# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Introduction</td>
</tr>
<tr>
<td>5</td>
<td>Your Benefits</td>
</tr>
<tr>
<td>8</td>
<td>Eligibility</td>
</tr>
<tr>
<td>8</td>
<td>How to Enroll</td>
</tr>
<tr>
<td>9</td>
<td>Medical Plan Choices</td>
</tr>
<tr>
<td>10</td>
<td>Prescription Drug Plan Choices</td>
</tr>
<tr>
<td>11</td>
<td>Preventive Health Coverage</td>
</tr>
<tr>
<td>16</td>
<td>Medical Plan Design Summary</td>
</tr>
<tr>
<td>18</td>
<td>Medical Plan Premiums</td>
</tr>
<tr>
<td>18</td>
<td>Domestic Partner Coverage</td>
</tr>
<tr>
<td>19</td>
<td>VSP Signature Vision Care Plan</td>
</tr>
<tr>
<td>20</td>
<td>Healthy Steps to Weight Loss Program</td>
</tr>
<tr>
<td>21</td>
<td>Strength &amp; Resilience Stress Management Program</td>
</tr>
<tr>
<td>22</td>
<td>Quit Today Smoking Cessation Program</td>
</tr>
<tr>
<td>23</td>
<td>Dental Plan Choices and Premiums</td>
</tr>
<tr>
<td>32</td>
<td>Life Insurance &amp; Accidental Life, Death &amp; Dismemberment (AD&amp;D)</td>
</tr>
<tr>
<td>32</td>
<td>Employee Supplemental Life Insurance</td>
</tr>
<tr>
<td>33</td>
<td>Spousal and Children's Supplemental Life Insurance</td>
</tr>
<tr>
<td>34</td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td>37</td>
<td>Useful Phone Numbers and Web Sites</td>
</tr>
<tr>
<td>38</td>
<td>Glossary of Frequently Used Benefits Terms</td>
</tr>
<tr>
<td>39</td>
<td>HIPAA Notice Legal Disclosures Forms</td>
</tr>
</tbody>
</table>
Introduction

As America continues to debate The Affordable Care Act, its provisions will begin to take root in 2014. Now more than ever, Americans will need to educate themselves on the issue of health care so that they can make the best decision they can for themselves and their families.

In addition to offering Americans health plan options, The Act also requires companies to make changes to their own healthcare plans and SVA has done so. They include eliminating lifetime maximum or annual limits for essential benefits, covering dependents to age 26, eliminating pre-existing conditions for all new enrollees (effective 1/1/14) and reducing all medical plan waiting periods to 90 days (effective 1/1/14).

SVA will continue to offer employees a comprehensive health plan for 2014 and continue to pay 75% of your healthcare costs. January 2014 will see a modest increase to employee premiums and a small increase in co-pays for primary care physician and specialist visits for the PPO. All with no reduction in benefits.

There is only one major change. The High Plan option will no longer be available. There are very few employees in this plan and sustaining it is not practical or fiscally responsible. Those employees currently in the High Plan will be “grandfather” and may remain in that plan, but you will not be permitted to select the High Plan if you are currently in the PPO or Standard PPO.

Please take the time to review this booklet carefully and my best to you and your family in 2014.

David Rhodes, President
SVA offers a wide range of benefits to ensure the safety, well-being and security of its employees and their families. We also recognize that as life changes, so do the benefits you need, and we continually seek to improve upon our benefit offerings.

The following pages are a general summary of your benefits. A more complete description of your benefits and the terms under which they are provided (including limitations and exclusions) are contained in the plan documents. If there are any discrepancies between the information in this comparison of plan benefits and the provisions of the plan documents, the plan documents are the controlling documents. The summary plan descriptions for medical and dental coverage are online at http://my.sva.edu under the Human Resources tab.

**HEALTH & WELLNESS**

**Medical Insurance**
After one month of employment, regular, full-time staff members are eligible to enroll in a health insurance plan. After 90 days, regular, part-time staff members who work 20 hours per week are also eligible to join the plan. SVA offers two plan options: two referral-free PPO plans. Employees may also elect coverage for a spouse, children or a domestic partner.

**Dental Insurance**
After one month of employment, regular, full-time staff members are eligible to enroll in a dental insurance plan. After 12 months, regular, part-time staff members who work a minimum of 1,000 hours/calendar year are also eligible to join. Individual and family coverage is available in either Aetna’s Passive PPO plan or Aetna’s DMO plan. Both plans are the same cost and are employee-paid.

**Life and Accidental Death and Dismemberment (AD&D) Insurance**
Life and AD&D coverage is provided at the College’s expense for regular, full-time employees after one month of employment. Regular part-time employees who work a minimum of 1,000 hours/calendar year are covered after 12 months and receive a fixed $50,000. The benefit amount for basic life insurance is 2x your base salary ($50,000 minimum). In addition, employees have the option to purchase supplemental life insurance and dependent life insurance at their own expense. These rates are based on elected coverage amounts and age.

**Voluntary Vision Care Plan**
Eligible administrative employees may enroll in the new voluntary VSP Signature Vision Care Plan. This new benefit provides comprehensive eye health care that includes an annual vision exam with your choice of in, or out-of-network providers, and eye wear to suit any budget. Employees may purchase employee only coverage as well as coverage for eligible dependents.

**Voluntary Short-Term Disability Program.**
Eligible administrative employees may enroll in the enriched voluntary short-term disability program. Employees are able to purchase up to 60% of their weekly salary that is payable tax-free in the event of a non-work related injury or illness diagnosed by a medical professional beginning with the eighth consecutive day of disability and continuing for up to 26 weeks.

**Short-Term Disability (STD)**
All administrative employees are eligible for Short-Term Disability as provided by New York State after meeting a 30 day eligibility requirement. Short-Term Disability benefits are payable for any non-work related injury or illness diagnosed by a medical professional beginning with the eighth consecutive day of disability, and continuing for up to 26 weeks. Once that time is exhausted, employees can file for Long-Term Disability (see next page). Short-term benefits are paid up to a maximum of $170 per week.

**Short-Term Disability (STD) Bank**
Regular, full-time employees are permitted to annually “bank” unused sick days for use in certified short-term disability leave. These “banked” days can be utilized following seven consecutive days of illness and after an employee has exhausted the sick days allotted to him/her for that current year. Employees can accumulate up to 130 days in the “bank.”
Long-Term Disability (LTD)
This coverage is provided at the College's expense for regular, full-time employees starting after one month of employment, and regular, part-time employees, who work a minimum of 1,000 hours/calendar year, after 12 months of employment. LTD coverage begins after an employee has been disabled for six consecutive months. Employees have the option to pay their own LTD premiums via payroll deduction. Doing so would make the employee eligible to collect this benefit tax free. To find out how to make this change, contact HR/Benefits.

Flexible Spending Accounts (FSA)
All eligible administrative employees enrolled in a health plan can contribute to a pre-tax savings account to pay for out-of-pocket health and dependent care expenses that are not covered by the health or dental plans. Employees determine the amount of their annual deduction (up to $2,500 for healthcare and $5,000 for dependent care), which will be deducted from their paycheck in equal installments throughout the year.

GlobalFit Fitness Program
Employees can take advantage of discounted corporate rates of up to 60% at fitness clubs nationwide. To locate a participating facility, visit www.globalfit.com.

CIGNA Healthy Steps to Weight Loss Program
All administrative staff are eligible to join CIGNA's voluntary non-diet weight loss program that will help employees learn to manage weight issues, build confidence, change habits, eat healthier and become more active. The program is available to all employees at no cost, regardless of their participation in the CIGNA plan.

CIGNA Strength and Resilience Stress Management Program
Eligible administrative staff can join CIGNA's voluntary stress management program that will help employees understand the sources of their stress, learn coping techniques, and manage stress on and off the job. This program is available to employees enrolled in a CIGNA PPO plan option at no cost.

CIGNA Quit Today Smoking Cessation Program
Eligible administrative staff can join CIGNA's voluntary smoking cessation program that provides vital tools and resources to support employees in their efforts to quit. This program is available to employees enrolled in a CIGNA PPO plan option at no cost. Participants are given the option of enrolling in either the telephone-based or Web-based program, both of which include free nicotine replacement products (patch or gum) mailed directly to your home. Both programs also include tailored educational materials and access to a personal wellness coach for guidance and support.

TIME OFF

Vacation
Full-time employees continue to receive vacation, accrued monthly, based on the amount of time they are employed by the College: 1 through 3 years – 2 weeks; 4 through 6 years – 3 weeks; 7 through 14 years – 4 weeks; 15 or more years – 5 weeks; Full time employees cannot use their vacation within the first five months of employment.

Regular part-time administrative employees who work a minimum of 1,000 hours per year are eligible for vacation after 24 consecutive months of employment. Part-time employees who meet the eligibility requirements above are now eligible for additional vacation time as follows: Years Worked: 2 through 3 years – 2 weeks; 4 through 6 years – 3 weeks; 7 through 14 years – 4 weeks; 15 or more years – 5 weeks.

A week is defined as those hours worked in accordance with the employee's regular part-time schedule.

Personal days
All regular, full-time employees are eligible for four paid personal days each year. All regular, part-time employees are eligible for two paid personal days each year.

Sick Leave
All regular, full-time employees are eligible for up to eight sick days each year. All regular part-time employees who have completed six months of employment are eligible for time off equal to 80% of the number of hours they regularly work over a two-week period.
EDUCATIONAL ASSISTANCE
Tuition Waivers and Tuition Assistance
Full-time administrative employees who complete six months of consecutive employment and part-time employees who complete one year of consecutive employment are eligible to enroll in up to two SVA Continuing Education or two SVA undergraduate (non-seeking) courses per semester, tuition free. This benefit may be applied to members of an employee’s immediate family (restrictions apply). In addition, all administrative employees who complete 18 months of consecutive employment may qualify for a tuition waiver towards the cost of a degree at SVA. This benefit may also be applied to members of an employee’s immediate family (restrictions apply). Finally, after 18 months of consecutive employment, those full-time employees who wish to pursue a degree program at another accredited institution can apply for assistance for up to $850 per undergraduate credit or $935 per graduate credit towards a job-related degree.

COMMUTING
TransitChek
Premium TransitChek is a pre-tax payroll deduction used to offset mass-transit commuting expenses (up to $130/mo, $1,560/yr). This benefit is available for both full- and part-time staff. SVA also offers a pre-tax payroll deduction for parking expenses (up to $250/mo, $3,000/yr). Post-tax payroll deductions for either mass-transit or parking are also offered and can be used if an employee’s monthly commuting costs exceed the allotted pre-tax benefit, limits are subject to change.

Discounts
SVA staff can take advantage of numerous discount opportunities around town, including:

- Museum of Modern Art (MoMA): Employees receive free admission to the Museum of Modern Art. Purchase of up to 5 additional same-day guest passes available for only $5 each. FREE film tickets. Discount on merchandise in the MoMA stores and online during Holiday Discount Days.
- Whitney Museum of American Art: Employees receive free admission for themselves and three guests. To receive free admission simply present a valid SVA Staff ID at the Corporate Membership Desk when you visit. Receive 20% discount on Whitney publications and products at the Whitney store and 10% at the cafe in the Whitney’s Lower Gallery, as well as Holiday Discount Days in the Whitney store.
- New Museum: Employees receive free admission to the New Museum. To receive free admission present a valid SVA Staff ID and State ID.
- Loews Theaters: SVA employees can purchase discount movie passes for $7 that can be used at any Loews Theater.
- Restaurants: Employees receive discounts at a variety of local restaurants.
- Cooper-Hewitt: Employees receive free admission to Cooper-Hewitt, National Design Museum. To receive free admission simply present a valid SVA employee ID at the Membership Desk. Receive 10% discount in the Shop at Cooper-Hewitt and the Cafe.
- P.S. 1: Employees receive free admission to P.S. 1 Contemporary Art Center. To receive free admission simply present a valid SVA employee ID at the Membership Desk.
- Liberty Mutual Auto and Home Discount Program: Employees can receive discounts of up to 10% off auto and up to 5% off home or renters insurance. For more information and a free, no- obligation rate quote, please visit MySVA/Human Resources.
- Verizon Wireless Friends & Family for SVA: Verizon's Wireless Employee Discount Program provides up to a 12% discount on monthly service fees, 25% on accessories, and discounts on equipment. SVA employees with existing accounts and those signing up for the first time are eligible to receive the discounts. For more information on how to register your employee discount, and/or sign up please visit MySVA/Human Resources.
- Zipcar: Employees of SVA are eligible for discounted access to Zipcar! Zipcar is a transportation alternative for getting in and around the city with hourly, business day, and full day rates available. For more details and to join, visit http://www.zipcar.com/schoolofvisualarts.
- AT&T: The AT&T Employee Benefit Program provides SVA employees with a 20% discount off most monthly recurring charges and waiver of activation fees ($36). For more details, visit http://www.wireless.att.com/business/enrollment; or walk-in to an AT&T store and use Foundation Account Number 2538416. Please bring your employee ID or paystub for verification purposes.

SVA Campus Store
All employees of the School of Visual Arts may purchase selected computer equipment at substantial savings through the SVA Campus Store. You can visit CAVA at 207 East 23 Street or online at www.sva.edu/cava.
Eligibility

If you are a regular full-time administrative staff member, you are eligible to participate in the Medical, Dental, Vision, Life, AD&D, Voluntary Life, Voluntary Short-Term Disability and Long-Term Disability insurance plans after completing one month of employment. If you meet these requirements and are not participating in one or more of the above, open enrollment is your opportunity to sign up!

Likewise, if you are a regular part-time administrative employee and work a minimum of 1,000 hours/calendar year, you are eligible to participate in the medical plan after a 90 day waiting period. You can also elect coverage for a spouse, domestic partner or children in the medical and dental plans. Explore your benefit options. Read on to learn how to enroll.

How To Enroll

If you are a current participant in the medical, dental, voluntary life insurance and voluntary short-term disability plans and do not wish to make any changes to your existing benefits, you need not do anything—your coverage will remain in effect without interruption.

If you are an eligible employee and would like to join a plan, you will need to complete the appropriate form located at the end of this booklet. Likewise, if you would like to move from one plan to another, or discontinue a benefit altogether, you will need to indicate this change on the corresponding form.

Finally, if you intend to participate in the flexible spending account in 2014, you must complete the CIGNA Healthcare Flexible Spending Account Enrollment, regardless of your participation in 2013. This is an annual enrollment and does not automatically carry over.

The due date for all enrollment/change forms is Monday, December 2, 2013. All forms should be sent to Benefits/Human Resources Department.

