and emotional well being of RIT Students.
The SHC is located in the August Center, a free-standing ambulatory care facility on the main campus between the residential and academic sides of campus. This well equipped facility provides medical treatment and office consultation space for a variety of outpatient services, as well as a 3-bed observation unit for use during Center hours. In addition to the August Center facility, the SHC provides emergency medical service coverage and/or transport 24 hours/day, 7 days/week via the RIT Ambulance.
HOW IS THE STUDENT HEALTH CENTER STAFFED?
The SHC is staffed by physicians, nurse practitioners, nurses, health educators and support staff - all well trained, fully licensed professionals. The SHC providers are licensed (as appropriate) in specialty areas that include Adult Medicine, Family Practice, Gynecology, Health Education, Sign

Language Interpreting for the Deaf, Alcohol and Other Drug Counseling. The Center serves as a teaching site for a variety of RIT academic programs including its Physician Assistant and Nutrition Programs; practicum experiences are provided for students of other colleges as well.

WHEN IS THE STUDENT HEALTH CENTER OPEN?

During the fall, winter and spring quarters, the SHC is open Monday-Thursday, 8:30 a.m. - 7:00 p.m.; Friday, 8:30 a.m. - 4:30 p.m.

During the summer and quarter breaks, the SHC is open weekdays, 8:30 a.m. - 4:30 p.m. The SHC is closed during university holidays. After normal hours of operation, campus coverage is maintained through the RIT Ambulance dispatched by Campus Safety (475-3333 V or 475-6654 TTY) who may refer/transport serious medical conditions or emergencies to a local hospital emergency department as the case demands.

Important Note: Please remember that every effort is made by SHC personnel to accommodate students at the times listed in this Brochure. Since this is a medical facility, however, unexpected emergencies occur making it impossible to adhere to fixed schedules at all times. Changes in hours are posted.

WHO CAN USE THE STUDENT HEALTH CENTER?

Unless otherwise indicated, the services and programs listed in this guide are available to all students. Full-time undergraduate students are required to pay the quarterly health fee. Part-time, graduate and co-op students may elect to pay the health fee or use the SHC on a fee-for-service basis.

STUDENT HEALTH FEE COVERAGE AND FINANCIAL RESPONSIBILITY

Most of the medical, mental health, and health education services provided by the SHC are paid for by the quarterly health fee with no additional charge to the patient or user of the service. This includes office visits, some routine laboratory work, some immunization service visits, minor surgery, bed observation, on-site specialty services, substance abuse counseling services, HIV antibody counseling services and health education programs. Diagnostic x-ray services are provided in cooperation with an off-campus radiology group. Billing for this service is routinely accomplished through the student's health insurance carrier. Charges for pharmaceuticals at the SHC or off-campus, referred procedures through the medical or gynecologic clinics, lab work processed at outside laboratories, tuberculin PPD tests, some serum injections, and certain specialty procedures are the responsibility of the student or parent/guardian. In addition, the cost of receiving medical care and psychiatric counseling beyond that provided by the SHC or other on-campus services including referrals to specialists, use of hospital emergency departments or hospitalization, is the responsibility of the student or parent.

HEALTH SERVICES AND HOW TO USE THEM

OUTPATIENT CLINICS AND SPECIALTY SERVICES

The SHC has three types of clinical services: Outpatient/General medical; Allergy/Immunization; and Sexual Health/Gynecology. All services operate on an appointment basis. Emergency appointments are accommodated as necessary.

OUTPATIENT/ GENERAL MEDICAL CLINIC

The Outpatient/General Medical Clinic is staffed by physicians, nurse teams and nurse practitioners, Monday through Friday from 8:30 a.m. to 4:30 p.m. Limited services are available Monday-Thursday from 4:30 p.m. to 7:00 p.m. When the SHC is closed, call Campus Safety (475-3333 V or 475-6654 TTY) for assistance.

ALLERGY/IMMUNIZATION CLINIC

Allergy injections are administered by appointment only on a regular basis in the Allergy Clinic at no additional charge to full-time undergraduate students. Students must provide their serum, instructions and schedule from their allergist.

SEXUAL HEALTH/GYNECOLOGY CLINIC

The Clinic is staffed by a full-time gynecologic nurse practitioner with training and experience in gynecology. Comprehensive services are provided by appointment and include complete pelvic

examinations, Pap smears, contraceptive services, pregnancy testing and counseling, and routine gynecological treatment.

PHYSICAL EXAMINATIONS

Routine physical examinations are not provided by the SHC. The SHC will assist students in arranging for physicals needed for coop, internships, etc. The student is responsible for this cost.

DISPENSARY SERVICES

For the convenience of RIT students, a limited range of prescriptive and non-prescriptive items and non-returnable orthopedic soft goods may be purchased at the SHC. Only prescriptions written by a SHC physician will be accepted. Payment is by check or cash at the time of service. The student may choose to use a community-based pharmacy.

LABORATORY SERVICES

Diagnostic laboratory testing is provided in support of all outpatient clinics and specialty services. Most of the lab work ordered at the SHC, including complete blood counts, mono testing, strep throat and urine cultures, cholesterol testing and glucose testing is sent to our reference lab. The patient is billed for this service by the laboratory.

RADIOLOGY

Diagnostic x-ray services are provided by a local radiology group. The patient is billed directly by the local radiology group for this service. Some HMO (Health Maintenance Organization) and PPG (Preferred Provider Group) based insurance plans exclude coverage for x-rays not authorized or taken in conjunction with that HMO/PPG. While every effort will be made by SHC staff to coordinate your level of coverage with the need for diagnostic x-ray services, you should be aware of your insurance coverage requirements and limitations at the time of your visit.

EKG

Electrocardiograph (EKG) diagnostic procedures are performed by staff physicians as needed. There is no additional charge for this service for students who have paid the quarterly fee.

MINOR SURGERY

During regular medical clinic hours, certain minor surgical procedures are performed by SHC staff physicians. Procedures include suturing of some lacerations, incision and drainage of some abscesses, removal of some small growths, and splinting or casting for some minor fractures. There is no additional charge for this service for students who have paid the quarterly health fee.

BORROWED ARTICLES

Crutches, canes and other re-usable medical supplies are available on a loan basis. Students will have their account charged for any equipment not returned.

BED OBSERVATION

The SHC provides a three-bed observation service. Patients can be maintained by providers for illness requiring observation, treatment and isolation of infectious disease, and for injury requiring in-bed care for the duration of hours of operation. This allows students to be observed and assisted until stable or until it is determined if another source of care is needed. There is no overnight service.

MEDICAL TRANSPORT SERVICES

The SHC will assist students in arranging medical transport services. Where there is an acute medical need, transportation may be provided by taxi to assist patients in getting to consulting physicians or other referral from SHC staff providers, for which students must pay. TRANSPORT SERVICES ARE NOT ARRANGED FOR SCHEDULED APPOINTMENTS WITH CONSULTING PHYSICIANS. Short-term on-campus transportation to and from classes for disabling injuries may be authorized by staff providers for transport by the Campus Mobility Van. In addition to the above, the SHC sponsors an emergency ambulance service. The service is operated by well-trained emergency medical student volunteers, utilizing a modern,
well-equipped Institute ambulance vehicle. The RIT Ambulance service operates on a 24 hour basis during the academic year and is dispatched through Campus Safety (475-3333 V or 475-

6654 TTY). The ambulance transport is to the emergency facility only. There may be a charge if another ambulance must provide the support.