PLEASE NOTE: Per IRS regulations (Section 125) regarding pre-tax benefits, if you miss this enrollment period you will not be able to change coverage or participate in the medical, dental, or supplemental life insurance plans until the next open enrollment in November 2014, or within 31 days of a qualifying event. Examples of a qualifying event include, but are not limited to: change in marital status, change in number of dependents, and changes which cause you to be eligible or ineligible for other medical, dental, or supplemental life coverage. You must notify HR and provide supporting documentation within 31 days of a qualifying event if you wish to make any changes to your plan.
Medical Plan Choices

SVA provides medical coverage to full- and part-time administrative staff who have met eligibility requirements. Employees may elect coverage for a spouse, domestic partner or children. SVA offers two plan choices through CIGNA HealthCare: PPO and the Standard PPO. If you are enrolling a family member (eligible members listed above), you must provide documentation that details your relationship to that person (i.e., marriage certificate, domestic partnership agreement, birth certificate, adoption paperwork).

Premium costs vary by plan choice and level of coverage; however, SVA pays for approximately 75% of premium costs for all options. For specific details about each plan’s coverage, employees are encouraged to view the summary plan descriptions by logging on to http://my.sva.edu and clicking on the Benefits: Summary Plan Descriptions section on the Human Resources homepage.

PPO OPTION
The PPO Option offers coverage for medical care through “in-network” and “out-of-network” providers and does not require you to select a primary physician or obtain referrals for specialist care. If you select an in-network provider, the plan pays a greater share of the costs than if you select an out-of-network provider. In-network coverage has no annual deductible, and features two co-pay amounts, one for primary care ($15) and another for specialist care ($20), and claims are handled by the provider so the participant does not have to submit a form for reimbursement. If you select an out-of-network provider, you must satisfy an annual deductible and are responsible for co-insurance payments up to the out-of-pocket maximum amount.

STANDARD PPO OPTION
The Standard PPO Option is a low-cost alternative to the existing PPO Option. It offers the same level of coverage for “in-network” care as the PPO, and an “out-of-network” option. The Standard PPO features two co-pay amounts, one for primary care ($15) and another for specialist care ($40), but does not require a participant to select a primary physician or obtain referrals for specialist care.

TO CONSIDER
CIGNA offers a variety of additional benefits to employees enrolled under any of the three medical plans:

1) Through online registration, myCIGNA.com allows you to access and manage information specific to the medical plan you have elected. The myCIGNA.com Web site helps you identify health risks, learn about treatments and medications and compare local providers to ensure you and your dependents are receiving the highest level of care.

2) The CIGNA Healthcare 24-Hour Health Information Line offers answers to your health questions 24 hours a day, nationwide. Calls are toll-free from anywhere in the U.S. You may contact the information line at 1.800.564.8982.

3) Through Healthy Rewards, CIGNA offers access to health and wellness programs and services that are often not covered by traditional benefits plans such as:
   • Weight management and nutrition
   • Alternative medicine (acupuncture, massage therapy & chiropractic care)
   • Vision and hearing care

Log on to www.mycigna.com or call 1.800.870.3470 to locate participating providers.
**Prescription Drug Plan Choices**

Employees and their dependents covered under any of the three medical plans offered by SVA receive additional benefits through the Prescription Drug Plan. The plan features two tiers, or categories, of prescription drugs:

- **Generic (First-Tier) Drugs**: Generic drugs are those whose active ingredients, dosage, quality and strength are identical to those of its brand counterpart. These medications are covered at the generic co-payment or co-insurance under a two-tier plan and typically cost less than brand drugs.

- **Brand (Second-Tier) Drugs**: Brand drugs are those which may or may not have an equally effective generic equivalent. These medications are covered at the brand co-payment or co-insurance under a two-tier plan.

**Prescription Drug Costs**

Co-payments for prescription drugs vary across the three medical plan choices (PPO and Standard PPO). Please refer to the Medical Plan Design Summary chart on the following page for more information about the costs associated with your specific plan or visit http://my.sva.edu to access the summary plan description for the coverage option you have elected.

**Participating Pharmacies and Prescription Drug Coverage**

It is important to note that the prescription drug benefits under each of the three medical plans only provide coverage for in-network, or participating pharmacies. CIGNA Prescription Drug Plans provide access to more than 54,000 national and independent pharmacies; you may locate participating pharmacies in your area by visiting www.cigna.com. For a comprehensive list of the medications or supplies covered under each of the three medical plans, log on to www.mycigna.com.

**Obtaining Medications and Supplies**

CIGNA prescription drug plans offer two ways to obtain medications and supplies. You may visit a participating pharmacy or take advantage of a home delivery pharmacy program called **CIGNA Home Delivery Pharmacy**. To save time on trips to the pharmacy, this feature offers convenient home delivery (with a free shipping option) of up to a 90-day supply of medication. Members may also save on prescriptions filled through the CIGNA Home Delivery Pharmacy based on the specific medical plan they have elected. Visit www.cigna.com to access CIGNA Home Delivery Pharmacy order forms on the "Drug Lists/Ordering" page or call CIGNA toll-free at 1.800.835.3784 for more information.

**Note**: If an emergency situation arises and you are not able to use a participating pharmacy, you are responsible for paying the full price of the prescription at the time it is filled. Contact CIGNA to obtain instructions for reimbursement for emergency prescriptions.
Preventive Health Coverage

Preventive health coverage is one of the most important benefits of your health plan. Getting the right preventive services at the right time can help you stay healthy by preventing diseases or by detecting a health problem at a stage that may be easier to treat.

However, because certain services can be done for preventive or diagnostic reasons, it's also important you understand exactly what preventive care is and which services your health plan covers as preventive services so you don't end up with unexpected out-of-pocket costs.

WHAT IS PREVENTIVE CARE?
Preventive care services are those provided when you don't have any symptoms of a disease or medical condition and are not already diagnosed with the condition for which the preventive service would be provided. Preventive care helps you to prevent some illnesses, such as the flu, by getting a vaccine against the disease. It also helps to detect illness that is present, but where there aren't any symptoms.

During your visit, your doctor will determine what tests or health screenings are right for you based on your age, gender, personal health history and current health. Even if you're in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. Through preventive exams and routine health screenings, your doctor can detect early warning signs of more serious problems.

Your plan covers preventive care services. The Patient Protection and Affordable Care Act requires that preventive care services be covered with no patient cost-sharing (deductible, coinsurance or copayment). If your plan has both in-network and out-of-network coverage, the preventive care services are likely covered with no patient cost-sharing only when you receive it from an in-network health care professional. For plans that are exempt or not required to comply with the Act yet, you may be responsible for paying a portion of the cost of preventive care services from in-network and out-of-network health care professionals as applicable.

Non-preventive or diagnostic services/supplies that are provided at the time of a preventive care office visit will be considered under your standard medical coverage. This means you may be required to pay a deductible, copay or coinsurance amount for covered services or supplies that are not preventive.

Please refer to your plan materials for specific details about the coverage and cost-share responsibilities under your plan.

Services and supplies considered as preventive care under your plan are described on the following pages1.
# Wellness Exams and Immunizations

<table>
<thead>
<tr>
<th>Wellness Exams and Immunizations</th>
<th>BIRTH TO 2 YEARS</th>
<th>AGES 3 TO 10</th>
<th>AGES 11 TO 21</th>
<th>AGES 22 AND OLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>WELL-BABY/WELL-CHILD/ WELL-PERSON EXAMS</td>
<td>Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 &amp; 30 months. Additional visit at 2-4 days for infants discharged less than 48 hours after delivery</td>
<td>Well child exams; once a year</td>
<td>Once a year</td>
<td>Periodic visits, depending on age</td>
</tr>
<tr>
<td>(includes height, weight, head circumference, BMI, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP)</td>
<td>2, 4 &amp; 6 months and 15-18 months</td>
<td>Ages 4-6</td>
<td>Tetanus, diphtheria, acellular pertussis (Tdap) given once, ages 11-64</td>
<td>Tetanus and diphtheria toxoids booster (Td) every 10 years; Tdap given once, ages 11-64</td>
</tr>
<tr>
<td>Haemophilus Influenzae type b conjugate (Hib)</td>
<td>2, 4 &amp; 6 months and 12-15 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td>12-23 months</td>
<td></td>
<td></td>
<td>May be required for persons at risk</td>
</tr>
<tr>
<td>Hepatitis B (HepB)</td>
<td>At birth, 1-4 months and 6-18 months</td>
<td>Ages 3-10 if not previously immunized</td>
<td>Ages 11-18 if not previously immunized</td>
<td>May be required for persons at risk</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)*</td>
<td></td>
<td>Ages 9-10, as doctor advises</td>
<td>Ages 11-12, catch-up, ages 13-26</td>
<td>Catch-up, through age 26</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>Annually 6 months and older</td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>Measles, Mumps and Rubella (MMR)</td>
<td>Ages 12-15 months</td>
<td>Ages 4-6</td>
<td>If not already immune</td>
<td>Rubella for women of childbearing age if not immune</td>
</tr>
<tr>
<td>Meningococcal (MCV)</td>
<td></td>
<td></td>
<td>All persons ages 11-18</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (Pneumonia)</td>
<td>2, 4 &amp; 6 months and 12-15 months</td>
<td></td>
<td></td>
<td>Ages 65 &amp; older, once (or younger than 65 for those with risk factors)</td>
</tr>
<tr>
<td>Poliovirus (IPV)</td>
<td>2 &amp; 4 months and 6-18 months</td>
<td>Ages 4-6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td>Ages 6-32 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>Ages 12-15 months</td>
<td>Ages 4-6</td>
<td>Second dose catch-up or if no evidence of prior immunization or chickenpox</td>
<td>Second dose catch-up or if no evidence of prior immunization or chickenpox</td>
</tr>
<tr>
<td>Zoster</td>
<td></td>
<td></td>
<td></td>
<td>Ages 60+</td>
</tr>
<tr>
<td>Health Screenings and Interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alcohol misuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Aspirin to prevent cardiovascular disease</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Autism</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cholesterol/Lipid Disorders</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colon Cancer Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Congenital Hypothyroidism Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Depression Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Developmental Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Developmental Surveillance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Caries Prevention (Evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride)</strong>&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral Health Evaluation/Assess for Dental Referral</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>BIRTH TO 2 YEARS</th>
<th>AGES 3 TO 10</th>
<th>AGES 11 TO 21</th>
<th>AGES 22 AND OLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol misuse</td>
<td></td>
<td></td>
<td></td>
<td>All adults</td>
</tr>
<tr>
<td>Aspirin to prevent cardiovascular disease&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Men ages 45-79; women ages 55-79</td>
<td></td>
</tr>
<tr>
<td>Autism</td>
<td>18, 24 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol/Lipid Disorders</td>
<td>Screening of children and adolescents (after age 2, but by age 10) at risk due to known family history; when family history is unknown; or with personal risk; factors (obesity, high blood pressure, diabetes)</td>
<td>Ages 20 and older if risk factors</td>
<td>All men ages 35 and older, or ages 20-35 if risk factors</td>
<td>All women ages 45 and older, or ages 20-45 if risk factors</td>
</tr>
</tbody>
</table>
| Colon Cancer Screening|                  |              |               | The following tests will be covered for colorectal cancer screening, ages 50 and older;  
|                       |                  |              |               | • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually  
|                       |                  |              |               | • Flexible sigmoidoscopy every 5 years  
|                       |                  |              |               | • Double-contrast barium enema (DCBE) every 5 years  
|                       |                  |              |               | • Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years |
| Congenital Hypothyroidism Screening | Newborns |              |               |                   |
| Depression Screening  |                  | Ages 12-18   |               | All adults        |
| Developmental Screening |                  | 9, 18 months | 30 months     |                   |
| Developmental Surveillance | Newborn 1, 2, 4, 6, 12, 15, 24 months | At each visit | At each visit     |                   |
| Diabetes Screening    |                  |              |               | Adults with sustained blood pressure greater than 135/80 |
| Dental Caries Prevention (Evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride)<sup>4</sup> | Children older than 6 months | Children older than 6 months |                   |                   |
| Oral Health Evaluation/Assess for Dental Referral | 12, 18, 24 months | 30 months, 3, 6 years |                   |                   |
# Health Screenings and Interventions

<table>
<thead>
<tr>
<th></th>
<th>BIRTH TO 2 YEARS</th>
<th>AGES 3 TO 10</th>
<th>AGES 11 TO 21</th>
<th>AGES 22 AND OLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Screening (not complete hearing examination)</td>
<td>All newborns by 1 month</td>
<td>4, 5, 6, 8 &amp; 10 or as doctor advises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Diet/Nutrition Counseling</td>
<td>Ages 6 and older — to promote improvement in weight status</td>
<td>Ages 6 and older — to promote improvement in weight status</td>
<td>Adults with hyperlipidemia, those at risk for cardiovascular disease or diet-related chronic disease</td>
<td></td>
</tr>
<tr>
<td>Hemoglobin or Hematocrit</td>
<td>12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Screening</td>
<td></td>
<td>Adolescents at risk</td>
<td>Men at risk</td>
<td></td>
</tr>
<tr>
<td>Iron Supplementation&lt;sup&gt;2&lt;/sup&gt;</td>
<td>6-12 months for children at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Screening</td>
<td>12, 24 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metabolic/Hemoglobinopathies (according to state law)</td>
<td>Newborns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity Screening</td>
<td>Ages 6 and older</td>
<td>Ages 6 and older</td>
<td>All adults</td>
<td></td>
</tr>
<tr>
<td>PKU Screening</td>
<td>Newborns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylactic Ocular (Eye) Medication to Prevent Blindness</td>
<td>Newborns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer Screening (PSA)</td>
<td></td>
<td></td>
<td>Men ages 50 and older or age 40 with risk factors</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STI) Screening</td>
<td></td>
<td>All sexually active adolescents</td>
<td>All adults at risk</td>
<td></td>
</tr>
<tr>
<td>Sickle Cell Disease Screening</td>
<td>Newborns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin cancer prevention counseling to minimize exposure to ultraviolet radiation</td>
<td>Ages 10–24 years</td>
<td>Ages 10–24 years</td>
<td>Ages 10–24 years</td>
<td></td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td></td>
<td>Individuals at risk</td>
<td>Adults at risk</td>
<td></td>
</tr>
<tr>
<td>Tobacco use/cessation interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculin test</td>
<td>Children at risk</td>
<td>Children at risk</td>
<td>Adolescents at risk</td>
<td></td>
</tr>
<tr>
<td>Ultrasound Aortic Abdominal Aneurysm Screening</td>
<td></td>
<td></td>
<td>Men ages 65–75 who have ever smoked</td>
<td></td>
</tr>
<tr>
<td>Vision Screening (not complete eye examination)</td>
<td>3, 4, 5, 6, 8 and 10 or as doctor advises</td>
<td>12, 15 and 18 or as doctor advises</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Women’s Health Screenings and Interventions

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia Screening</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Bacteriuria Screening</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Discussion/Referral for Counseling Related to BRCA1/BRCA2 test</td>
<td>Women at risk</td>
</tr>
<tr>
<td>Discussion About Potential Benefits/Risk of Breast Cancer Preventive Medication</td>
<td>Women at risk</td>
</tr>
<tr>
<td>Breast Cancer Screening (Mammogram)</td>
<td>Women ages 40 and older, every 1–2 years</td>
</tr>
<tr>
<td>Breast-feeding support/counseling, supplies&lt;sup&gt;4&lt;/sup&gt;</td>
<td>During pregnancy and after birth</td>
</tr>
<tr>
<td>Cervical Cancer Screening (Pap test)</td>
<td>Ages 21–65, every 3 years</td>
</tr>
<tr>
<td>HPV DNA test with pap test</td>
<td>Women ages 30–65 every 5 years</td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>Sexually active women ages 24 and under &amp; older women at risk</td>
</tr>
<tr>
<td>Contraception counseling/education. Contraceptive products and services&lt;sup&gt;4,6&lt;/sup&gt;</td>
<td>Women with reproductive capacity</td>
</tr>
<tr>
<td>Counseling on sexually transmitted diseases</td>
<td>Sexually active women, annually</td>
</tr>
<tr>
<td>Domestic and interpersonal violence screening</td>
<td>All women</td>
</tr>
<tr>
<td>Folic Acid Supplementation&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Women planning or capable of pregnancy</td>
</tr>
<tr>
<td>Gestational diabetes screening</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>Sexually active women at risk</td>
</tr>
<tr>
<td>Hepatitis B Screening</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>HIV screening and counseling</td>
<td>Sexually active women, annually</td>
</tr>
<tr>
<td>Osteoporosis Screening</td>
<td>Age 65 or older (or 60 for women at risk)</td>
</tr>
<tr>
<td>Rh Incompatibility Test</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>Tobacco Use/Cessation Interventions</td>
<td>Pregnant women</td>
</tr>
</tbody>
</table>

**NOTE:** If your doctor provides medical services during your preventive care visit that are not included in the preventive care list, these items will be considered under your standard medical plan coverage. This means you may be responsible for paying a share (copay or coinsurance) of the cost. Please see your plan materials for specific details about your plan coverage.

<sup>1</sup> Gender criteria apply depending on vaccine brand.

<sup>2</sup> Certain preventive medications noted above may be available to you at no cost. Your doctor will be required to give you a prescription for these medications, including over-the-counter (OTC) medications, for them to be covered under your Pharmacy benefit.

<sup>3</sup> Preventive health services are based on recommendations from the U.S. Preventive Services Task Force (A and B recommendations), the Advisory Committee on Immunization Practices (ACIP) for immunizations, and the American Academy of Pediatrics’ Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov. This document is a general guide. Always discuss your particular preventive care needs with your doctor.

**Exclusions**

This document does not guarantee coverage for all preventive services. Immunizations for travel are generally not covered. Other non-covered services can include any medical service or device that is not medically necessary, and any services and supplies for or in connection with experimental, investigational or unproven services. This document contains only highlights of preventive health services. The specific terms of coverage, exclusions and limitations, including legislated coverage, are included in the Summary Plan Description or Insurance Certificate.
## Medical Plan Design Summary

For a more detailed description of these plans, please refer to the Summary Plan Descriptions on MySVA.

### PLAN PROVISIONS

<table>
<thead>
<tr>
<th>PLAN HIGHLIGHTS</th>
<th>PPO OPTION</th>
<th>PLAn HiGHLiGHtS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$15 co-pay PCP; $20 co-pay specialist</td>
<td>$500/$1,250</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>N/A</td>
<td>$400/$1,000</td>
</tr>
<tr>
<td>Physician Office Visit</td>
<td>$15 co-pay PCP; $20 co-pay specialist</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
<tr>
<td>Prescription Drug Card</td>
<td>$5 co-pay generic; $20 co-pay name brand</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
</tbody>
</table>

### Hospital/Surgical Services

<table>
<thead>
<tr>
<th>HOSPITAL/SURGICAL</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Surgery</td>
<td>100%</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>100%</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>100%</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$25 co-pay (waived if admitted)</td>
<td>$25 co-pay (waived if admitted)</td>
</tr>
</tbody>
</table>

### Wellness Benefits

<table>
<thead>
<tr>
<th>WELLNESS BENEFITS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Baby Care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Annual Physical Exam</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(applies to all covered dependents through age 26 and includes routine immunizations)</td>
<td>No Calendar Year Max</td>
<td>No Calendar Year Max</td>
</tr>
<tr>
<td>Adult Preventive Care for Employee and All Dependents</td>
<td>100%</td>
<td>No Calendar Year Max</td>
</tr>
<tr>
<td></td>
<td>No Calendar Year Max</td>
<td></td>
</tr>
</tbody>
</table>

### Mental/Nervous

<table>
<thead>
<tr>
<th>MENTAL/NERVOUS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mental/Nervous</td>
<td>100%</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
<tr>
<td>Outpatient Mental/Nervous Facility</td>
<td>No Calendar Year Max</td>
<td>100%</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 co-pay, then 100%</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
</tbody>
</table>

### Alcohol/Substance Abuse

<table>
<thead>
<tr>
<th>ALCOHOL/SUBSTANCE ABUSE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Alcohol/Substance Abuse</td>
<td>100%</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
<tr>
<td>Outpatient Alcohol/Substance Abuse Facility</td>
<td>100%</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 co-pay, then 100%</td>
<td>80% of R&amp;C fees after deductible</td>
</tr>
</tbody>
</table>

### Miscellaneous

<table>
<thead>
<tr>
<th>MISCELLANEOUS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Care</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Vision</td>
<td>One exam per calendar year—maximum of $150 per year</td>
<td>One exam per calendar year—maximum of $150 per year</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%, 120 visits per year</td>
<td>100% 120 visits per year</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hospice Facility</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
## PLAN PROVISIONS

<table>
<thead>
<tr>
<th>PLAN HIGHLIGHTS</th>
<th>STANDARD PPO OPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Co-insurance</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Physician Office Visit</strong></td>
<td>$15 co-pay PCP, $40 co-pay specialist</td>
</tr>
<tr>
<td><strong>Prescription Drug Card</strong></td>
<td>$10 co-pay generic, $20 co-pay name brand</td>
</tr>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td><strong>OUT-OF-NETWORK</strong></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td><strong>$750/$1,875</strong></td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td><strong>$1,000/$2,000</strong></td>
</tr>
<tr>
<td><strong>Co-insurance</strong></td>
<td><strong>80% of R&amp;C fees after deductible</strong></td>
</tr>
<tr>
<td><strong>Physician Office Visit</strong></td>
<td><strong>80% of R&amp;C fees after deductible</strong></td>
</tr>
<tr>
<td><strong>Prescription Drug Card</strong></td>
<td><strong>80% of R&amp;C fees after deductible</strong></td>
</tr>
</tbody>
</table>

### HOSPITAL/SURGICAL

| **Inpatient Surgery** | 100% |
| **Inpatient Hospital Services** | 100% |
| **Outpatient Surgery** | 100% |
| **Outpatient Hospital Services** | $25 co-pay (waived if admitted) |
| **Emergency Room** | 80% of R&C fees after deductible |
| **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient Surgery** | **80% of R&C fees after deductible** |
| **Inpatient Hospital Services** | **80% of R&C fees after deductible** |
| **Outpatient Surgery** | **80% of R&C fees after deductible** |
| **Outpatient Hospital Services** | **80% of R&C fees after deductible** |
| **Emergency Room** | **80% of R&C fees after deductible** |

### WELLNESS BENEFITS

| **Well Baby Care** | 100% |
| **Annual Physical Exam** | 100% |
| **Adult Preventive Care for Employee and All Dependents** | 100% |
| **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Well Baby Care** | 100% |
| **Annual Physical Exam** | 100% |
| **Adult Preventive Care for Employee and All Dependents** | 100% |

### MENTAL/NERVOUS

| **Inpatient Mental/Nervous** | 100% |
| **Outpatient Mental/Nervous Facility** | 100% |
| **Office Visits** | $40 co-pay, then 100% |
| **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient Mental/Nervous** | **80% of R&C fees after deductible** |
| **Outpatient Mental/Nervous Facility** | **80% of R&C fees after deductible** |
| **Office Visits** | **80% of R&C fees after deductible** |

### ALCOHOL/SUBSTANCE ABUSE

| **Inpatient Alcohol/Substance Abuse** | 100% |
| **Outpatient Alcohol/Substance Abuse Facility** | 100% |
| **Office Visits** | $40 co-pay, then 100% |
| **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient Alcohol/Substance Abuse** | **80% of R&C fees after deductible** |
| **Outpatient Alcohol/Substance Abuse Facility** | **80% of R&C fees after deductible** |
| **Office Visits** | **80% of R&C fees after deductible** |

### MISCELLANEOUS

| **Chiropractic Care** | Not Covered |
| **Massage Therapy** | Not Covered |
| **Acupuncture** | Not Covered |
| **Vision** | One exam per calendar year—maximum of $150 per year |
| **Home Health Care** | 100%, 120 days per year |
| **Skilled Nursing Facility** | 100% |
| **Hospice Facility** | 100% |

**RATES EFFECTIVE JANUARY 1, 2014**

*PPO/Standard PPO Out-of-Network charges are subject to Reasonable and Customary reimbursement levels.*

*Reasonable & Customary Fees — see glossary for more details*

**Disclaimer:** This is an overview only of the plans offered by SVA. Should there be a difference between what is displayed here and the actual Cigna SPD; the Cigna SPD will prevail.
Medical Plan Premiums

<table>
<thead>
<tr>
<th>PLAN</th>
<th>COVERAGE</th>
<th>PAYROLL DEDUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SEMI-MONTHLY</td>
</tr>
<tr>
<td>PPO</td>
<td>Single</td>
<td>$78</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; Child</td>
<td>$146</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; Children</td>
<td>$206</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; Spouse</td>
<td>$229</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>$285</td>
</tr>
<tr>
<td>STANDARD PPO</td>
<td>Single</td>
<td>$26</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; Child</td>
<td>$47</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; Children</td>
<td>$67</td>
</tr>
<tr>
<td></td>
<td>Employee &amp; Spouse</td>
<td>$78</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>$102</td>
</tr>
</tbody>
</table>

Domestic Partner Coverage

SVA extends medical and dental plan eligibility to domestic partners of full- and part-time administrative staff. Employees who wish to provide coverage for their partners must, in accordance with insurance guidelines, provide documentation of their domestic partnership, which may include partner registration if they live in a state that provides for such registration.

Domestic partners, for enrollment purposes, are defined as two unrelated individuals who are:

- At least 18 years of age and mentally competent to sign the required affidavit
- Sharing the necessities of life, living together and have had an emotional and financial commitment to one another for a minimum of 12 consecutive months
- Neither married nor legally separated from someone else

Employees who meet these qualifications may submit an enrollment form for medical and/or dental coverage for their partner along with:

- A completed and notarized Declaration of Domestic Partnership
- A completed Declaration of Domestic Partnership for Benefits Eligibility
- Two forms of documentation as evidence that the partners are committed to one another (Examples: joint-tenancy lease, jointly-held mortgage, joint checking account, bills or driver’s license showing the same address, an insurance policy or will indicating the partner as beneficiary, or a copy of a registration certificate)
**ADDITIONAL GUIDELINES REGARDING COVERAGE**

- Termination of the partnership, and thus benefits for the partner, will need to be communicated in writing and the Declaration of Termination of Domestic Partnership submitted within 31 days of status change.
- An employee will be eligible to seek benefits for another domestic partner 12 months from the date indicated on the Declaration of Termination.
- If the partnership is, at any time, found not to be in accordance with the guidelines for coverage, domestic partner benefits will be terminated retroactively and SVA is entitled to seek reimbursement for any claims and/or premium paid on the partner’s behalf.

**IMPORTANT ISSUES TO NOTE**

Because domestic partners do not satisfy the definition of a dependent under Section 152 of the Internal Revenue Code, the value of coverage for an employee’s partner is taxable to the employee and considered income. Whereas state laws do not recognize a domestic partner as a “spouse,” there is no pre-tax benefit for employees who wish to cover their domestic partner. As such, premiums for domestic partner medical coverage must be deducted separately from premiums for the employee’s medical coverage. To understand the total cost for coverage, combine the premium rate for “Single” coverage under the plan of your choice and the premium rate for “Employee & Spouse” under the same plan. We strongly suggest that all employees considering domestic partner coverage seek both legal and accounting advice concerning these matters.

**PLEASE ALSO NOTE THE FOLLOWING**

- Coverage will not be extended to the children of an employee’s domestic partner, unless the children have been legally adopted by the employee.
- Termination of coverage for a domestic partner does not qualify that person for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
- Coverage will not be extended to a domestic partner under the Family and Medical Leave Act (FMLA) of 1993 as the act does not include unmarried domestic partners within its definition of “spouse.”
- Domestic partners are not recognized as eligible dependents under the Flexible Spending Program.

---

**VSP® Signature Vision Care Plan**

VSP® Signature Vision Care Plan includes:

- Value and Savings
- Personalized Care
- Great Eyewear — from classic styles to the latest designer frames
- Choice of Providers
- No claim forms to complete
- Online access at www.vsp.com to review plan coverage, find a VSP Doctor, view the latest eye health and wellness and benefit information
- No ID card required
Healthy Steps to Weight Loss Program

SVA continues to offer employees Healthy Steps to Weight Loss Program, a voluntary program that will help participants learn to manage their weight using a non-diet approach that will help to build confidence, change habits, eat healthier and become more active. This program is available to all SVA employees at no cost, regardless of participation in the CIGNA medical plan.

As a Healthy Steps to Weight Loss Program participant, you have the option of enrolling in the telephone-based program, or the online-based program or both. Both options include the support and guidance of a dedicated health advocate available 24/7, to help you to adopt and develop healthy eating and exercise habits to lose weight.

The telephone-based program includes:
- A dedicated health advocate who work with you one-on-one according to your needs, preferences and motivation
- A workbook and toolkit
- 24/7 support for questions and enrollment
- Healthy Rewards discounts

The Web-based program includes:
- 12-phase self-paced program that includes weekly emails filled with learning themes and tips
- The online program adjusts to your nutritional needs and preferences
- 24/7 support for questions and enrollment
- Healthy Rewards discounts

If you are interested in enrolling in the VSP® Signature Vision care Plan, please complete the appropriate enrollment Form located at the end of this booklet.