HOW STUDENTS ARE ACTIVE IN THE STUDENT HEALTH CENTER

The SHC welcomes and encourages student participation in the on-going process of maintaining the quality of services, improving the way we do things and developing new programs to meet student needs. Feedback: There are a number of places to direct your comments/suggestions on how we can improve our services. You are encouraged to speak directly to the staff who have served you
or to their supervisor. A letter to the Director will receive a written response. Appointments to discuss concerns with the Director, the
Medical Director or Staff Assistant are also encouraged. You may also send your comments by e-mail. See the SHC home page (accessible through the RIT/Student Affairs home page) for details. The Student Health Advisory Council (SHAC) represents all Institute students and exists to provide input and assistance in the planning and evaluation of services, the preparation and review of the budget and special projects of the SHC. The group is made up of representatives from various student organizations and elected bodies, as well as interested students. The SHC places great value on the work of the Council and encourages your active participation. Interested students should contact the SHC at (585) 4752255 V or 475-5155 TTY or 475-5850 TTY. Peer Educators are students trained to help students by sharing information on sexuality issues, drugs, including alcohol, and sexual assault. They identify appropriate resources for health education and care, and make referrals.

SIGN LANGUAGE INTERPRETER

A full-time certified interpreter is on the staff to assist with those who are deaf or hearing-impaired.

MEDICAL EXCUSES FOR CLASS ABSENTEEISM

The SHC does not issue written medical excuses. Verbal information will be made available to faculty only with the written permission of the student.

HEALTH EDUCATION

Education is an integral part of the Student Health Center. Ask about our formal and informal classes, counseling for personal assistance, special presentations for your academic classes or campus residences, and resources for class assignments

PART II

STUDENT INSURANCE PLAN

BASIC ACCIDENT & SICKNESS

The Rochester Institute of Technology (RIT) Accident and Sickness Plan has been developed especially for RIT students. The Plan provides coverage for illnesses and injuries that occur on and off campus, and includes special cost-saving features to keep the coverage as affordable as possible. RIT is pleased to offer the Plans as described in this Brochure.

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

ELIGIBILITY

1. UNDERGRADUATE STUDENTS – as noted below.
(except international students)

RIT requires all students to have adequate medical insurance. If a student does not have coverage, this requirement may be satisfied by enrolling for Basic Accident & Sickness coverage BEFORE THE ENROLLMENT DEADLINE DATE OF SEPTEMBER 30, 2005, or later date if appropriate. Students can enroll in this Plan by either:

- Sending the Enrollment Form on the last page of this Brochure with their payment to the Plan Coordinator: University Health Plans, One Batterymarch Park, Quincy, MA 02169.

- Going Online at www.universityhealthplans.com: Students have the option to either put the charge on their RIT student account or payment can be made online with a credit card

Students first registering at RIT in the Winter, Spring or Summer quarters must enroll within 30 days from the start of the quarter.

Other comments:

A. Refer to Part III for enrollment method for adding Optional Supplemental Coverage.

2. GRADUATE AND FULL TIME MATRICULATED EVENING DIVISION STUDENTS:
Students may voluntarily enroll in this plan by sending the Enrollment Form on the last page of this Brochure with their payment to the Plan Coordinator: University Health Plans, One Batterymarch Park, Quincy, MA 02169 or enrolling online at www.universityhealthplans.com and students have the option to either put the charge on their RIT student account or pay online with a credit card.

3. INTERNATIONAL STUDENTS
All matriculated, RIT international students on A, B, E, F, G, I, J, K, O, Q, R and V visa's will be automatically enrolled in RIT's Basic Accident and Sickness policy.

These international students will be billed semi-annually based on their active registration status for the period (Fall/Winter and/or Spring/Summer). Coverage will terminate on March 13, 2006 if the student is not registered during the Spring/Summer period. Students first attaining active registration status in the Winter or Summer quarters will be billed 50% of the semi-annual premium and coverage will be provided until the next semi-annual billing cycle. All other international students wishing to enroll should download and fill out the Insurance Application found at www.universityhealthplans.com

4. OTHER STUDENTS:
ELI, SVP and foreign scholars may enroll through referral from their departments. Contact the Risk Management and Safety Services Office at (585) 475-4903 for enrollment information.

5. DEPENDENT COVERAGE:
Insured students may also enroll their dependents (spouse and unmarried children under age 19 residing with and supported by the Insured) in this Student Insurance Plan. To enroll your dependents, complete the Enrollment Form on the last page of this Brochure and mail with your payment to the Plan Coordinator: University Health Plans, One Batterymarch Park, Quincy, MA 02169. (Refer to "Addition of Dependents" section located on page 12). You can also enroll your dependents online at www.universityhealthplans.com. Payment must be made with a credit card for this option.

Students must be registered and enrolled in the Basic Plan in order for dependents to be eligible for insurance coverage.

MASTER POLICY
The Master Policy (referred to below as "this Policy" or "the Policy") issued to Rochester Institute of Technology (the Policyholder) contains the complete details of coverage and is the governing document. It may be inspected during normal business hours at the Risk Management and Safety Services Office. The Master Policy shall prevail in the event of any conflict between this Brochure and the Policy.

DEFINITION OF TERMS

Accident:

An occurrence, which (a) is unforeseen, (b) is not due to or contributed to by Sickness or disease of any kind, and (c) causes Injury.

Actual Charge:
The Actual Charge made for a covered service by the provider that furnishes it.
Aggregate Maximum:
The maximum benefit that will be paid under the Policy for all Covered Medical Expenses incurred by a Covered Person that accumulate from one year to the next.
Coinsurance:
The percentage of Covered Medical Expenses payable by Aetna under this Accident and Sickness Insurance Plan.
Covered Medical Expenses:
Those charges for any treatment, service or supplies covered by the Policy which are (a) not in excess of the Reasonable Charges, or (b) not in excess of the charges that would have been made in the absence of this coverage, and (c) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefit Provisions.
Covered Person:
A covered student whose coverage is in effect under the Policy. See the Eligibility sections of this Brochure for additional information.
Creditable Coverage:
Creditable Coverage means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.
Deductible:
A specific amount of Covered Medical Expenses that must be incurred by, and paid for by the Covered Person before benefits are payable under the Plan. Deductible amounts are the responsibility of the Covered Person.
Elective Treatment:
Medical treatment that is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities (unless otherwise provided in the Policy); immunization; vaccines; treatment of infertility; and routine physical examinations.
Emergency Medical Condition:
A medical or behavioral condition, the onset of which is sudden, and manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate, medical attention to result in (a) placing the health of the person afflicted with such condition in severe jeopardy, or, in the case of a behavioral condition placing the health of such person or others in serious jeopardy, (b) serious impairment to such person’s bodily functions, (c) serious dysfunction of any bodily organ or part of such person, or (d) serious disfigurement of such person. It does not include elective care, routine care, or care for non-emergency Sickness.
Injury:
Bodily Injury caused by an accident; this includes related conditions and recurrent symptoms of such Injury.
Medically Necessary:
A service or supply that is necessary and appropriate; for the diagnosis or treatment of a Sickness; or Injury; based on generally accepted current medical practice.

In order for a treatment, service, or supply to be considered Medically Necessary, the service or supply must:

- Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply; both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply; both as to the Sickness or Injury involved and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply; both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply; both as to the Sickness or Injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances; Aetna will take into consideration:

- Information relating to the affected person's health status;
- Reports in peer reviewed medical literature;
- ù -Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical, mental health, or dental professional; or
- Those furnished mainly for the personal comfort or convenience; of the person; any person who cares for him or her; or any person who is part of his or her family; any health care provider; or health care facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished; in a Physician's or a dentist's office; or other less costly setting.

Non-Preferred Provider:

A health care provider that has not contracted to furnish services or supplies at a Negotiated Charge.

Pharmacy:

An establishment where Prescription Drugs are legally dispensed.

Preferred Provider:

A health care provider that has contracted to furnish services or supplies for a Negotiated Charge; but only if the provider is, with Aetna’s consent, included in the Directory as a Preferred Care Provider for the service or supply involved, and the class of which the Covered Person is a member.

Physician:

A legally qualified physician licensed by the state in which they practice, and any other practitioner that must by law be recognized as a doctor legally qualified to render treatment.

Prescription:

An order of a prescriber for a Prescription Drug. If it is an oral order, it must be promptly put in writing by the Pharmacy.

Reasonable Charge:

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate; based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances; Aetna may have an agreement; either directly or indirectly through a third party; with a provider which sets the rate that Aetna will pay for a service or supply. In these instances; in spite of the methodology described above; the Reasonable Charge is the rate established in such agreement.

In determining the Reasonable Charge for a service or supply that is:

- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity
- The degree of skill needed
- The type of specialty of the provider
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

Sickness:

A disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and
complications of pregnancy.

ANNUAL INSURANCE COSTS

BASIC BENEFITS

Student Only..$550
Spouse (Additional)..$1,092
Child(ren) (Additional)..$822

OPTIONAL ENHANCED SUPPLEMENTAL

Each Insured $366

· NOTE: This optional coverage is per insured and is not pro-ratable.

Premium Refund Policy

Except for medical withdrawal due to a covered Accident or Sickness, any student who has not incurred any claims and who withdraws from school within the first 31 days for which coverage is purchased shall not be covered under the Plan and a full refund of premium will be made. Students withdrawing after such time will remain covered under this Plan for the full period for which premium has been paid. No refund will be allowed.

A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata
refund of premium will be made for such person upon written request received by University Health Plans within 90 days of
withdrawal from school.

WAIVER PROCESS

For International Students only:

Refer to RIT Center for Student Transition & Support website for special conditions and instructions:

http://www.rit.edu/internationalservices

CONTINUOUSLY INSURED

Continuously Insured is defined as: A person who was insured under prior Creditable Coverage, including Student Health Insurance policies issued to RIT, and is now insured under this Plan. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except as specified in the Pre-Existing Conditions provision.

Previously insured students and dependents must re-enroll for coverage by September 30,2005 for the Fall quarter and by March13, 2006, for the 3rd quarter if paying on a semi-annual basis in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in continuous coverage occurs, the definition of a Pre-Existing Condition will apply in determining coverage of any condition which existed during the break. Students re-enrolled through RIT will be considered to have continuous coverage.

LATE ENROLLMENT

Under certain circumstances, coverage for late enrollees may be possible. Any enrollment occurring 30 days after the first day of the quarter is considered a late enrollment. Refer to the Master Policy for details. Please refer to the General Provisions section of this Brochure for the definition of a Pre-Existing Condition, which applies to all late enrollees under this Plan.

POLICY PERIOD

All students and dependents enrolled in the Plan will be insured for the period for which premium has been paid, including interim vacations. Coverage begins at 12:01 A.M., on August 15, 2005 or the date premium is paid, if later, and ends at 12:01 A.M. on August 15, 2006 except as noted below in Termination of Student Coverage section on page 24.

International Students

All students and their dependents will be insured for the period for which premium has been paid, including interim vacations.

Coverage begins at 12:01 am on August 15, 2005 or the date premium is paid, if later, and ends at 12:01 am on March 13, 2006. If the second semi-annual premium is paid, coverage will extend to 12:01 am on August 15,2006.

ADDITION OF DEPENDENTS

If an Insured adds a new dependent after the effective date of coverage, coverage will become effective for such dependent on the date the application and premium is received. An Enrollment Card and premium must be submitted within the thirty (30) day enrollment period for which the student is first enrolled. If the dependent is a newborn child and no other children are covered under the plan, notification of the birth along with the appropriate premium must be submitted within 30 days of such birth. (Addition of a spouse must be within 30 days of marital status change.)

An Enrollment Card and premium need not be submitted if the newly added dependent is a child and the Insured already has one or more covered children. However, written notice of the new child must be submitted within the 30 day period.

Benefits for covered newborn children are payable for medically diagnosed congenital defects, birth abnormalities or premature birth. Benefits are not payable for routine nursing care of a newborn well baby following full-term or premature birth, except as required under the Maternity portion of the Plan.

Newborn Infant Coverage and Adopted Child Coverage

A newborn child shall be insured for Injury, Sickness, premature birth, and medically diagnosed congenital defects and birth abnormalities for 31 days from the date of birth. At the end of this 31-

day period, coverage will cease under the RIT Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the Covered Person must (1) enroll the child within 31 days of birth and (2) pay the additional premium starting from the date of birth.
Coverage is provided for a child legally placed for adoption with a covered student for 31 days from the moment of placement, provided the child lives in the household of the covered student and is dependent upon the covered student for support. To extend coverage for an adopted child past the 31 days, the Covered Person must (1) enroll the child within 31 days of placement of such child and (2) pay any additional premium, if necessary, starting from the date of placement.
For further assistance and premium information, please contact University Health Plans.

PREFERRED PROVIDER NETWORK

The Chickering Group has arranged for you to access a Preferred Provider Network in your local community. Acute care facilities and mental health networks are available nationally if you require hospitalization outside the immediate area of the RIT campus. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because significant savings may be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Preferred Providers are independent contractors and are neither employees nor agents of RIT, Chickering Claims Administrators, Inc., or Aetna Life Insurance Company (Aetna). A complete list of providers can be found by accessing Aetna's DocFindR Service at: www.chickering.com, click on "Find Your School" enter Policy Number 812809.

Pre-admission certification is designed to help you receive quality, cost-effective medical care.

- All inpatient admissions, including length of stay, should be certified by contacting Chickering Claims Administrators, Inc. Your service provider may be able to assist you.
- Pre-Certification does not guarantee the payment of benefits for your inpatient admission. Each claim is subject to medical policy review in accordance with the exclusions and limitations contained in the Policy as well as a review of eligibility, adherence to notification guidelines, and benefit coverage.

Pre-Certification of Non-Emergency Inpatient Admissions:
The patient, Physician or hospital should telephone at least three business days prior to the planned admission.
Notification of Emergency Admissions:
The patient, patient's representative, Physician, or hospital should telephone within one business day following admission.
Chickering Claims Administrators, Inc.
Attention: Managed Care Dept.
P.O. Box 15708
Boston, MA 02215-0014
(800) 466-3185
Hours: Monday through Friday, 8:30 a.m. to 5:30 p.m. (ET)

DESCRIPTION OF BASIC BENEFITS

Summary of Benefits

The following benefits are subject to the Policy limits and exclusions. All coverage is based on the Reasonable Charge allowance
unless otherwise specified and is payable per condition.

BASIC ACCIDENT:
Lifetime Maximum - $103,000 per condition
Coinsurance Level

Covered Medical Expenses are payable as follows:
100% of the Negotiated Charge or the Reasonable Charge allowance (Preferred and Non-Preferred Providers respectively) for the first $3,000 of Covered Medical Expenses; 80% thereafter. Covered Medical Expenses include (a) hospital room and board, (b) miscellaneous hospital expenses, (c) inpatient and outpatient surgery, (d) inpatient and outpatient anesthetist, (e) inpatient and outpatient Doctor visits, (f) consultant, (g) licensed nurse, (h) hospital outpatient department, (I) emergency room, (j) diagnostic x-ray and lab tests, (k) outpatient prescription drug, (l) ambulance, (m) durable medical equipment, and (n) other expenses incurred for the treatment of an Injury.

BASIC SICKNESS:
Lifetime Maximum - $52,000 per condition
Coinsurance Level
Covered Medical Expenses are payable as follows:
100% of the Negotiated Charge or the Reasonable Charge allowance (Preferred and Non-Preferred Providers respectively) at the following schedule of Covered Medical Expenses for the first $2,000; 80% thereafter.

Hospital Room and Board Expense
Covered Medical Expenses are payable for the daily semi-private room rate and general nursing care by the hospital up to a maximum of $425 per day.