The due date for all enrollment forms is Monday, December 2, 2013. All forms should be sent to Benefits/Human Resources Department. Your benefit will become effective on January 1, 2014.


**SEMI-MONTHLY COST**
If you are interested in enrolling in the Healthy Steps to Weight Loss Program, please call 1.866.417.7848 or visit www.myCIGNA.com to enroll online. If you wish to enroll in the online-based program and you are not a participant in the medical plan, please visit www.cignabehavioral.com; click on the link “Login to access your benefits” and enter the employee ID “sva”

**Strength and Resilience Stress Management Program**

SVA continues to offer employees Strength and Resilience Stress Management Program, a voluntary program that will help participants take control and gain the strength to cope with their stress. This program is available to SVA employees **enrolled in one of the CIGNA PPO plan options** at no cost.

As a Stress Management Program participant, you have the option of enrolling in the telephone-based program or the Web-based program or both. Both options include the support and guidance of a dedicated wellness coach available 24/7, and help to develop a personal stress management plan.

The telephone-based program includes:
- Personal stress management plan
- Dedicated wellness coach
- Workbook and toolkit
- Support line available 24/7

The Web-based program includes:
- An 8-week self paced program
- Weekly educational e-mails with key learning themes and tips
- Secure convenient support

If you are interested in enrolling in the Stress Management Program, please call 1.866.417.7848 or visit www.myCIGNA.com to enroll online if you are a participant in the CIGNA PPO medical plan.
Quit Today Smoking Cessation Program

SVA continues to offer employees Quit Today, a voluntary program that provides vital tools and resources to support participants in their efforts to quit smoking. This program is available to SVA employees enrolled in one of the CIGNA PPO plan options at no cost.

As a Quit Today participant, you have the option of enrolling in the telephone-based program or the Web-based program or both. Both options include free nicotine replacement products (patch or gum) mailed directly to your home.

The telephone-based program includes:

- One-on-one support from a wellness coach who will help you create a plan based on your personal goals, preferences and health needs
- Optional group coaching sessions
- A workbook with valuable information to guide you through the process of quitting
- Nicotine replacement products (patch or gum)

The Web-based program includes:

- Convenient online registration for the program
- A two week plan to quit and a six week post-quit module
- E-mails sent to you with articles of interest
- Online tools to track your progress
- The ability to contact a personal wellness coach for additional support
- Nicotine replacement products (patch or gum)

If you are interested in enrolling in the Quit Today Program, please call 1.866.417.QUIT or visit www.myCIGNA.com to enroll online if you are a participant in the CIGNA PPO medical plan.

**NOTE:** Only one course of over-the-counter Nicotine Replacement Therapy is available per participant, per calendar year.
Dental Plan Choices

Employees of SVA are eligible to participate in SVA’s dental insurance plan after one month of employment as a regular full-time administrative employee or after 12 months as a regular part-time employee working a minimum of 1,000 hours/calendar year. Dependents of eligible employees may also participate. If you are enrolling a family member, you must provide documentation that details your relationship to that person (i.e., marriage certificate, domestic partnership agreement, birth certificate, adoption paperwork).

SVA offers a comprehensive dental plan with the Aetna Freedom-of-Choice voluntary dental program to help employees best meet their dental insurance needs. The benefits include:

- The option of two plan choices: the DMO Network or the Passive PPO Plan
- The ability to switch between the plans on a monthly basis
- Significantly enhanced benefits in the DMO network
- Flexibility to use an in-network or out-of-network dentist in the PPO
- Orthodontia covered for dependent children through age 19 under the PPO and DMO option.
- Calendar year maximum increased to $2,000.

The entire cost of participation in the dental program is paid by the employee and is deducted on a pre-tax basis from the employee’s paycheck.

You may access a summary plan description by logging on to MySVA at: http://my.sva.edu and clicking on the Benefits: Summary Plan Descriptions section on the Human Resources homepage.

Dental Plan Premiums

<table>
<thead>
<tr>
<th>LEVEL OF COVERAGE</th>
<th>SEMI-MONTHLY</th>
<th>ANNUALLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE</td>
<td>$23.00</td>
<td>$552.00</td>
</tr>
<tr>
<td>EMPLOYEE &amp; 1 DEPENDENT</td>
<td>$43.17</td>
<td>$1,036.20</td>
</tr>
<tr>
<td>EMPLOYEE &amp; FAMILY</td>
<td>$70.86</td>
<td>$1,700.64</td>
</tr>
</tbody>
</table>

RATES EFFECTIVE JANUARY 1, 2014
## Dental Benefits Summary

**Annual Deductible**
- Individual: None
- Family: None

**Preventive Services**
- 100%

**Basic Services**
- 100%

**Major Services**
- 60%

**Annual Benefit Maximum**
- None

**Office Visit Copay**
- $0

**Orthodontic Services**
- 50%

**Orthodontic Deductible**
- None

**Orthodontic Lifetime Maximum**
- ***

**Partial List of Services FOC DMO**

### Preventive
- Oral examinations (a)
- Cleanings (a) Adult/Child
- Fluoride (a)
- Sealants (permanent molars only) (a)
- Bitewing X-rays (a)
- Full mouth series X-rays (a)

### Basic
- Root canal therapy
  - Anterior teeth / Bicuspid teeth
- Scaling and root planing (a)
- Gingivectomy*
- Amalgam (silver) fillings
- Composite fillings (anterior teeth only)
- Stainless steel crowns
- Incision and drainage of abscess*
- Uncomplicated extractions
- Surgical removal of erupted tooth*
- Surgical removal of impacted tooth (soft tissue)*

### Major
- Space Maintainers
- Inlays
- Onlays
- Crowns
- Full & partial dentures
- Pontics
- Root canal therapy, molar teeth
- Osseous surgery (a)*
- Surgical removal of impacted tooth (partial bony/ full bony)*
- General anesthesia/Intravenous sedation*
- Denture repairs

---

**Orthodontia is covered only for children (appliance must be placed prior to age 20)**

---

**24 months of comprehensive orthodontic treatment plus 24 months of retention**

---

*(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.*
Other Important Information
This benefits summary of the Aetna Dental DMO (Dental Maintenance Organization) provides information on benefits provided when services are rendered by a participating dentist. In order for a covered person to be eligible for benefits, dental services must be provided by a primary care dentist selected from the network of participating DMO dentists. Due to state law, limited (varying by state) DMO® benefits for non-emergency services rendered by non-participating providers are available for plan contracts written in: CT, IL, KY and OH and for members residing in MA and OK (regardless of contract situs state).

Specialty Referrals
1. Under the DMO dental plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna Dental. If Aetna’s payment to the specialty dentist is based on a negotiated fee, then the member's copayment for the service will be based on the same negotiated fee. If Aetna's payment is on another basis, then the copayment will be based on the dentist's usual fee for the service, reviewed by Aetna for reasonableness.
2. DMO members may visit an orthodontist without first obtaining a referral from their primary care dentist. In an effort to ease the administrative burden on both participating Aetna dentists and members, Dental has opened direct access for DMO members to orthodontic services.

Emergency Dental Care
If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. You should contact your Primary Care Dentist to receive treatment. If you are unable to contact your PCD, contact Member Services for assistance in locating a dentist. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:
1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion. (This item does not apply to California residents)
8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.


11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.

13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.

14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:
   (a) during the first 31 days the person is eligible for this coverage, or
   (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
      (i) after the end of the 12-month period starting on the date the person became a covered person; or
      (ii) as a result of accidental injuries sustained while the person was a covered person; or
      (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.

16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.

17. Those for a crown, cast or processed restoration unless:
   (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
   (b) the tooth is an abutment to a covered partial denture or fixed bridge.

18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.


20. Services needed solely in connection with non-covered services.

21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services. (This item does not apply to California residents)

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule
The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.
Dental Benefits Summary

Tooth Missing But Not Replaced Rule - This item does not apply to California and Texas residents.
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person’s dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:
(a) the service must be listed on the Dental Care Schedule;
(b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:
(a) the copayment for the approved less costly service; plus
(b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers
Consult Aetna Dental’s online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. Not every provider listed in the directory will be accepting new patients. Although Aetna Dental has identified providers who were not accepting patients in our DMO plan as known to Aetna Dental at the time the provider directory was created, the status of a provider’s practice may have changed. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.
In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.
All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Arizona, DMO, Advantage Dental, Basic Dental and Family Preventive Dental Plans are provided or administered by Aetna Health Inc.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. Aetna does not provide dental services and, therefore, cannot guarantee any results or outcomes. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.
## Dental Benefits Summary

### Annual Deductible*
- **Individual**: $50
- **Family**: $150

### Preventive Services
- **Basic Services**: 80%
- **Major Services**: 50%

### Annual Benefit Maximum
- **Passive PPO**
  - **With PPOII Network**: $2,000

### Orthodontic Services**
- **Deductible**: None
- **Lifetime Maximum**: $1,500

### Partial List of Services

#### Preventive
- **Oral examinations (a)**
- **Cleanings (a) Adult/Child**
- **Fluoride (a)**
- **Sealants (permanent molars only) (a)**
- **Bitewing X-rays (a)**
- **Full mouth series X-rays (a)**

#### Basic
- **Amalgam (silver) fillings**
- **Composite fillings (anterior teeth only)**
- **Stainless steel crowns**
- **Space Maintainers**
- **Uncomplicated extractions**

#### Major
- **Inlays**
- **Onlays**
- **Crowns**
- **Full & partial dentures**
- **Pontics**
- **Incision and drainage of abscess**
- **Surgical removal of erupted tooth**
- **Surgical removal of impacted tooth (soft tissue)**
- **Root canal therapy**
  - **Anterior teeth / Bicuspids teeth**
  - **Scaling and root planing (a)**
  - **Gingivectomy**
  - **Root canal therapy, molar teeth**
  - **Osseous surgery (a)**
  - **Surgical removal of impacted tooth (partial bony/ full bony)**
  - **General anesthesia/intravenous sedation**
  - **Denture repairs**

---

*The deductible applies to: Basic & Major services only
**Orthodontia is covered only for children (appliance must be placed prior to age 20).

---

*Certain services may be covered under the Medical Plan. Contact Member Services for more details.
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.
Partial List of Exclusions and Limitations* - Coverage is not provided for the following:

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.

2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.

3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.

4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.

5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.

6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.

7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.

8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person;
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.

9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.


11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.

13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.

14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:
   (a) during the first 31 days the person is eligible for this coverage, or
   (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
      (i) after the end of the 12-month period starting on the date the person became a covered person; or
      (ii) as a result of accidental injuries sustained while the person was a covered person; or
      (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.

16. Those for a crown, cast or processed restoration unless:
   (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
   (b) the tooth is an abutment to a covered partial denture or fixed bridge.

17. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule
The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

(a) the service must be listed on the Dental Care Schedule;
(b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

(a) the copayment for the approved less costly service; plus
(b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers
Consult Aetna Dentals online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern. In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Arizona, DMO®, Advantage Dental, Basic Dental and Family Preventive Dental Plans are provided or administered by Aetna Health Inc. In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and Indemnity Dental plans are provided or administered by Aetna Life Insurance Company.
Dental Benefits Summary

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.
Life Insurance & Accidental Life, Death & Dismemberment (AD&D)

Life Insurance and AD&D is provided at SVA’s expense for regular full-time employees after one month of employment. Regular part-time employees who work a minimum of 1000 hours/calendar year are covered after 12 months. The benefit amount for basic life insurance is 2x your base salary ($50,000 minimum). Part-time employees who meet eligibility requirements are given a fixed $50,000 of coverage. In addition, employees have the option to purchase supplemental life insurance and dependent life insurance at their own expense. These rates are based on elected coverage amounts and age. A group certificate of insurance is available for viewing on MySVA/Human Resources to explain your coverage in detail.

**NOTE:** Life insurance coverage reduces by 50% at age 70. All coverage cancels at retirement.

Employee Supplemental Life Insurance

Supplemental life insurance is coverage that you pay for; it pays your beneficiary (the person, persons, or legal entity who receives a benefit payment) if you die while you are covered by the policy. You must select your beneficiary [ies] when you complete your enrollment application; your selection is legally binding. You can purchase supplemental life insurance in increments of 1x-4x your annual salary, not to exceed $500,000. For coverage amounts in excess of $250,000 (guarantee issue) you will be required to provide evidence of insurability by completing a Statement of Health that is satisfactory to the insurance carrier. You may enroll for, or make changes to your supplemental life insurance during Open Enrollment each year, and it will remain in effect for the entire year unless you have a qualifying event. If you already have supplemental life insurance coverage and do not wish to make any changes, your coverage and coverage for eligible dependents will automatically continue subject to the terms of the contract.
### Spouse Supplemental Life Insurance

If you elect supplemental life insurance for yourself, you may choose to purchase spouse supplemental life insurance in increments of $10,000, to a maximum of $250,000. Coverage cannot exceed 50% of the amount of your employee supplemental life insurance coverage. If you are electing coverage for the first time, or electing to increase your current coverage, your spouse will be required to provide evidence of insurability by completing a Statement of Health that is satisfactory to the insurance carrier.

### Child[ren] Supplemental Life Insurance

You may choose to purchase child[ren] supplemental life insurance coverage in the amount of $10,000 for each child – no medical information is required.

Child[ren] must be unmarried and are covered from 2 weeks to 19 years old, or 25 years if a full-time student.

1 Unmarried child[ren] over age 19 may be covered if they are disabled and primarily dependent upon the employee for financial support. Child[ren] from 2 weeks to 6 months are limited to a reduced benefit of $1,000.
Flexible Spending Accounts (FSA)

SVA offers employees enrolled in a health plan the opportunity to participate in a Health Care Reimbursement Account and/or a Dependent Care Reimbursement Account. A reimbursement account provides employees a way to pay for eligible out-of-pocket health care and dependent care expenses not covered by your health plan on a pre-tax basis through payroll deductions. This means that the contributions you make to your flexible spending account(s) are deducted before taxes are calculated on your pay.

HEALTH CARE ACCOUNT
The Health Care Reimbursement Account can be used for eligible health-related expenses not covered by your health plan. Eligible expenses can be for yourself, your spouse, or other eligible family members as defined by IRS regulations—even if they are not covered under SVA’s health plan.