Miscellaneous Hospital Expense
Covered Medical Expenses for hospital miscellaneous expenses, operating room, lab tests, X-rays, anesthesia, drugs and medicines (excluding take home drugs), therapeutic services, and supplies are payable up to a maximum of $1,200 per condition.

In-Hospital Doctor's Fee Expense Benefits - When you or your covered dependent require a doctor's services due to reasons of sickness for which benefits are payable under the Miscellaneous Hospital Expenses Benefits provision, benefits will be payable at 100% of expenses incurred up to $65 per visit for non-surgical services limited to one visit per day. An additional $125 will be paid for the services of a consultant or specialist to confirm or determine a diagnosis.

Nurse Expense
Covered Medical Expenses are payable up to a maximum of $60 per day.

Surgical Benefits (Inpatient and Outpatient)
Surgical Expense
Covered Medical Expenses for charges for surgical services, including anesthesia, performed by a Physician are payable up to a maximum of $1,500 per condition. Expenses for an assistant surgeon are also covered under this benefit.

Out of Hospital Doctor's Fee
Physician's Office Visits
Covered Medical Expenses are payable up to a maximum of $65 per visit and up to a maximum of 10 visits per Policy Year. An additional maximum of $125 will be paid for the services of a consultant to confirm or determine a diagnosis.
Benefits are not payable for the first visit unless at the time treatment is received; (a) the Student Health Center is open and a referral is obtained, (b) the Student Health Center is closed, (c) the student is 50 miles or more from campus, (d) the student is an active participant in a Co-op program or (e) the student or dependent is not eligible to be seen at the Student Health Center.

Out-Patient Expense Benefits
When you or your covered dependent require Out-Patient Services, benefits will be payable at 100% in accordance with the following schedule per year:
Outpatient Services .... up to $750
Diagnostic X-ray and laboratory: .... up to $1,000
MRI and CAT Scans:................................up to $1,000
This benefit is provided (a) for students when referred for such services by the RIT Student Health Center or when required by an attending physician when the RIT Student Health Center is not available, or (b) for dependents when required by the attending physician.

Sickness Dental Benefit
Removal of impacted wisdom teeth is payable up to a maximum of $100 per tooth.

Mental Health and Chemical Abuse Benefits
Inpatient Expense —Mental Health
Covered Medical Expenses for the treatment of mental health while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness.
Outpatient Expense —Mental Health
Covered Medical Expenses for the care or treatment of a mental health condition by a licensed or accredited health service organization or hospital or by a licensed practitioner are payable at 80% of the Negotiated Charge or Reasonable Charge (Preferred and Non-Preferred Providers respectively) up to a maximum of $2,000 per Policy Year. (This benefit also includes treatment and subsequent diagnosis of Attention Deficit Disorder.)
This benefit is payable only when referred by the RIT Student Health Center or the Counseling Career Development Center unless (a) the student is 50 miles or more from campus, (b) the student is an active participant in a Co-op program, or (c) the student or dependent is not eligible to be seen at the Student Health Center or Counseling or Career Development Center.

Inpatient Expense —Chemical Abuse
Covered Medical Expenses for the treatment of chemical abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness.
Covered Medical Expenses include charges incurred for detoxification up to a maximum of 7 days per Policy Year.

Outpatient Expense —Chemical Abuse
Covered Medical Expenses for the care or treatment of chemical abuse by a licensed or accredited health service organization or hospital or by a fully licensed practitioner are payable up to a maximum of 60 visits per Policy Year for outpatient treatment with up to a maximum of 20 visits per Policy Year for family counseling.

Maternity Benefits
Maternity Expense (No Referral Required)
Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits are payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. In the event of an early discharge, coverage is available for at least one home care visit; this visit will be payable at 100% and will not be subject to any Plan Copays or Deductibles, if applicable.

Coverage also includes parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

Voluntary Termination of Pregnancy Expense
Covered Medical Expenses for voluntary termination of pregnancy are payable up to a maximum of $250 per year.

Women's Health Benefit (No Referral Required)
The Plan will pay for one baseline mammogram for women between the ages of 35 and 40. Women age 40 and over have coverage for one annual mammogram per Policy Year, thereafter. Coverage will be provided more frequently if recommended by a Physician for Covered Persons who have a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer. Covered Medical Expenses are payable on the same basis as any X-ray expense. The Plan will pay for one routine annual Pap smear screening, including the related office visit, for women age 18 and older. Covered Medical Expenses are payable on the same basis as any other expense.

Ambulance Expense
Covered Medical Expenses are payable up to a per trip maximum of $200 for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness.

Diabetic Treatment Expense
Covered Medical Expenses are payable at 100% of the Negotiated Charge or Reasonable Charge (Preferred and Non-Preferred Providers respectively).

Prostate Cancer Screening Expenses
Covered Medical Expenses include one annual (or more frequently if recommended by a Physician) Digital Rectal exam and Prostate Antigen Specific (PSA) test. Covered Medical Expenses are payable on the same basis as any other expense.

Prescription Contraceptive Medical Expenses
Covered Medical Expenses are payable on the same basis as any expense. Covered Medical Expenses also include any expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive.

Coverage of oral contraceptives, Lunelle, Depo-Provera, Patch or Ring is provided under the separate Prescription Drug portion of the Plan.

Prescription Drug Benefit
Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness occurring during the Policy Year,
are payable up to a maximum of $400 per Policy Year after a $1 per Prescription Drug Deductible. Covered medications include oral contraceptives, Lunelle, Depo-Provera, Patch and Ring. Expenses incurred for office visits in conjunction with the administration of a covered prescription contraceptive is provided under the Medical portion of the Plan.

End of Life Care
Covered Medical Expenses include care provided at acute care facilities which specialize in the treatment of terminally ill patients diagnosed with advanced cancer. Reimbursement for services is provided at 100% of the Negotiated Charge. In the absence of a Negotiated Charge,

reimbursement is provided at 100% of the acute care's facility's reimbursement rate under the Medicare program, after any applicable Deductible.

Home Health Care Expense
Covered Medical Expenses are payable incurred within 12 months from the date of the first home health care visit. The maximum number of covered visits is limited to 40. Four hours of home health aide service shall be considered as one home care visit.

Informed Health®Line Service
This service provides you with 24-hour telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses can provide you with current, easy-to-understand information on a wide range of health issues including prevention strategies, self-care, chronic conditions, and complex medical situations. Informed Health Line nurses cannot diagnose, prescribe, or give medical advice. Contact your Physician with any questions or concerns regarding your health care needs. The toll-free number you can call to access this service is (800) 556-1555. A Consumer Health information Service Provided on Audio Tape and Online
In 2003, an audio health library feature was added to the Informed Health Line. The Informed Health Line telephone greeting, provided in both English and Spanish, will allow a caller to talk with a registered nurse or connect directly to the audio health library.
• The library will include 2,000 topics in English and 705 in Spanish.
• Callers can listen to information on sensitive health topics with the comfort of knowing it is confidential
• This service will include the option to connect to an Informed Health Line registered nurse with any questions after listening to a topic. (This Service is not underwritten by Aetna.)
General Provisions
State Mandated Benefits
The Plan will always pay benefits in accordance with any applicable New York State Insurance Law(s).

PART III
OPTIONAL ENHANCED SUPPLEMENTAL BENEFIT
An Enhanced Supplemental Plan is available for an additional cost, subject to the following enrollment conditions. Please note that mental health services are not eligible for coverage under this Supplemental Plan. When this optional Supplemental Plan is purchased, Covered Medical Expenses incurred for an Injury or Sickness while insured
and in excess of the $103,000 for any one Accident and in excess of $52,000 for any one Sickness, will be payable at 100% up to a maximum lifetime benefit of $250,000 for any one covered Accident or any one covered Sickness.
Covered Medical Expenses include (a) hospital room and board, (b) miscellaneous hospital expenses, (c) inpatient and outpatient surgery, (d) inpatient and outpatient anesthetist, (e) inpatient and outpatient Doctor visits, (f) consultant, (g) licensed nurse, (h) hospital outpatient department, (I) emergency room, (j) diagnostic x-ray and lab tests, (k) outpatient prescription drug, (l) ambulance, (m) durable medical equipment, and (n) other expenses incurred for the care and treatment of an Injury or Sickness, subject to the exclusions and limitations of the Plan.