You can contribute up to $2,500 annually in pre-tax dollars to the Health Care Account. The amount you elect to contribute will be deducted from your paycheck in equal installments throughout the year. Medication expenses may be reimbursed from the FSA Health Care Account if the medicine or drug:

- Requires a prescription
- Is an OTC medicine or drug and the individual obtains a prescription
- Or is insulin

WHAT IS A PRESCRIPTION?
For purposes of these rules, the IRS clarifies that a prescription means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

EXAMPLES OF EXPENSES THAT CAN BE COVERED BY THE HEALTH CARE ACCOUNT:
- Co-payments and deductibles
- Vision care, including the cost of eyeglasses and contact lenses
- Acupuncture
- Orthodontic care
- Other IRS approved medical costs

You may also refer to the IRS publication 502–Medical Expenses, accessible through www.irs.gov or by calling 800.829.3676 for more information and examples of expenses that are covered.

DEPENDENT CARE ACCOUNT
The Dependent Care Reimbursement Account can be used for eligible dependent care services that enable you, or you and your spouse to work. The age limit for dependent children is 13 years of age.

You can contribute up to $5,000 annually in pre-tax dollars to the Dependent Care Account. The amount you elect to contribute will be deducted from your paycheck in equal installments throughout the year.

EXAMPLES OF EXPENSES THAT CAN BE COVERED BY THE DEPENDENT CARE ACCOUNT:
- Licensed day care centers or nursery schools
- Dependent care in your home or dependent care in another person’s home (if fewer than seven children are being cared for)
  A disabled spouse or parent who is claimed as a dependent on your federal income tax return

You may also refer to the IRS publication 503–Dependent Care Expenses, accessible through www.irs.gov or by calling 1.800.829.3676, for more information and examples of expenses that are covered.
This program is governed by the IRS and is subject to minimum and maximum contribution amounts. Tax law requires that an employee’s choices in a FSA be made in advance of the plan year. This means that after the effective date of the plan, no changes can be made until the next enrollment period unless an IRS qualifying event occurs. In addition, federal regulations require that any funds in your FSA not claimed by health care or dependent care expenses in the calendar year cannot be refunded to you and cannot be carried over to the following year.

Our plan year covers January 1 through December 31. However, under an IRS ruling you can continue to incur eligible expenses through March 15 of the following year. Reimbursement claims must be submitted to CIGNA no later than April 30. If the deadline is not met, the unused money is forfeited and subject to the “Use It or Lose It” rule.

**NOTE:** Even if you are currently enrolled in the Flexible Spending Account Plan, you must complete a new application for 2014. Once an annual FSA amount is elected, a participant cannot increase or decrease the amount for the rest of the plan year unless they meet a “qualifying event.”

### EXAMPLES OF A QUALIFYING EVENT:
- Marriage
- Birth of a Child
- Divorce or Legal separation
- Death
- Change in Residence

Notice must be given to the Benefits administrator within 31 days of the qualifying event.

### GETTING REIMBURSED

You will receive a debit card when you enroll in the FSA. You may use the card to pay for qualified health care expenses at authorized health care providers and pharmacies. When you use the card, funds are automatically deducted from your FSA and you pay nothing out of your pocket at the time of service, as long as there is enough money in your FSA to pay for the charge. If you do not use your debit card, you must submit claims directly to your FSA to receive payment.

To submit a claim go to MyCigna.com and click “Online Reimbursement Request.”

You may continue to complete and sign a Health Care Request for Reimbursement Form available in the booklet or by calling Human Resources.

If you have any FSA questions or would like to check the balance of your account, contact CIGNA Healthcare FSA Claims at 1.800.244.6224 or online at www.mycigna.com.

The worksheet will help you estimate your upcoming health care expenses that are eligible for reimbursement through the Flexible Spending Account.
Flexible Spending Accounts Worksheet

HOW MUCH SHOULD YOU CONTRIBUTE TO YOUR FLEXIBLE SPENDING ACCOUNT?

Use this worksheet to help estimate your health care costs in 2014 that qualify for reimbursement using your Flexible Spending Account. Remember that money remaining in your Flexible Spending Account at the end of the year is forfeited so be conservative in your estimates.

<table>
<thead>
<tr>
<th>COVERED EXPENSE</th>
<th>DESCRIPTION</th>
<th>YOUR ESTIMATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANNUAL PLAN DEDUCTIBLES</td>
<td>Applies to both your medical and dental plan deductibles.</td>
<td>$</td>
</tr>
<tr>
<td>DOCTOR VISITS</td>
<td>In-network co-pays or other expenses related to doctor visits.</td>
<td>$</td>
</tr>
<tr>
<td>ROUTINE PHYSICAL EXAM</td>
<td>In-network co-pays or other expenses related to doctor visits.</td>
<td>$</td>
</tr>
<tr>
<td>PRESCRIPTION DRUGS (INCLUDING ORAL CONTRACEPTIVES)</td>
<td>Co-pays for generic and brand name or Tel-Drug 90-day supply.</td>
<td>$</td>
</tr>
<tr>
<td>EMERGENCY ROOM</td>
<td>In-network co-pays or other expenses related to hospital visits.</td>
<td>$</td>
</tr>
<tr>
<td>DENTAL CARE</td>
<td>Annual deductible for basic and major services in the PPO only; 50% out-of-pocket for orthodontic services DMO and PPO.</td>
<td>$</td>
</tr>
<tr>
<td>VISION CARE</td>
<td>In-network co-pays or other expenses for annual eye exam, glasses, LASIK and contact lenses.</td>
<td>$</td>
</tr>
<tr>
<td>OTHER PLANNED UNCOVERED EXPENSEES</td>
<td>Eligible over the counter medications with a prescription.</td>
<td>$</td>
</tr>
<tr>
<td>TOTAL ESTIMATED HEALTH-CARE EXPENSES (Maxi-</td>
<td>mum $2,500)</td>
<td>$</td>
</tr>
</tbody>
</table>
## Useful Phone Numbers and Web Sites

| HUMAN RESOURCES DEPARTMENT/BENEFITS | 212.592.2640  
gthomasjones@sva.edu |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GEORGETTE THOMAS JONES, Benefits Manager</td>
<td></td>
</tr>
</tbody>
</table>
| CIGNA HEALTH CARE  
CUSTOMER SERVICE | 1.800.244.6224  
www.cigna.com |
| AETNA  
MEMBER SERVICES | 1.877.238.6200  
www.aetna.com |
| CIGNA HOME DELIVERY PHARMACY | 1.800.835.3784  
www.teldrug.com |
| CIGNA 24-HOUR HEALTH INFO LINE | 1.800.564.8982  |
| CIGNA FSA CLAIMS | 1.800.244.6224  
www.mycigna.com |
| CIGNA HEALTHY STEPS TO WEIGHT LOSS PROGRAM | 1.866.417.7848  
For non-members: www.cignabehavioral.com |
| CIGNA STRENGTH & RESILIENCE STRESS MANAGEMENT PROGRAM | 1.866.417.7848  
For CIGNA PPO members: www.mycigna.com |
| CIGNA QUIT TODAY SMOKING CESSATION PROGRAM | 1.866.417.QUIT  
For CIGNA PPO members: www.mycigna.com |
| TRANSITCHEK  
ENROLLMENT & CUSTOMER SERVICE CENTER | 1.866.823.3248  
www.tams.transitchek.com |
| DOMESTIC PARTNER REGISTRATION | New York: www.cityclerk.nyc.gov  
New Jersey: www.state.nj.us/health/vital/dp2.shtml |
| LINCOLN FINANCIAL GROUP  
(VOLUNTARY SHORT-TERM DISABILITY) | 1.800.423.2765  |
| NATIONAL BENEFIT LIFE INSURANCE COMPANY  
(NYS DISABILITY) | 1.800.535.2710  |
| VSP VISION PLAN | 1.800.877.7195  
www.vsp.com |
Glossary

Active, Full-Time Employee
An SVA employee who works a minimum of 35 hours per week on a continuous basis.

Beneficiary
A person designated by a participant, or by the terms of an employee benefit plan, to receive benefits under a health benefits plan.

Benefit Year
An SVA benefit year runs January 1 through December 31.

Benefits
The portion of the costs of covered services paid by a health plan. For example, if a plan pays the remainder of a doctor's bill after an office visit co-payment has been made, the amount the plan pays is the “benefit.” Or, if the plan pays 80% of the reasonable and customary cost of covered services, that 80% payment is the “benefit.”

Benefits Package
A compilation of benefits options offered by an employer.

Brand Name Drug
A drug manufactured by a pharmaceutical company which has chosen to patent the drug's formula and register its brand name.

CIGNA

CIGNA Home Delivery Pharmacy
The CIGNA mail-order prescription service that dispenses medications to covered persons for up to a 90-day supply.

Co-insurance
The portion of eligible expenses that plan members are responsible for paying, most often after the deductible is met.

Coordination of Benefits
A provision that applies when a person is covered under more than one group health benefit plan. It requires that payment of benefits be coordinated by all plans to eliminate over-insurance or duplication of benefits.

Co-payment or Co-pay
Amount that a plan member must pay the provider at the time of service.

Covered Services
Hospital, medical and other health care services incurred by the enrollee that are entitled to a payment of benefits under a health benefit contract.

Deductible
The dollar amount that a plan member must pay for eligible health expenses before a traditional health plan will begin reimbursement of eligible claims.

Dependent
A person eligible for coverage under an employee benefits plan based on their relationship to the employee. Examples: spouses, children, adopted children and domestic partners.

Explanation of Benefits (EOB)
A statement provided by a health care administrator that explains the benefits provided, the allowable reimbursement amounts, any deductibles, co-insurance or other adjustments taken and the net amount paid.

Flexible Spending Account (FSA)
An account that reimburses the participant for qualified health costs or dependent care expenses through one pre-tax savings account. At the end of the plan year, unused dollars are forfeited by the account holder.

Generic Drug
A prescription drug that has the same active ingredient formula as a brand name drug.

Group Health Coverage
A health benefit plan that covers a group of people as permitted by state and federal law.

Indemnity Plan
A health benefit plan that pays a percentage of covered charges within reasonable and customary levels up to an out-of-pocket maximum.

In-Network Provider
Any health care provider (physician, hospital, etc.) that belongs to a health plan's contracted network. Staying in-network gives members the advantage of significant discounts.

Maintenance Medication
Medications that are prescribed for long-term treatment of chronic conditions such as diabetes, high blood pressure or asthma. At SVA, maintenance medications are available through Tel-Drug Rx, CIGNA's mail-order service, for up to a 90-supply and at participating network retail pharmacies for up to a 30-day supply.

Mental/Nervous (Behavioral Care)
Assessment and therapeutic services used in the treatment of mental health and substance abuse problems.

Open Enrollment
A period when eligible employees and dependents can enroll in, or make changes in, a health benefits plan.

Out-of-Network Provider
Any health care provider that does not belong to a health plan's contracted network.

Out-of-Pocket
Co-payments, deductibles, or fees paid by participants for health services.

Out-of-Pocket Maximum
The most a plan member will pay per year for reasonable and customary health expenses before the plan pays 100% of covered health expenses for the rest of that year.

Participating Provider
A physician, hospital, pharmacy, laboratory, or other appropriately licensed facility or provider of health services or supplies that has entered into an agreement with a health plan to provide services or supplies to a patient enrolled in a health benefit plan.

Pre-Existing Condition
A health condition (other than a pregnancy) or medical problem that was diagnosed or treated before enrollment into a health plan.

Preferred Provider Organization (PPO)
A specific type of health plan with a contracted network of physicians. Within SVA's PPO plans, members can visit physicians both in and out of the network (an annual deductible and out-of-pocket maximum applies to out-of-network visits), and can visit specialists without a referral. Members do not need to choose a primary physician for coverage.

Provider Directory
Listings of providers who have contracted with a health plan to provide care to its participants. You can search CIGNA's provider directory at www.cigna.com.

Reasonable and Customary (R&C)
The maximum fee that a health plan will reimburse an out-of-network provider for a given service.
HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

SVA’S PLEDGE TO YOU
This notice is intended to inform you of the privacy practices followed by the School of Visual Arts (the Plan) and the Plan’s legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on September 29, 2011.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. School of Visual Arts requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information
Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

HOW WE MAY USE YOUR PROTECTED HEALTH INFORMATION
Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment
We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations
We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment
Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law
We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization
When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates
We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor
We may disclose protected health information to certain employees of School of Visual Arts for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.
YOUR RIGHTS

Right to Inspect and Copy
In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the Benefits Manager. The contact person is listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend
If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the Benefits Manager. The contact person is listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures
You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the Benefits Manager. The contact person is listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions
You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the Benefits Manager. The contact person is listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications
You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the Benefits Manager. The contact person is listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach
You have the right to be notified in the event that we (or one of our business associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice
If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the Benefits Manager. The contact person is listed below.

OUR LEGAL RESPONSIBILITIES

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:
Georgette Thomas Jones, Benefits Manager
School of Visual Arts
209 East 23rd Street
New York, NY 10010
(212) 592-2640 / gthomasjones@sva.edu

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

The effective date of this Notice of Privacy Practices is September 29, 2011.
Legal Disclosures

The following section includes the following legal disclosures:

- Coordination of Benefits
- Creditable Coverage Notice
- Continuing Coverage Through COBRA
- Privacy Rights Under HIPAA
- Special Enrollment Rights Under HIPAA
- Women’s Health and Cancer Rights Act
- Newborns’ and Mothers’ Health Protection Act
- Mental Health Parity
- Summary of Benefits and Coverage
- Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)
- Medicare Part D Notice of Creditable Coverage
Coordination of Benefits

Your medical and dental options contain a coordination of benefits provision that is designed to prevent the duplication of coverage and overpayment of benefits when you or your eligible dependents are covered by more than one plan. Here is how coordination of benefits works:

If you are the patient, the School of Visual Arts plan will pay benefits first. The other plan will pay benefits according to its own coordination of benefits rule after you submit a claim.

- If your spouse is the patient and has coverage through another plan, his or her plan will pay benefits first. The School of Visual Arts plan will pay its normal benefits minus any benefits paid by the first plan. This means that your spouse will not receive any benefit from the School of Visual Arts plan if your spouse's plan pays benefits that are equal to or greater than the benefits School of Visual Arts would pay.

- If your child is the patient and he or she is covered by the School of Visual Arts plan and your spouse's plan, the decision about which plan pays first is covered by the "birthday rule." This means that the School of Visual Arts plan pays first if your birthday (month/day) comes before your spouse's in the calendar year. For example, if your birthday is March 1 and your spouse's is April 1, School of Visual Arts benefits pay first. Otherwise, your spouse's plan pays first. If the School of Visual Arts plan pays second, it will reduce its normal benefit by the amount paid by the other plan.
**Creditable Coverage Notice**

**YOUR RIGHT TO DOCUMENTATION OF HEALTH COVERAGE**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 18 months. The 18-month exclusion period is reduced by your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion.

You have the right to receive a certificate of prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Contact the plan administrator of your previous coverage to obtain a certificate of prior coverage.