Only students and dependents insured for the Basic Accident and Sickness Plan may purchase this Enhanced Supplemental Plan. The Supplemental Plan must be purchased by September 30, 2005 for the Fall Quarter, or within 30 days after the start of the quarter in which the student is first enrolled in the Basic Plan for the academic year. Students and Dependents must enroll in the Basic Accident and Sickness Plan in order to be eligible for the Optional Supplemental Plan. The

Optional Supplemental Plan must be purchased at the same time as enrollment under the Basic Plan.

Note: To purchase this optional coverage, students will need to submit an Enrollment Form shown on the last page of this Brochure for the Enhanced Supplemental Plan and include premium payment. Students who purchase the Enhanced Supplemental Plan must also enroll any eligible dependents who are insured under the Basic Plan. Dependents may not be enrolled for this Enhanced Supplemental Plan without the student being enrolled or without being insured under the Basic Plan.

PART IV
RIT STUDENT INSURANCE PLANS
TERMS & CONDITIONS -
Pre-Existing Conditions
Expenses incurred by a Covered Person as a result of a Pre-Existing Condition will not be considered covered expenses unless no
charges are incurred or treatment rendered for the condition for a period of 6 months while covered under this Program, or the
Covered Person has been covered under the Program for 12 consecutive months, whichever happens first.
Special Rules As to A Pre-Existing Condition
If a person has Creditable Coverage and such coverage terminated within 63 days prior to the date he or she enrolled (or was enrolled) in this Program, then any limitation as to a Pre-Existing Condition under this Program will apply for that person only to the extent that such limitation would have applied if he or she had remained covered under the prior Creditable Coverage. Also, if a person enrolls (or is enrolled) in this Program immediately after any applicable probationary period has been served, and that person had Creditable Coverage which terminated within 63 days prior to the first day of such probationary period, then any
limitation as to a Pre-Existing Condition will apply for that person only to the extent that such limitation would have applied if he or she had remained covered under the prior Creditable Coverage. Pre-Existing Conditions will apply to students and their covered dependents who elect coverage more than 30 days after the date such person becomes eligible for coverage under the Program.

Subrogation/Reimbursement Right of Recovery Provision
Immediately upon paying or providing any benefit under this Plan; Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person; due to a Covered Person's Injuries or illness; to the full extent of benefits provided; or to be provided by Aetna. In addition; if a Covered Person receives any payment from any potentially responsible party; as a result of an Injury or illness; Aetna has the right to recover from; and be reimbursed by; the Covered Person for all amounts this Plan has paid; and will pay as a result of that Injury or illness; up to and including the full amount the Covered Person receives; from all potentially responsible parties. A "Covered Person" includes; for the purposes of this provision; anyone on whose behalf this Plan pays or provides any benefit; including but not limited to the minor child or Dependent of any Covered Person; entitled to receive any benefits from this Plan.
As used in this provision, the term "responsible party" means any party possibly responsible for making any payment to a Covered Person or on a Covered Person's behalf due to a Covered Person's Injuries or illness or any insurance coverage responsible making such payment; including but not limited to:
- Uninsured motorist coverage;

- Underinsured motorist coverage;
- Personal umbrella coverage;
- Med-pay coverage;
- Workers compensation coverage;
- No-fault automobile insurance coverage; or
- Any other first party insurance coverage.

The Covered Person shall do nothing to prejudice Aetna's subrogation and reimbursement rights. The Covered Person shall; when requested; fully cooperate with Aetna's efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party; including an attorney; of the intention to pursue or investigate a claim; to recover damages; due to Injuries sustained by the Covered Person.

The Covered Person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties; and are to be paid to Aetna before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments; even if such payment to the Plan will result in a recovery to the Covered Person; which is insufficient to make the Covered Person whole; or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party; and regardless of whether the settlement or judgement received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments; even those designated as "pain and suffering" or "non-economic damages" only.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms; the Covered Person and this Plan agree that Aetna shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Coordination of Benefits

If the Covered Person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of a plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used as the first secondary coverage. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers' Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set
forth in the Policy.

Exclusions

The Plan neither covers nor provides benefits for the following:

1. Services normally provided without charge by the Student Health Services or by health care providers employed by the school.
2. Expenses incurred as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

3. Expenses incurred for eye refractions, vision therapy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or Prescriptions or examinations except as required for repair caused by a covered Injury.
4. Expenses incurred as a result of Injury due to participation in a riot. “Participation in a riot” means taking part in a riot in any way,
including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken
against persons who are trying to restore law and order.
5. Expenses incurred for treatment provided in a governmental hospital unless there is legal obligation to pay such charges in the
absence of insurance.

6. Expenses incurred as a result of an Injury or Sickness due to working for wage or profit or for which benefits are payable under
any Worker’s Compensation or Occupational Disease Law.
7. Expenses for the treatment for Injury to the extent benefits are payable under any state no-fault automobile coverage; first party
medical benefits payable under any other mandatory no-fault law.
8. Expense incurred as the result of dental treatment, except as provided for Injury to sound, natural teeth or removal of impacted
wisdom teeth as provided elsewhere in the Policy.
9. Expenses incurred for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve,
alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent
needed to:
-Improve the function of a part of the body that: (a) is not a tooth or structure that supports the teeth; and (b) is malformed as a
result of a severe birth defect; (including harelip, and webbed fingers or toes); or (c) as direct result of disease; or surgery
performed to treat a disease or Injury.
-Repair an Injury (including reconstructive surgery for a prosthetic device for a Covered Person who has undergone a
mastectomy) which occurs while the Covered Person is covered under the Policy. Surgery must be performed in the calendar
year of the Accident, which causes the Injury; or in the next calendar year.
10. Expenses incurred as a result of an Injury sustained or Sickness contracted while in the service of the armed forces of any
county. Upon the Covered Person entering the armed forces of
any country, the unearned pro-rata premium will be refunded to the Policyholder.
11. Expenses incurred as a result of allergy shots and injections, preventive medicines, serums, vaccines or oral contraceptives
unless otherwise provided in the Policy.
12. Expense incurred for a treatment, service, or supply, which is not Medically Necessary; as determined by Aetna; for the diagnosis, care, or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended, or approved; by the person's attending Physician or dentist.

In order for a treatment; service; or supply; to be considered Medically Necessary; the service or supply must:

- Be care; or treatment; which is likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the Sickness or Injury involved; and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person; and be as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than, any alternative service or supply; both as to the Sickness or Injury involved; and the person's overall health condition; and
- As to diagnosis, care, and treatment be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances; Aetna will take into consideration:

- Information relating to the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical, mental health, or dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person; any person who cares for him or her; or any persons who is part of his or her family; any health care provider; or health care facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely and adequately; be diagnosed; or treated; while not confined; or
- Those furnished solely because of the setting; if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office; or other less costly setting.

13. Expenses incurred for treatment of mental or nervous disorders unless otherwise provided in the Policy.
14. Expenses incurred for the treatment of chemical abuse or dependence unless otherwise provided in the Policy.
15. Expenses incurred after the date insurance terminates for a Covered Person except as may be specifically provided in the
Extension of Benefits Provision.
16. Expenses incurred for any services rendered by a member of the Covered Person’s immediate family.
17. Expenses incurred for Injury resulting from the play or practice of intercollegiate sports (this coverage is available under the
Excess Accident Plan). Intramural and club sports covered as any other illness or injury.
18. Expenses for contraceptive methods, devices or aids, and charges for or related to artificial insemination, in-vitro fertilization, or
embryo transfer procedures, elective sterilization or its reversal, or elective abortion unless otherwise provided in the Policy.
19. Expenses for treatment of Injury or Sickness to the extent that payment is made as a judgement or settlement by any person
deemed responsible for the Injury or Sickness (or his/her insurers).
20. Expenses incurred for or in connection with: procedures; services; or supplies that are, as determined by Aetna, to be

experimental or investigational. A drug; a device; a procedure; or treatment will be determined to be experimental or
investigational if:
There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature; to
substantiate its safety and effectiveness; for the disease or Injury involved; or
If required by the FDA; approval has not been granted for marketing; or
A recognized national medical or dental society or regulatory agency has determined; in writing; that it is experimental;
investigational; or for research purposes; or
The written protocol or protocols used by the treating facility; or the protocol or protocols of any other facility studying
substantially the same drug; device; procedure; or treatment; or the written informed consent used by the treating facility; or
by another facility studying the same drug; device; procedure; or treatment; states that it is experimental; investigational; or
for research purposes.
However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a
disease; if Aetna determines that:
The disease can be expected to cause death within one year; in the absence of effective treatment; and
The care or treatment is effective for that disease; or shows promise of being effective for that disease; as demonstrated by
scientific data. In making this determination; Aetna will take into account the results of a review by a panel of independent

medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease
involved.
Also, this exclusion will not apply with respect to drugs that:
Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
Are being studied at the Phase III level in a national clinical trial; sponsored by the National Cancer Institute;
If Aetna determines that available, scientific evidence demonstrates that the drug is effective; or shows promise of being
effective; for the disease.
21. Expenses incurred for which no member of the Covered Person’s immediate family has any legal obligation for payment.
22. Expenses incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or
her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be
disabled. Such services and supplies are custodial care without regard to:
• by whom they are prescribed; or
• by whom they are recommended; or
• by whom or by which they are performed.
23. Expenses incurred for the removal of an organ from a Covered Person for the purpose of donating or selling the organ to any
person or organization. This limitation does not apply to a donation by a Covered Person to a spouse, child, brother, sister, or

parent.
24. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or
developmental delays, except as specifically provided in the Policy.
25. Expenses incurred for, or related to, sex change surgery or to any treatment of gender identity disorders.
26. Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other
preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is
specifically provided in the Policy.
27. Expenses incurred as a result of commission of a felony.
28. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.
29. Expenses incurred for breast reduction/mammoplasty
30. Expenses incurred for gynecomastia (male breasts).
31. Expenses incurred for sinus surgery, except for acute purulent sinusitis.
32. Expenses for charges that are not reasonable charges, as determined by Aetna.
33. Expenses for treatment of covered students who specialize in the mental health care field, and who receive treatment as part of
their training in that field.
34. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails;
and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when medically necessary;
because the Covered Person is diabetic; or suffers from circulatory problems.
35. Expenses arising from a pre-existing condition (applies to Late Enrollees only).
36. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Policy and
performed while the Policy is in effect.
Any exclusion above will not apply to the extent that coverage of the charges is required under any law
that applies to the coverage.
Extension of Benefits
If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination
date and during the continuance of that hospital confinement shall be payable in accordance with the Policy, but only while they are
incurred during the 90-day period following such termination of insurance.
Benefits will continue to be available for a Covered Person who incurs medical expenses directly relating to a pregnancy that began
before coverage under the Policy ceased. This benefit will be covered only for the period of the pregnancy.
Termination of Student Coverage
Insurance for a covered student will end on the first of these to occur:
(a) The date the Policy terminates;
(b) the last day for which any required premium has been paid;
(c) the date on which the covered student withdraws from the school because of entering the armed forces of any country.
Premiums will be refunded on a pro rata basis when application is made within 90 days from withdrawal; if withdrawal from school

is for other than entering the armed forces, no premium refund will be made. Students will be covered for the policy term for which
they are enrolled and for which premium has been paid.

CLAIM INFORMATION
In the event of injury or sickness, the Insured should:
Report to the RIT Student Health Center to obtain appropriate medical treatment during its hours of operation.
When away from the Institute, or when the Student Health Center is not available, secure treatment from a physician, out-patient
facility or hospital.
Preferred Providers will send medical bills directly to Chickering Claims Administrators, Inc. for payment. For services received from
a non-Preferred Provider, notify Chickering Claims Administrators, Inc. within thirty (30) days.
Claim forms may be obtained from the RIT Student Health Center, University Health Plans website (www.universityhealthplans.com) and Chickering Claims Administrators, Inc. Only one claim form is required for each accident or
sickness. Please note that a fully completed form must be submitted by the student before claims related to a medical condition
can be paid.
Medical care providers are reimbursed directly unless a receipted bill is presented. If a bill has been paid, reimbursement will be
made to the Insured Student.
Complaint and Appeals Procedures
New York State mandates that the following information be provided to all insureds:
The complaints and appeals process is designed to address coverage issues, complaints and problems. If you have a coverage
issue or other problem, call Chickering Customer Services at (877) 409-7356. A representative will address your concern. If you are
dissatisfied with the outcome of the initial contact, the decision may be appealed.
You may also submit a request, in writing, along with all pertinent correspondence, to:
Chickering Claims Administrators, Inc.
P.O. Box 15708Boston , MA 02215-0014
For purposes of the following section, the term “you” pertains to you or your covered dependent.
INTERNAL APPEALS PROCEDURE
Aetna has established a procedure for resolving appeals. If you have an appeal; please follow this procedure:
• An Appeal is defined as a written request for review of a decision that has been denied in whole or in part; after
consideration of any relevant information; a request for: claim payment; certification; eligibility; referral; etc.
First Level Appeals Procedure
• An Appeal must be submitted to Aetna within 180 days of the date Aetna provides notice of denial. The address is on
your ID card. The Appeal may be submitted by you, or by a representative; designated by you.
• You may submit an oral grievance in connection with:
• A denial of; or failure to pay for; a referral; or
• A determination as to whether a benefit is covered under this Plan;
by calling Customer Services. The Customer Services telephone number is on your ID card. If you are required to leave

a recorded message; your message will b e acknowledged within one business day after the call was recorded.
Aetna will summarize the nature of the grievance in writing. You will be required to sign a written acknowledgement of
the grievance. Such acknowledgement will be mailed promptly to you.. You must sign and return the acknowledgement; with any amendments; in order to initiate the grievance. Upon receipt of the signed acknowledgement, the process below will be followed.
• An acknowledgment letter will be sent to you within 1 day of Aetna's receipt of an oral Appeal; and within 5 days of Aetna's receipt of a written Appeal. This letter may request additional information. If so; the additional information must be submitted to Aetna within 15 days of the date of the letter.
• You will be sent a response within 30 days of Aetna's receipt of the Appeal. The response will be based on the information provided with; or subsequent to; the Appeal.
• If the Appeal concerns an eligibility issue; and if additional information is not submitted to Aetna after receipt of Aetna's
response; the decision is considered Aetna's final response 45 days after receipt of the Appeal. For all other Appeals; if additional information is to be submitted to Aetna after receipt of Aetna's response; it must be submitted within 15 days of the date of Aetna's response letter.
• Aetna's response will be sent within 30 days from the date of Aetna's first response letter.
In any urgent or emergency situation; the Expedited Appeal procedure may be initiated by a telephone call to Customer
Services. The Customer Services telephone number is on your ID card. A verbal response to the Appeal will be given to you and to your provider within 2 days provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Aetna's verbal response.
Second Level Appeals Procedure
If you are dissatisfied with Aetna's grievance determination; you or a representative designated by you, may submit a written
appeal within 60 business days after receipt of such determination.
• An acknowledgement letter will be sent to you within 15 days of Aetna's receipt of the written appeal. This letter may request additional information. If so; the additional information must be submitted to Aetna within 15 days of the date of the letter.
• Aetna's final response for an urgent or emergency situation will be sent within 2 business days. For all other situations; a response will be sent within 30 business days from the date of Aetna's receipt of all necessary
information.
If additional time is needed to resolve an Appeal; except in an urgent or emergency situation; Aetna will provide a written
notification; indicating that additional time is needed; explaining why such time is needed; and setting a new date for a
response. The additional time will not be extended beyond another 30 days.
You must exhaust the Internal Appeals Procedure before requesting an External Appeal. However; you are not required to
exhaust the Internal Appeals Procedure prior to requesting an External Appeal, if you and Aetna have agreed that the matter
may proceed directly to an External Appeal.
Aetna will keep the records of your complaint for 3 years.
EXTERNAL APPEAL
RIGHT TO AN EXTERNAL APPEAL
Under certain circumstances; you have a right to an external appeal of a denial of coverage. Specifically; if Aetna has denied coverage on the basis that the service is not necessary; or is an