The School of Visual Arts Medical Plans exclude coverage for pre-existing conditions. You will need to provide a certificate or other documentation of your previous coverage in order to receive credit under School of Visual Arts’ Medical Plans.

You have the right to receive a certificate of prior health coverage from School of Visual Arts if you are enrolled or become eligible to enroll through another employer group health plan or if you buy health insurance other than through an employer group health plan. Contact Georgette Thomas Jones, Benefits Manager to get a certificate of prior coverage under School of Visual Arts’ Medical Plan.

**CONTINUING COVERAGE THROUGH COBRA**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you to temporarily extend you and your dependents’ medical and dental benefits in certain situations where coverage would otherwise end (like at your termination of employment). If you elect COBRA coverage, your medical and dental benefits will continue for a defined period of time. Your spouse and dependent children can also continue coverage under COBRA. You will be required to pay the premiums for this continued coverage, which will be the full cost of the plan plus a 2% administrative fee. For more information about continuing coverage through COBRA, please contact Georgette Thomas Jones, Benefits Manager at (212) 592-2640.
Privacy Rights Under HIPAA

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information.

This Plan, the Plan Administrator and the Plan Sponsor will not use or disclose information that is protected by HIPAA (protected health information) except as necessary for treatment, payment, and other health care operations of the Plan, or as permitted or required by law. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of your Employer.

The Plan also requires all of its business associates (as that term is defined by HIPAA) to observe HIPAA’s privacy requirements.

Protected health information may be used by and disclosed to Human Resources, and Benefits employees of your Employer who are responsible for carrying out administrative functions for the Plan (such as enrollment/disenrollment, determinations of eligibility and benefits due, provider payments, participant reimbursements and audits).

However, these employees will only have access to the information on a “need to know” basis and will use only the minimum necessary protected health information to accomplish the intended Plan administration purpose.

Special Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan in the future, provided that you request enrollment within 30 days after your other coverage ends. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you add coverage under these instances, the maximum length of any preexisting condition exclusion under this plan is 12 months. However, a preexisting condition exclusion does not apply to the pregnancy of you or, if applicable, your covered spouse, or to any newborn or adopted child who is added to the coverage within 30 days of the birth or adoption.
Women’s Health and Cancer Rights Act

The Women’s Health and Cancer Rights Act of 1998 requires that all health insurance plans that cover mastectomy also cover the following medical care:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce symmetrical appearance
- Treatment of physical complications in all stages of mastectomy, including lymphedema
- Mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient’s physical needs.

If you have questions about your benefits under the Cigna medical plans, please call the member services number on your medical ID card or contact Georgette Thomas Jones, Benefits Manager at (212) 592-2640.

Newborns’ and Mothers’ Health Protection Act

Federal law (Newborns’ and Mothers’ Health Protection Act of 1996) prohibits the plan from limiting a mother’s or newborn’s length of hospital stay to less than 48 hours for a normal delivery or 96 hours for a Cesarean delivery or from requiring the provider to obtain preauthorization for a stay of 48 or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for Cesarean delivery.
## Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 requires plans to provide mental health and substance abuse benefits at the same level that benefits for medical and surgical related benefits are offered. Key changes that will affect most group health plans include:

- Group health plans are prohibited from having annual or lifetime maximum dollar limits for mental health benefits that are lower than medical or surgical benefits.
- The new law expands mental health benefits to include substance use disorder benefits.
- Cost-sharing provisions, such as deductibles and copays, or a plan’s terms regarding the amount, duration and scope of mental health benefits are no longer restricted from the plan.

## Summary of Benefits and Coverage

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical benefits. Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

The SBC for our Cigna medical plan options are available from Human Resources/Benefits. To get a copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options go to http://my.sva.edu under the Human Resources tab or, contact Georgette Thomas Jones, Benefits Manager at (212) 592-2640.
Premium Assistance Under Medicaid & the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1.866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of December 31, 2012. You should contact your State for further information on eligibility.
<table>
<thead>
<tr>
<th>State</th>
<th>Program</th>
<th>Website/Subsite</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td>MEDICAID</td>
<td><a href="http://www.medicaid.alabama.gov">www.medicaid.alabama.gov</a></td>
<td>855.692.5447</td>
</tr>
<tr>
<td>ALASKA</td>
<td>MEDICAID</td>
<td><a href="http://health.hss.state.ak.us/dpa/programs/medicaid">http://health.hss.state.ak.us/dpa/programs/medicaid</a></td>
<td>Outside of Anchorage 888.318.8890 907-269-6529</td>
</tr>
<tr>
<td>ARIZONA</td>
<td>CHIP</td>
<td><a href="http://www.azahcccs.gov/applicants">www.azahcccs.gov/applicants</a></td>
<td>877.764.5437 (Maricopa County): 602.417.5437</td>
</tr>
<tr>
<td>COLORADO</td>
<td>MEDICAID</td>
<td><a href="http://www.colorado.gov">www.colorado.gov</a></td>
<td>800.866.3513</td>
</tr>
<tr>
<td>ALASKA</td>
<td>CHIPLink</td>
<td><a href="http://health.hss.state.ak.us/dpa/programs/medicaid">http://health.hss.state.ak.us/dpa/programs/medicaid</a></td>
<td>Outside of Anchorage 888.318.8890 907-269-6529</td>
</tr>
<tr>
<td>COLORADO</td>
<td>MEDICAID</td>
<td><a href="http://health.hss.state.ak.us/dpa/programs/medicaid">http://health.hss.state.ak.us/dpa/programs/medicaid</a></td>
<td>Outside of Anchorage 888.318.8890 907-269-6529</td>
</tr>
<tr>
<td>FLORIDA</td>
<td>MEDICAID</td>
<td><a href="http://www.flmedicaidtplrecovery.com">www.flmedicaidtplrecovery.com</a></td>
<td>877.357.3268</td>
</tr>
<tr>
<td>GEORGIA</td>
<td>MEDICAID</td>
<td>Website: <a href="http://dch.georgia.gov">http://dch.georgia.gov</a></td>
<td>Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) 800.869.1150</td>
</tr>
<tr>
<td>IDAHO</td>
<td>MEDICAID AND CHIP</td>
<td>Medicaid: <a href="http://www.accesstohealthinsurance.idaho.gov">www.accesstohealthinsurance.idaho.gov</a></td>
<td>Medicaid: 800.926.2588</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CHIP: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a></td>
<td>CHIP: 800.926.2588</td>
</tr>
<tr>
<td>IOWA</td>
<td>MEDICAID</td>
<td><a href="http://www.dhs.state.ia.us/hipp">www.dhs.state.ia.us/hipp</a></td>
<td>888.346.9562</td>
</tr>
<tr>
<td>KANSAS</td>
<td>MEDICAID</td>
<td><a href="http://www.kdheks.gov/hcf">www.kdheks.gov/hcf</a></td>
<td>800.792.4884</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>MEDICAID</td>
<td><a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a></td>
<td>800.635.2570</td>
</tr>
<tr>
<td>LOUISIANA</td>
<td>MEDICAID</td>
<td><a href="http://www.lahipp.dhh.louisiana.gov">www.lahipp.dhh.louisiana.gov</a></td>
<td>888.695.2447</td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td>MEDICAID AND CHIP</td>
<td>Website: <a href="http://dch.mass.gov/public/hipp">http://dch.mass.gov/public/hipp</a></td>
<td>MASSACHUSETTS—MEDICAID AND CHIP</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.mass.gov/MassHealth">www.mass.gov/MassHealth</a></td>
<td>800.462.1120</td>
</tr>
<tr>
<td>MINNESOTA</td>
<td>MEDICAID</td>
<td><a href="http://www.dhs.state.mn.us">www.dhs.state.mn.us</a></td>
<td>Click on Health Care, then Medical Assistance 800.657.3629</td>
</tr>
<tr>
<td>MISSOURI</td>
<td>MEDICAID</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
<td>MISSOURI—MEDICAID</td>
</tr>
<tr>
<td>MONTANA</td>
<td>MEDICAID</td>
<td><a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a></td>
<td>800.694.3084</td>
</tr>
<tr>
<td>NEBRASKA</td>
<td>MEDICAID</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a></td>
<td>800.383.4278</td>
</tr>
<tr>
<td>NEVADA</td>
<td>MEDICAID</td>
<td><a href="http://dwss.nv.gov">http://dwss.nv.gov</a></td>
<td>800.992.0900</td>
</tr>
<tr>
<td>State</td>
<td>Website</td>
<td>Medicaid Phone</td>
<td>CHIP Phone</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------</td>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td>New Jersey — Medicaid and CHIP</td>
<td>Medicaid: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid">http://www.state.nj.us/humanservices/dmahs/clients/medicaid</a></td>
<td>800.356.1561</td>
<td>800.701.0710</td>
</tr>
<tr>
<td>New York — Medicaid</td>
<td><a href="http://www.nyhealth.gov/health_care/medicaid">www.nyhealth.gov/health_care/medicaid</a></td>
<td>800.541.2831</td>
<td></td>
</tr>
<tr>
<td>North Carolina — Medicaid</td>
<td><a href="http://www.ncdhhs.gov/dma">www.ncdhhs.gov/dma</a></td>
<td>919.855.4100</td>
<td></td>
</tr>
<tr>
<td>North Dakota — Medicaid</td>
<td><a href="http://www.nd.gov/dhs/services-medicalserv/medicaid">www.nd.gov/dhs/services-medicalserv/medicaid</a></td>
<td>800.755.2604</td>
<td></td>
</tr>
<tr>
<td>Oklahoma — Medicaid and CHIP</td>
<td><a href="http://www.insureoklahoma.org">www.insureoklahoma.org</a></td>
<td>888.365.3742</td>
<td></td>
</tr>
<tr>
<td>Pennsylvania — Medicaid</td>
<td><a href="http://www.dpw.state.pa.us/hipp">www.dpw.state.pa.us/hipp</a></td>
<td>800.692.7462</td>
<td></td>
</tr>
<tr>
<td>Rhode Island — Medicaid</td>
<td><a href="http://www.ohhs.ri.gov">www.ohhs.ri.gov</a></td>
<td>401.462.5300</td>
<td></td>
</tr>
<tr>
<td>South Carolina — Medicaid</td>
<td><a href="http://www.scdhhs.gov">www.scdhhs.gov</a></td>
<td>888.549.0820</td>
<td></td>
</tr>
<tr>
<td>South Dakota — Medicaid</td>
<td><a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
<td>888.828.0059</td>
<td></td>
</tr>
<tr>
<td>Texas — Medicaid</td>
<td><a href="https://www.gethipptexas.com">https://www.gethipptexas.com</a></td>
<td>800.440.0493</td>
<td></td>
</tr>
<tr>
<td>Vermont — Medicaid</td>
<td><a href="http://www.greenmountaincare.org">www.greenmountaincare.org</a></td>
<td>800.250.8427</td>
<td></td>
</tr>
<tr>
<td>Virginia — Medicaid and CHIP</td>
<td>Medicaid Website: <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">www.dmas.virginia.gov/rcp-HIPP.htm</a></td>
<td>800.432.5924</td>
<td>CHIP Website: <a href="http://www.famis.org">www.famis.org</a></td>
</tr>
<tr>
<td>Washington — Medicaid</td>
<td><a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a></td>
<td>800.562.3022 ext. 15473</td>
<td></td>
</tr>
<tr>
<td>West Virginia — Medicaid</td>
<td><a href="http://www.dhhr.wv.gov/bm">www.dhhr.wv.gov/bm</a></td>
<td>877.598.5820 HMS Third Party Liability</td>
<td></td>
</tr>
<tr>
<td>Wisconsin — Medicaid</td>
<td><a href="http://www.badgercareplus.org/pubs/p-10095.htm">www.badgercareplus.org/pubs/p-10095.htm</a></td>
<td>800.362.3002</td>
<td></td>
</tr>
</tbody>
</table>

To see if any more States have added a premium assistance program since December 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323 Ext. 61565
Cigna HealthCare - PROCLAIM System

Medical Choices:
Cigna PPA Network: Other:  
☐ PPA/PPO  ☐ Standard PPO  ☐ Staff  ☐ Faculty

Policy #: 3211716
Department __________________________

SECTION A - FOR EMPLOYEE TO COMPLETE - Please Type or Print in Black Ink

<table>
<thead>
<tr>
<th>Social Security Number (Required Information)</th>
<th>Last Name</th>
<th>First</th>
<th>Initial</th>
<th>Coverage Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address
Street Name
Apartment #
City
State
Zip Code

Name of Employer
SCHOOL OF VISUAL ARTS
Your Job Title
Date of Hire

SECTION B - FOR ENROLLMENT CHANGES

Reason for Change (Check all applicable boxes)
☐ Add Spouse - Date of Marriage ___/___/___ (Complete Sections C, D, and E)
☐ Add Domestic Partner
☐ Add Dependent Child - Date of Birth/Adoption ___/___/___ (Complete Sections C, D and E)
☐ Delete Dependent(s) - (Complete Sections C and E) Termination Date ___/___/___
☐ Name Change - List Former Name Here __________________________
☐ Address Change - Show New Address in Section A
☐ Change in Plant/Division Change Effective Date ___/___/___
☐ Other __________________________

SECTION C - ADDITIONAL INFORMATION (COMPLETE WITH NEW ENROLLMENT OR CHANGED INFORMATION)

<table>
<thead>
<tr>
<th>Medical</th>
<th>Add</th>
<th>Delete</th>
<th>Last Name, First Name, M.I.</th>
<th>Sex</th>
<th>Date of Birth (MM/DD/YY)</th>
<th>Social Security Number or Medicare HIC #</th>
<th>Pre-existing Condition</th>
<th>Full Time Student if 19 or older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>☐</td>
<td>☐</td>
<td>Employee</td>
<td>☑</td>
<td>N/A</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Spouse</td>
<td>☐</td>
<td>☐</td>
<td>☑ Spouse</td>
<td>☑</td>
<td>☑ N/A</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Child</td>
<td>☐</td>
<td>☐</td>
<td>☑ Child</td>
<td>☑</td>
<td>☑ No</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Child</td>
<td>☐</td>
<td>☐</td>
<td>☑ Child</td>
<td>☑</td>
<td>☑ Yes</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Child</td>
<td>☐</td>
<td>☐</td>
<td>☑ Child</td>
<td>☑</td>
<td>☑ No</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Child</td>
<td>☐</td>
<td>☐</td>
<td>☑ Child</td>
<td>☑</td>
<td>☑ No</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

Identify Handicapped Dependent(s) Name __________________________ Name __________________________
*To be completed by employer.

SECTION D - OTHER INSURANCE

Are you, your spouse or dependent(s) covered by Medicare or any other Health insurance? ☐ Yes ☐ No If yes, please complete the following:

Spouse’s or Dependent’s Employer: __________________________ Effective Date: __________________________
Name of Health Insurance Company: __________________________ Policy #: __________________________

Names of Individual covered by other insurance: __________________________

SECTION E - APPLICATION AUTHORIZATION

Check One:
☐ I hereby request enrollment of myself and eligible family dependents and authorize my employer to deduct from my wages or salary the amount of contributions, if any, for the coverage requested. I understand that the coverage provided will be subject to the terms and conditions of the group insurance policy. The information above is true and correct to the best of my knowledge and I understand that my benefits may be affected by failure to provide complete, accurate and timely information. I have read and agree to the Authorization to Disclose Confidential Information found on the back of this form.

☐ OR - I hereby waive all coverages offered to me.

Signature __________________________ Date __________________________
Policyholder Representative Signature __________________________ Date __________________________
PROVISIONS

* "Cigna HealthCare" refers to the various HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

* The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

* The DHMO (Cigna Dental Care) plan is underwritten or administered by Cigna Health and Life Insurance Company, Cigna HealthCare of Connecticut, Inc. or Cigna Dental Health, Inc. and its operating subsidiaries.

* The Cigna Dental PPO, EPO and Indemnity plans are underwritten or administered by Cigna Health and Life Insurance Company, with network management services provided by Cigna Dental Health, Inc. and certain of its operating subsidiaries.

* I agree, for myself and my covered dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent of services provided and to the extent permitted by state law.

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize pre-tax deductions from my earnings of the required contributions, if any toward the cost of the coverage if I am eligible for such.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer’s Section 125 Plan.

*Cigna*, the "Tree of Life" logo, "Cigna HealthCare", "Cigna Choice Fund", "Cigna Care Network" and "Cigna Dental Care" are registered service marks of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. In Arizona, HMO plans are offered by Cigna HealthCare of Arizona, Inc. In California, HMO and Network plans are offered by Cigna HealthCare of California, Inc. In Connecticut, HMO plans are offered by Cigna HealthCare of Connecticut, Inc. in North Carolina, HMO plans are offered by Cigna HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by CGLIC or CHLIC.

© 2012 Cigna
Dental Enrollment/Change Request
Aetna Life Insurance Company

Employer Group Information:
(To Be Completed by Employer)

Employee Name - Full Name of Business or Organization
School of Visual Arts
209 East 23rd Street
New York, NY 10010

Group Number

Suffix

Account

Plan Number

A. Type of Activity - Employee Completes Sections A - E.

Instructions: Refer to the instructions on the back before completing this form. You, the employee, must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Change</th>
<th>Remove or Terminate</th>
<th>Continuation of Coverage, etc., COBRA, State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check one:</td>
<td>Check all that apply</td>
<td>Check all that apply</td>
<td>(Not all options are available. Contact Employer for available options.)</td>
</tr>
<tr>
<td>New Enrollee/Subscriber</td>
<td>Reinstatement</td>
<td>Child</td>
<td>Effective Date</td>
</tr>
<tr>
<td>Date of Event</td>
<td>Reason</td>
<td>Reason</td>
<td>Coverage for:</td>
</tr>
<tr>
<td>Date of Hire</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Employee Information

Social Security Number

Last Name, First Name, M.I.

Primary Language Spoken

Employer Name Address:

Employee/Subscriber Number, Street, Apt, City, State, ZIP Code

Telephone Numbers:

Home ( ), Work ( )

Employee Status:

Active ( ), Retired ( )

C. Plan Option - Your selection must be offered by your employer.

Check One:

- Indemnity Dental
- Dental EPP
- Dental Fund/Health Fund
- Dental PPO
- DMO/Advantage/Basic
- FOC/PO
- FOC/DMO

D. Individuals Covered - List individuals for whom you are adding, changing, or removing coverage. Attach sheet to list additional children.

<table>
<thead>
<tr>
<th>Name (First, Middle Initial, Last)</th>
<th>Sex</th>
<th>Birthdate</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Date of Birth</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Explain otherwise in last names in Special Remarks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Self ( ), Other ( )

If "Yes" to Prior Insurance Plan, Other Dental Coverage or Misdwre above, provide effective date, name & policy number of insurance carrier, dental plan or other source.

Does any dependent listed above live at a different address than the Employee? If "Yes," who and what address? Yes ( ), No ( )

Special Remarks

E. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this application. I understand that in the event I fail to sign this form within 31 days after the above transaction request or that for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected.

Employees Signature - Required X

F. Employer Verification - To be Completed by Employer

Employer Signature

Date

E-Mail Address

Title

Date

Visit us at www.aetna.com

Please make a copy for your records.
Instructions

- Complete the Employer Group Information at the top of the form.
- Complete Section F - Employer Verification in the lower right corner of the form.
- Employer must complete this section for all new enrollments or coverage changes.
- Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Section A - Type of Activity:
- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request. Provide Effective Date(s) and Date of Event(s) where requested.

Section B - Employee Information:
- Complete all information in order for your Enrollment/Change Request to be processed.

Section C - Plan Option:
- Select only an option offered by your employer.

Section D - Individuals Covered:
- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents(s), if applicable. Indicate Relationship Code, Sex, Birthdate, and Social Security Number for each individual listed.
- Relationship Code - Use ONLY: H=Husband, W= Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.
- Late Entrant - If you are not enrolling within your employer’s eligible enrollment period, check "Yes".
- If you or your dependents(s) were covered under your employer’s or other prior insurance plan, check the "Yes" box(es) and provide name and policy number of insured, premium, policy number of any other carrier, and the name and policy number of any other insurance carrier.
- If a dependent is Handicapped and financially dependent, check "Yes" and provide proof of handicapped status from the attending physician.
- If a dependent is a Student, check "Yes". Refer to your Summary Coverage for plan definitions. Astina may request that you provide proof of educational institution.
- Primary Dentist Office ID Number - Provide the office ID number for the primary dentist from the appropriate provider directory or from "Dentist", Astina's online provider directory at "www.astina.com".
- If you are a current patient, please check the "Yes" box under Current Patient.
- Optional - Indicate the Race/Ethnicity for yourself and your dependents by checking the appropriate box(es). If your Race/Ethnicity is not either the selections listed, please check the "Other" box and write in Race/Ethnicity for yourself and your dependents in the special space provided.

Section E - Employee Signature:
- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment/Change Request in order for it to be processed.

Section F - Employer Verification:
- Employer must complete this section for all new enrollments or coverage changes.
- Employer must sign and date the Enrollment/Change Request in order for it to be processed.

Conditions of Enrollment

Applicant Acknowledgment and Agreement

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided or administered by the following entities (collectively referred to as "Astina"):
   - Astina DMO, Astina Dental PPO, Dental ERP, Astina HealthFund/Astina DentalFund, and Astina Indemnity Dental: Astina Life Insurance Company
   - In the states of AZ, CA, GA, MD, MO, NC, NJ and TX, Astina DMO, Advantage and Basic plans may also be provided by one of the following: Astina Dental of California Inc., Astina Dental Inc. (NJ), Astina Dental Inc. (TX), Astina Health Inc., or Astina Health Inc. (AZ).

2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.

3. I understand and agree that this Enrollment/Change Request may be transmitted to Astina or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Provider") to give Astina or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Astina to use such information and to disclose such information to affiliated providers, payers, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

5. I understand and agree that with the exception of Astina Rx Home Delivery, all participating providers (including all participating primary care doctors) and vendors are independent contractors and are neither agents nor employees of Astina. Astina Rx Home Delivery, LLC., is a subsidiary of Astina Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Misrepresentation

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any material thereto may have violated state law.

Attention Colorado Residents: An insurer/agent who knowingly provides false or misleading information to defraud a Colorado claimant regarding insurance proceeds must be reported to the insurance division.

Attention Kentucky and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
New Jersey Dental Enrollment/Change Request
Aetna Life Insurance Company

A. Type of Activity - To Be Completed by Employer
Refer to instructions on back before completing this form. Print clearly.

1. Enrollment
   - New Enrollee/Subscriber
     Effective Date __/__/____
     Date of MVI __/__/____

2. Change - Check all that apply.
   - Add Spouse
   - Add Domestic Partner
   - Add Dependent Child
   - Name Change
   - Change Plan
   - Other
   - Add/Add Change Dental Office ID Number

3. Remove or Terminate - Check all that apply.
   - Remove Spouse*
   - Remove Domestic Partner*
   - Remove Dependent Child*
   - Employee Withdrawal/Termination

4. Continuation of Coverage, i.e., COBRA, State, Total Disability - Not all options are available or applicable. Contact Employer for available options.
   - Coverage For:
     - Employee
     - Dependent
   - Length of Continuation: __ 12 mos. __ 18 mos. __ 24 mos. __ 36 mos.
   - Total Disability - Attach proof of total disability

B. Employee Information - Complete Sections B - G.

Last Name: First Name: M.L. __/__/____
Home Address
Apartment No. City, State
Employer Name
Primary Email Address
Work Telephone __/__/____
Home Telephone

C. Plan Option - Your selection must be offered by your employer.
Check One:
- Indemnity Dental
- DMPO/Advantage Basic
- DMPO/Dental Fund/Health Fund
- FOC/Indemnity
- Dental PPO
- FOC/PPO
- Dental EPO
- FOC/DMO

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time post secondary student.

<table>
<thead>
<tr>
<th>Last Name, First Name, M.L.</th>
<th>Sex</th>
<th>Birthdate</th>
<th>Social Security Number</th>
<th>Late Entree</th>
<th>Other Dental Coverage</th>
<th>Dental Office ID Number</th>
<th>Current Plan</th>
<th>Previous Coverage Check If Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. Other/Previous Insurance

If your spouse employed? Yes No
If "Yes," give name & address of your spouse's employer.

If "Yes" to Previous Coverage, include name(s) of persons of previous carrier and plan number and submit a copy of the Certificate of Endorsement Coverage that was issued by the previous carrier, if available.

F. Dependent Information

Does any dependent listed in Section D live at a different address than the Employee? Yes No
If "Yes," who and what address?

Explain the circumstances.

If any dependent's last name differs from yours, explain the circumstances.

G. Employee Signature

If you have questions concerning the benefits and services provided by or excluded under this Agreement, contact a Member Services representative at 1-800-323-5930 before or after signing this form.

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of this Enrollment/Change Request. I authorize deductions from my earnings for any required contributions.

Employee Signature - Required

H. Employer Verification - To Be Completed by Employer

Employee Signature - Required

Please make a copy for your records. visit us at www.aetna.com
Instructions

Employer

- Complete the Employer Group Information in the upper right corner of the form.
- Section A - Type of Activity:
  - Check boxes indicating reason(s) for submitting Enrollment/Change Request.
  - Complete Section B - Employer Verification in the lower right corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date the Enrollment/Change Request to order it to be processed.

Employee - Complete Sections B - G.

Section B - Employee Information:
Complete all information in order for your Enrollment/Change Request to be processed.

Section C - Plan Option:
- Check one Plan Option.
- Select only an option offered by your employer.

Section D - Individuals Covered:
- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependents, if applicable. Include Sex, Birthdate, and Social Security Number for each individual listed.

Late Enrollee - If you are not enrolling within your employer's eligible enrollment period, check "Yes".
- If a dependent is a full-time post secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status. If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Dental coverage, check off the "Yes" box(es) and complete Section E - Other/Previous Insurance.

From the appropriate provider directory, locate the office 6 digit ID number for the primary care dentist. Indicate office ID number selection(s) on the form.

Section E - Other/Previous Insurance:
Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, government and any other at will coverage, a church plan or Medicare.

Section F - Dependent Information:
Complete this section for all new enrollments or coverage changes.

Section G - Employee Signature:
- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the Enrollment/Change Request to order it to be processed.

Section H - Employer Verification:
- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the Enrollment/Change Request to order it to be processed.

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and each dependents named on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to Aetna Life Insurance Company*, Aetna Dental Inc. (NJ) or any consumer reporting agency acting on their behalf information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.

   * Aetna Indemnity Dental, Dental PPO, Healthfund/DentalFund and/or Dental EPP are provided or administered by Aetna Life Insurance Company. Aetna DMO Basic or Advantage Dental are provided by Aetna Dental Inc. (NJ).

b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which Aetna Life Insurance Company or Aetna Dental Inc. (NJ) has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.

c) I know that I have a right to receive a copy of the authorization if I request one.

d) I agree that a photocopy of this authorization is as valid as the original.

2. I acknowledge by enrolling in an Aetna Life Insurance Company or Aetna Dental Inc. (NJ) plan, coverage is provided by Aetna Life Insurance Company or Aetna Dental Inc. (NJ) in accordance with the contract.

3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by Aetna Life Insurance Company or Aetna Dental Inc. (NJ).

4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an Enrollment/Change Request form for a health benefit plan is subject to criminal and civil penalties.
**LINCOLN LIFE & ANNUITY**  
**COMPANY OF NEW YORK**

**ENROLLMENT FORM FOR GROUP INSURANCE**

Please Use Ink or Type  
GROUP ID:  
GROUP POLICY #:  
Billing Division or Location:

**A. Employee Information (Complete for ALL Enrollments)**

<table>
<thead>
<tr>
<th>Employer Name/Company Name (Please Print)</th>
<th>County</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>School of Visual Arts</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse Last Name</td>
<td>First Name</td>
<td>Middle Initial</td>
<td>Social Security Number</td>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gender: [ ] Male [ ] Female</th>
<th>Marital Status: [ ] Married [ ] Single</th>
<th>Home Phone</th>
<th>Work Phone</th>
</tr>
</thead>
</table>

**Completed By Employer**

Average Hours Worked Per Week:  
Occupation:

<table>
<thead>
<tr>
<th>Earnings: [ ] Hourly [ ] Monthly [ ] Weekly [ ] Yearly</th>
<th>Date of Full-Time Employment:</th>
<th>Rehire Date:</th>
</tr>
</thead>
</table>

| $                                      |                                |

**B. Product Selection (Complete for ALL Enrollments)**

**Basic Coverage** NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

<table>
<thead>
<tr>
<th>Class</th>
<th>Effective Date</th>
<th>Type of Coverage</th>
<th>Amount of Coverage</th>
<th>Total Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Basic Group Life/AD&amp;D</td>
<td>[ ] Yes [ ] No</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long Term Disability</td>
<td>[ ] Yes [ ] No</td>
<td>$</td>
</tr>
</tbody>
</table>

**Voluntary Coverage** NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

<table>
<thead>
<tr>
<th>TYPE OF COVERAGE</th>
<th>AMOUNT OF COVERAGE</th>
<th>TOTAL PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Employee Life Insurance</td>
<td>[ ] Yes [ ] No</td>
<td>$</td>
</tr>
<tr>
<td>Voluntary Spouse Life Insurance</td>
<td>[ ] Yes [ ] No</td>
<td>$</td>
</tr>
<tr>
<td>Voluntary Dependent Child Benefit</td>
<td>[ ] Yes [ ] No</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

**C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)**

<table>
<thead>
<tr>
<th>Primary Beneficiary's Last Name</th>
<th>First</th>
<th>MI</th>
<th>Relationship of Beneficiary</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contingent Beneficiary's Last Name</th>
<th>First</th>
<th>MI</th>
<th>Relationship of Beneficiary</th>
<th>Social Security Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

**Note:** A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

**Accelerated Death Benefit Information:** This benefit is included with your Life insurance, at no additional premium charge. The Death Benefit payable to your Beneficiary upon your death will be reduced by any Accelerated Death Benefits received plus an interest charge. Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs and may be taxable. For this reason, you should consult your personal tax advisor before claiming this benefit.
E. Request for Coverages. This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- [ ] REQUEST COVERAGE for which I am or may become eligible under the group policies issued by Lincoln Life & Annuity Company of New York. I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.