experimental or investigational treatment; you may appeal that decision to an External Appeal Agent, an independent entity certified by the State, to conduct such appeals.
RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT NECESSARY
If Aetna has denied coverage on the basis that the service is not necessary; you may appeal to an External Appeal Agent; if you satisfy the criteria listed below:
• The service; procedure; or treatment; must otherwise be a Covered Medical Expense under this Plan; and
• You must have received a final adverse determination through the first level of the internal review process; and Aetna
must have upheld the denial; or you and Aetna must agree in writing; to waive any internal appeal.
RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL
If you have been denied coverage on the basis that the service is an experimental or investigational treatment; you must
satisfy the following criteria:
• The service must otherwise be a Covered Medical Expense under this Plan; and
• You must have received a final adverse determination through the first level of the internal appeal process; and Aetna
must have upheld the denial; or you and Aetna must agree in writing to waive any internal appeal.
In addition; your attending physician must certify that you have a life-threatening or disabling condition or disease. A “lifethreatening
condition or disease” is one which; according to the current diagnosis of the attending physician; has a high probability of death. A “disabling condition or disease” is any medically determinable physical or medical impairment that
can be expected to result in death; or that has lasted; or can be expected to last; for a continuous period of not less than 12 months; which renders you unable to engage in any substantial gainful activities. In the case of a dependent child under the age of 18; a “disabling condition or disease” is any medically determinable physical or mental impairment of
comparable severity.

Your attending physician must also certify that the life-threatening or disabling condition or disease is one for which
standard health services are ineffective; or medically inappropriate; or one for which there does not exist a more beneficial
standard service or procedure covered under this Plan; or one for which there exists a clinical trial (as defined by law).
In addition; your attending physician must have recommended at least one of the following:
• A service; procedure or treatment that two documents from available medical and scientific evidence indicate is likely to
be more beneficial to you than any standard Covered Medical Expense (only certain documents will be considered in
support of this recommendation –your attending physician should contact the State in order to obtain current
information as to what documents will be considered acceptable); or
• A clinical trial for which you are eligible (only certain clinical trials can be considered).
For the purposes of this section; your attending physician must be a licensed; board certified; or board eligible physician;
qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.
THE EXTERNAL APPEAL PROCESS

If; through Aetna's internal appeal process; you have received a final adverse determination upholding a denial of coverage
on the basis that the service is not necessary; or is an experimental or investigational treatment; you have 45 days from
receipt of such notice to file a written request for an external appeal. If you and Aetna have agreed to waive any internal
appeal; you have 45 days from the receipt of such waiver to file a written request for an external appeal. Aetna will provide
an external appeal application with the final adverse determination issued through Aetna's internal appeal process or its
written waiver of an internal appeal.
You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882.
The completed application must be submitted to the New York State Department of Insurance at the address listed in the
application. If you satisfy the criteria for an external appeal; the State will forward the request to a certified External Appeal
Agent.
You will have the opportunity to submit additional documentation with the request. If the External Appeal Agent determines
that the information you submit represents a material change from the information on which Aetna based its denial; the
External Appeal Agent will share this information with Aetna in order for it to exercise its right to reconsider its decision. If
Aetna chooses to exercise this right; Aetna will have 3 business days to amend or confirm its decision. Please note that in
the case of an expedited appeal (described below); Aetna does not have a right to reconsider its decision.
In general; the External Appeal Agent must make a decision within 30 days of receipt of the completed application. The
External Appeal Agent may request additional information from you; your physician or Aetna. If the External Appeal Agent
requests additional information; it will have 5 additional business days to make its decision. The External Appeal Agent
must notify you in writing of its decision within 2 business days.
If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious
threat to your health; you may request an expedited external appeal. In that case, the External Appeal Agent must make a
decision within 3 days of receipt of the completed application. Immediately after reaching a decision, the External Appeal
Agent must try to notify you and Aetna by telephone or facsimile of that decision. The External Appeal Agent must also notify
you in writing of its decision.
If the External Appeal Agent overturns Aetna's decision that a service is not necessary; or approves coverage of an
experimental or investigational treatment; Aetna will provide coverage subject to the other terms and conditions of this Plan.
If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial;

Aetna will only cover the costs of services required to provide treatment to you according to the design of the trial. Aetna
shall not be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of
managing research; or costs which would not be covered under this Plan for non-experimental or non-investigational
treatments provided in such clinical trial.
The External Appeal Agent's decision is binding on both you and Aetna. The External Appeal Agent's decision is
admissible in any court proceeding.
You will be charged a fee of $50 for an external appeal. The external appeal application will instruct you on the manner in
which you must submit the fee. Aetna will also waive the fee if Aetna determines that paying the fee would pose a hardship
to you. If the External Appeal Agent overturns the denial of coverage; the fee shall be refunded to you.

RESPONSIBILITIES

It is your responsibility to initiate the external appeals process. You may initiate the external appeal process by filing a
completed application with the New York State Department of Insurance. If the requested service has already been

provided to you; your attending physician may file an expedited appeal application on your behalf; but only if you have
consented to this in writing.
Under New York State law; your completed request for appeal must be filed within 45 days of either the date upon which you
receive written notification from Aetna that it has upheld a denial of coverage; or the date upon which you receive a written
waiver of any internal appeal. Aetna has no authority to grant an extension of this deadline.

COVERED SERVICES AND EXCLUSIONS

In general, this Plan does not cover experimental or investigational treatments. However; this Plan shall cover an
experimental or investigational treatment approved by an External Appeal Agent in accordance with this section. If the
External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial; Aetna
will only cover the costs of services required to provide treatment to you; according to the design of the trial. Aetna shall not
be responsible for the costs of investigational drugs or devices; the costs of non-health care services; the costs of
managing research; or costs which would not be covered under this Plan for non-experimental or non-investigational
treatments provided in such clinical trial.

INSURANCE AFTER POLICY TERMINATION

Students insured under this Accident and Sickness Insurance plan whose eligibility ends may purchase continuation coverage by
calling University Health Plans at (800) 437-6448 PRIOR TO August 15, 2006 or before your policy termination date if earlier.

CERTIFICATE OF CREDITABLE COVERAGE

Your coverage under this health plan is “creditable coverage” under Federal law. When your coverage terminates, you can request a
Certificate of Creditable Coverage, which is evidence of your coverage under this health plan. You may need such a certificate if you
become covered under a group health plan or other health plan within 63 days after your coverage under this health plan terminates.
If the subsequent health plan excludes or limits coverage for medical conditions you have before you enroll, this Certificate may be
used to reduce or eliminate those exclusion or limitations. In order to obtain a Certificate of Creditable Coverage, please contact
Chickering Claims Administrators, Inc., PO Box 15708, Boston, MA 02215-0014.
Presented by:
University Health Plans. Inc.
One Batterymarch Park
Quincy, MA 02169-7454
(800) 437-6448
www.universityhealthplans.com
Administered by:
Chickering Claims Administrators, Inc.
P.O. Box 15708
Boston, MA 02215-0014
(800) 466-3185
www.chickering.com
Underwritten by:
Aetna Life Insurance Company (ALIC)
151 Farmington Avenue
Hartford, CT 06156
Policy No. 812809
The Chickering Group is an internal business unit of Aetna Life Insurance Company.

NOTICE
Aetna considers nonpublic personal member information confidential and has policies and procedures in place to protect the
information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health plan, 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), vendors, consultants, government authorities, and their respective
agents. These parties are required to keep personal information confidential as provided by applicable law. Participating
network/preferred providers are also required to give you access to your medical records within a reasonable amount of time after
you make a request.
By enrolling in the plan, you permit us to use and disclose this information as described above on behalf of yourself and your
dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and
disclosure of personal information, please call the toll-free Customer Services number on your ID card or visit Chickering’s Student
Connection Link on the internet at www.chickering.com

Important Note
Please keep this Brochure as it provides a general summary of your coverage. A complete description of the benefits and full terms
and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy, the Master Policy
will govern and control the payment of benefits.
This insurance Policy provides limited benefits for health insurance ONLY. It does NOT provide basic hospital, basic medical,
major medical insurance, Medicare Supplement, long-term care insurance, nursing home insurance only, home health care
insurance only, a nursing home and home health care insurance as defined by the New York State Insurance Department. This
insurance coverage is being offered on a primary basis. The insurance Policy itself sets forth the rights and obligations of you and
the insurance company. It is therefore important to read this Brochure carefully.
This student plan fulfills the definition of creditable coverage explained in the Health Insurance Portability and Accountability Act
(HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the Customer Service number on your
ID card.
Additional disclosure information about your Plan can be found by accessing Chickering's Student Connection Link at
www.chickering.com.
PART V
EXCESS ACCIDENT PLAN
RIT maintains an Excess Accident Plan, at no charge, for all RIT students. This Excess Accident Plan provides up to $10,000 of
coverage in full at the Negotiated Charge or Reasonable Charge (Preferred and Non-Preferred Providers respectively) for accidents
occurring on campus or occurring off-campus at an RIT sponsored activity. (Accidental Death and Dismemberment Benefit provided
by UNUM.)
Expenses incurred for injuries resulting from the play or practice of intercollegiate sports is limited to $1,000.
(This does not include Intramural or Club Sports.) All other primary medical insurance benefits must be first paid prior to this
Excess Accident Plan's benefits being paid. If the student is enrolled under the RIT Basic Student Accident and Sickness Insurance
Plan, that Plan is considered primary coverage. Any accident claims submitted under the Basic Plan will automatically be submitted
to the Excess Accident Plan if all accident expenses have not been covered under the Basic Plan and the accident meets the
definition of a covered accident under this Plan. Claim Forms for students not enrolled in the RIT Basic Plan can be obtained by
calling the Risk Management and Safety Services Office at (585) 475-4903.
Accidental Death and Dismemberment Benefits
This benefit provides Accidental Death and Dismemberment coverage of up to $10,000.
Accidental Death and Dismemberment Benefit:
This insurance coverage provides accidental death and dismemberment coverage underwritten by Unum Provident Life Insurance

Company of America.
Benefits are payable for the accidental death and dismemberment of the eligible insureds of up to a maximum of $10,000
(Exclusions and limitations may apply.) Coverage is provided for accidents occuring on or off-campus at RIT sponsored activities.
For definitions of eligibility and a complete loss schedule, detailing the benefits received for accidental death, dismemberment, loss
of sight, speech or hearing, please refer to your master policy available at your school.
To file a claim for Accidental Death and Dismemberment, please contact Chickering Claims Administrators, Inc. at (800) 466-3185
for the appropriate claim forms.
PART VI
OTHER PLAN BENEFITS
VISION BENEFITS
Vision One® Discount Program
The Vision One Discount Program helps you save on many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 25% discount on LASIK surgery (the laser vision correction procedure). Call **(800) 793-8616** for additional Program information and provider locations, or simply log onto www.chickering.com, click on “Find Your School” enter Policy Number 812809 to find a Vision One provider near you.

Please note that these discounts are subject to change.
Product or Service Vision One Cost
EYEGLASS FRAMES (retail prices)
Up to $60.99 $24$61 to $80.99 $34$81 to $100.99 $44$101 and up 40% off retail
LENSES PER PAIR (uncoated plastic)
Single vision $30Bifocal $49Trifocal $59Standard Progressive (no-line bifocal) $99
LENS OPTIONS PER PAIR
(add to lens prices above)
Polycarbonate $30Scratch-resistant coating $12Ultraviolet coating $12Solid or gradient tint $ 8Glass $15Photochromic $34Antireflective coating $35
EYE EXAMS FOR PLANS
THAT DO NOT COVER EYE EXAMS
For eyeglasses $38 Standard contact lenses $78For specialty contact lenses $10 off retail fee

EYE EXAMS FOR PLANS
THAT COVER EYE EXAMS
Refer to your health benefits plan documents.
CONTACT LENSES
Retail: Visit any Vision One location and receive up to a
20% discount (10% on disposables) off retail prices.
CONTACT LENS REPLACEMENT PROGRAM
Call 1-800-391-LENS (5367) to order replacement contact
lenses for additional savings and convenience.
ADDITIONAL VISION-RELARE ITEMS
Visit any Vision One location and receive a 20% discount
off retail prices.
LASIK PROCEDURE
You and your family members can receive up to a 25% discount off the surgeon’s fee through the NuVision® LASIK network.

This discount program is not underwritten by Aetna

WORLDWIDE EMERGENCY TRAVEL ASSISTANCE SERVICES
These services are designed to assist RIT students when traveling more than 100 miles from home anywhere in the world. Medical
Repatriation and Return of Mortal Remains services are also available from the insured's campus location.
If you experience a medical emergency while traveling more than 100 miles from home or campus, you have access to a
comprehensive group of emergency assistance services provided by Assist America, Inc.
Eligible participants have immediate access to doctors, hospitals pharmacies and other services when faced with an emergency
while traveling. The Assist America Operations Center can be reached 24 hours a day, 365 days a year to provide services
including: medical consultation and evaluation; medical referrals; foreign hospital admission guarantee; prescription assistance;
lost luggage assistance; legal and interpreter assistance; and travel information such as Visa and passport requirements, travel
advisories, etc.
Medical Evacuation and Return of Mortal Remains Services
In the event that an insured becomes injured and adequate medical facilities are not available locally, Assist America will use
whatever mode of transport, equipment and personnel necessary to evacuate you to the nearest facility capable of providing required
care. In the event of death of a participant, Assist America will render every possible assistance in return of mortal remains including
locating a funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping
container as well as paying for transport. Please note: Any third party expenses incurred are the responsibility of the Participant.
Please refer to your ID card, attached to this Brochure, for the toll free number when calling within the U.S. (1-800-872-1414). When
travelling outside the U.S., call collect (dial U.S. access code) +301-656-4152. With one phone call, you will be connected to a
global network of over 600,000 pre-qualified medical providers. Assist America Operations Centers have worldwide assistance
capabilities and are known throughout the world as a premier Emergency Assistance Services provider.
NOTE: ASSIST AMERICA PAYS FOR ALL ASSISTANCE SERVICES IT PROVIDES. ALL ASSISTANCE SERVICES MUST BE
ARRANGED AND PROVIDED BY ASSIST AMERICA. ASSIST AMERICA DOES NOT REIMBURSE FOR SERVICES NOT PROVIDED
BY ASSIST AMERICA.
The Assist America program meets and exceeds the requirements of USIA for International Students & Scholars.
Emergency Travel Assistance Services are administered by Assist America, Inc.