- [ ] NOT ENROLL myself in the Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

- [ ] NOT ENROLL my dependents in the Program. I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

ACCIDENT & HEALTH INSURANCE FRAUD: Any person who knowingly and with intent to defraud any insurance company or other person:

1. files an application for insurance or a statement of claim containing any materially false information; or
2. conceals, for the purpose of misleading, information concerning any fact material thereto;

commits a fraudulent insurance act, which is a crime. Such person shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each violation.

The insurance requested on this enrollment form will not be effective until approved by the group insurance service office of Lincoln Life & Annuity Company of New York, and the initial premium is paid to Lincoln Life & Annuity Company of New York. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Signature of Employee: ____________________________ Date Signed: _______________________

GLAD 4 NY

Rev. 04/07
Voluntary Life Insurance
SUMMARY OF BENEFITS

Sponsored by: School of Visual Arts

<table>
<thead>
<tr>
<th>All Full-Time Employees</th>
<th>Employee</th>
<th>Spouse</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Benefit</td>
<td>Choice of 1X -2X -3X - 4X Basic Annual Earnings, rounded to the next higher $1,000</td>
<td>Choice of $10,000 increments Employee must elect coverage for spouse to be eligible. Not to exceed 50% of employee elected amount.</td>
<td>$1,000 Child: 14 days to 6 months $10,000 Child: 6 months to age 19 (to age 25 if full-time student) Newborn children to age 14 days are not eligible for a benefit Employee must elect coverage for dependents to be eligible.</td>
</tr>
<tr>
<td>Amount</td>
<td>Employees age 70 and older, maximum benefit is $50,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum Amount</td>
<td>$20,000</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Maximum Amount</td>
<td>$500,000</td>
<td>$250,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Guarantee Issue</td>
<td>$250,000</td>
<td>$50,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Reduction</th>
<th>Employee</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits will reduce:</td>
<td>50% at age 70</td>
<td>50% at age 70</td>
</tr>
<tr>
<td>Benefits terminate at retirement</td>
<td>Benefits terminate at employees retirement</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Definition: Accelerated Death Benefit</td>
</tr>
<tr>
<td>See Definition: Portability</td>
</tr>
<tr>
<td>See Definition: Conversion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Employee</th>
<th>Spouse and Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>All full-time employees working 35 or more hours per week in an eligible class are eligible for coverage. A delayed effective date will apply if the employee is not actively at work.</td>
<td>Cannot be in a period of limited activity on the day coverage takes effect.</td>
<td></td>
</tr>
</tbody>
</table>

(Please see other side)
To calculate your estimated premium, please follow the instructions below:

EXAMPLE
John Doe, Age 35

1) List your annual earnings

\[ $\underline{31,200} \]

2) Determine the amount of coverage you want
(you may choose 1, 2, 3 or 4 times annual salary)

3) Multiply by 1, 2, 3 or 4

\[ \underline{124,800} \]

(Round up to the next higher $1,000 increment)

($124,800 rounds up to $125,000)

4) Write in the total amount of coverage you have elected, divided by $1,000

\[ 125 \]

5) Find your age and factor and multiply
(see table below)

\[ 0.000 \]

Your estimated semi-monthly premium = $7.50

<table>
<thead>
<tr>
<th>AGE</th>
<th>Semi-Monthly Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25</td>
<td>0.0350</td>
</tr>
<tr>
<td>25-29</td>
<td>0.0350</td>
</tr>
<tr>
<td>30-34</td>
<td>0.0500</td>
</tr>
<tr>
<td>35-39</td>
<td>0.0600</td>
</tr>
<tr>
<td>40-44</td>
<td>0.0700</td>
</tr>
<tr>
<td>45-49</td>
<td>0.1050</td>
</tr>
<tr>
<td>50-54</td>
<td>0.1700</td>
</tr>
<tr>
<td>55-59</td>
<td>0.3250</td>
</tr>
<tr>
<td>60-64</td>
<td>0.3250</td>
</tr>
<tr>
<td>65-69</td>
<td>0.5000</td>
</tr>
<tr>
<td>70-74</td>
<td>0.9750</td>
</tr>
<tr>
<td>75-79</td>
<td>1.5900</td>
</tr>
<tr>
<td>80+</td>
<td>1.5900</td>
</tr>
</tbody>
</table>
ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type

| GROUP ID:SVANY | GROUP POLICY #:000010147650 | Billing Division or Location: 1251124 |

A. Employee Information (Complete for ALL Enrollments)

<table>
<thead>
<tr>
<th>Employer Name/Company Name (Please Print)</th>
<th>County</th>
<th>Employer ZIP</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>School of Visual Arts</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse Last Name</td>
<td>First Name</td>
<td>Middle Initial</td>
<td>Social Security Number</td>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

| Gender: □ Male □ Female | Marital Status: □ Married □ Single | Home Phone ( ) | Work Phone ( ) |

Completed By Employer

<table>
<thead>
<tr>
<th>Average Hours Worked Per Week:</th>
<th>Occupation:</th>
</tr>
</thead>
</table>

Earnings: □ Hourly □ Monthly □ Weekly □ Yearly

<table>
<thead>
<tr>
<th>Date of Full-Time Employment:</th>
<th>Rehire Date:</th>
</tr>
</thead>
</table>

B. Product Selection (Complete for ALL Enrollments)

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.

All coverage amounts are subject to the limitations and exclusions as stated in the policy.

<table>
<thead>
<tr>
<th>TYPE OF COVERAGE</th>
<th>AMOUNT OF COVERAGE</th>
<th>TOTAL PREMIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Short Term Disability</td>
<td>□ Yes □ No*</td>
<td>□ Option 1: 60% of weekly salary up to $2,500 per week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Option 2: 50% of weekly salary up to $2,500 per week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Option 3: 40% of weekly salary up to $2,500 per week</td>
</tr>
</tbody>
</table>

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.
--Actual deductions may vary slightly from above illustrations due to rounding--
C. Beneficiary Information (Complete ONLY for Life/AD&D)

<table>
<thead>
<tr>
<th>Primary Beneficiary's Last Name</th>
<th>First</th>
<th>MI</th>
<th>Relationship of Beneficiary</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contingent Beneficiary's Last Name</th>
<th>First</th>
<th>MI</th>
<th>Relationship of Beneficiary</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Accelerated Death Benefit Information: This benefit is included with your Life insurance, at no additional premium charge. The Death Benefit payable to your Beneficiary upon your death will be reduced by any Accelerated Death Benefits received plus an interest charge. Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs and may be taxable. For this reason, you should consult your personal tax advisor before claiming this benefit.

E. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- REQUEST COVERAGE for which I am or may become eligible under the group policies issued by Lincoln Life & Annuity Company of New York. I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.

- NOT ENROLL myself in the Program. I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

- NOT ENROLL my dependents in the Program. I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

ACCIDENT & HEALTH INSURANCE FRAUD: Any person who knowingly and with intent to defraud any insurance company or other person:

1. files an application for insurance or a statement of claim containing any materially false information; or
2. conceals, for the purpose of misleading, information concerning any fact material thereto;

commits a fraudulent insurance act, which is a crime. Such person shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

THIS WARNING DOES NOT APPLY TO APPLICATION FOR LIFE INSURANCE.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of Lincoln Life & Annuity Company of New York, or its insurance partners, and the initial premium is paid to Lincoln Life & Annuity Company of New York. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect. **By signing below, you agree that all statements made above are to the best of your knowledge and belief.**

Employee Full Name: ___________________________ Employee Signature: ___________________________

Date: ___________________________
Voluntary Short-Term Disability Insurance  
Specialty Worksite

SUMMARY OF BENEFITS

Sponsored by: School of Visual Arts  
Effective date:  October 01, 2011

All Active Employees

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

Eligibility
All full-time and part-time active employees working 20 or more hours per week in an eligible class are eligible for coverage on the policy effective date.

Maximum Weekly Benefit
Choice of 40%, 50% or 60% of weekly salary up to $2500 per week

Maximum Benefit Duration
26 weeks

Elimination Period
Benefits begin on:
8 days for an accident
8 days for an illness

Rehabilitation Assistance Benefit
Employees who participate in an approved rehabilitation program are eligible to receive an additional 5% of benefit. Additionally, approved program costs may be reimbursed.

Survivor Income
A benefit may be paid to your survivor if you should die while you were eligible to receive benefits under this policy.

Pre-Existing Condition
No treatment for 3 months prior to the coverage effective date unless it begins after you have performed your regular occupation on a full-time basis for 6 months following the coverage effective date.

Waiver of Premium
You will not be required to pay premium during any time of approved total or partial disability.

Enrollment
You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again until your annual open enrollment.
Understanding Your Benefits

**Total Disability**
You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.

**Partial Disability**
You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.

**Continuation of Disability**
If you return to work full-time but become disabled from the same disability within two weeks of returning to work, you will begin receiving benefits again immediately.

**Pre-Existing Condition**
Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date.

**Benefit Exclusions**
You will not receive benefits in the following circumstances:
- Your disability is the result of a self-inflicted injury.
- You are not under the regular care of a doctor when requesting disability benefits.
- Your disability is covered under a worker’s compensation plan and/or is due to a job-related sickness or injury.
- You are receiving payment under a salary continuance or retirement plan sponsored by the group policyholder.

**Benefit Termination**
This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information
Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

©2008 Lincoln National Corporation

Group Insurance products are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which is not licensed and does not solicit business in New York. In New York, group insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group companies. Product availability and/or features may vary by state. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Each affiliate is solely responsible for its own financial and contractual obligations.
### Monthly Premium Calculations

**Note:** Start by calculating your weekly salary; yearly base salary divided by 52 weeks (do not include overtime pay)

#### Employee Calculation

| Example: John Doe, Yearly Base Salary | $40,000/52=$769.23 wk |

#### 40% Benefit

| **Enter your Weekly Benefit Earnings (Multiply weekly earnings by 40%)¹** | This is your weekly benefit (rounded to next highest dollar) $308.00 |
| **Weekly Pay per $10 benefit (Divide Weekly Earnings by 10)** | $30.80 |
| **Rate Factor (in cents)** | $0.33 |
| **Your estimated Monthly Premium (Rate factor x Weekly pay per $10 benefit)** | $10.16 |
| **You estimated Semi-Monthly Premium (Monthly Premium divided by 2)** | $5.08 |

#### 50% Benefit

| **Enter your Weekly Benefit Earnings (Multiply weekly earnings by 50%)¹** | This is your weekly benefit (rounded to next highest dollar) $385.00 |
| **Weekly Pay per $10 benefit (Divide Weekly Earnings by 10)** | $38.50 |
| **Rate Factor (in cents)** | $0.33 |
| **Your estimated Monthly Premium (Rate factor x Weekly pay per $10 benefit)** | $12.71 |
| **You estimated Semi-Monthly Premium (Monthly Premium divided by 2)** | $6.35 |

#### 60% Benefit

| **Enter your Weekly Benefit Earnings (Multiply weekly earnings by 60%)¹** | This is your weekly benefit (rounded to next highest dollar) $462.00 |
| **Weekly Pay per $10 benefit (Divide Weekly Earnings by 10)** | $46.20 |
| **Rate Factor (in cents)** | $0.33 |
| **Your estimated Monthly Premium (Rate factor x Weekly pay per $10 benefit)** | $15.25 |
| **You estimated Semi-Monthly Premium (Monthly Premium divided by 2)** | $7.62 |

---

1. Sample calculations for illustration purposes only.
# Health Care Flexible Spending Account Enrollment/Change Form

<table>
<thead>
<tr>
<th>INITIAL ELECTION</th>
<th>CHANGE</th>
<th>TERMINATION</th>
</tr>
</thead>
</table>

## EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>EMPLOYEE SOCIAL SECURITY NO. <em>(Required)</em></th>
<th>EMPLOYER NAME <em>(Required)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School of Visual Arts</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYEE LAST NAME</th>
<th>EMPLOYEE FIRST NAME</th>
<th>M.I.</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPLOYEE ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP/POSTAL CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## PRE-TAX FLEXIBLE SPENDING ACCOUNT

Choose the annual amount you would like to have withheld from your salary and placed into a Health Care Flexible Spending Account for reimbursement of eligible health care expenses.

**Annual Amount Elected:** $\_\_\_\_\_ (not a per pay period amount)

Annual amount elected will be divided by the number of pay periods in the Plan Year.

## AUTHORIZATION

I hereby authorize my employer to reduce my earnings by the amount stated above for deposit into my Health Care Flexible Spending Account and to make this money available to me for the reimbursement of health care out-of-pocket expenses as appropriate. I understand that I will forfeit any unused balance in my account at the end of the Plan Year. I also understand that I cannot change my plan participation during the Plan Year unless I have a change in family status, as defined in the Regulations under Internal Revenue Code Section 125.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## DEBIT CARD

If you elect a Health Care Flexible Spending Account (FSA), you may be eligible to receive an FSA debit card to access your health care FSA funds and pay for qualified health care expenses. Please check with your employer to verify if this is a benefit feature available to you.

You can use the debit card at the time of service at any pharmacy, doctor's office or other vendor for qualified health care goods and services up to your available balance. You may also submit the debit card number to providers to pay for qualified charges.

The card may be used for qualified expenses only. Please keep all itemized receipts and statements. You will be required to submit receipts to CIGNA HealthCare to document your debit card expenditures.

By enrolling in the Health Care FSA and receiving a debit card, you agree to read and adhere to the provisions in the cardholder statement you receive with the card and understand the card may be deactivated if you do not comply with those provisions. Your card also will be deactivated if you end your employment or are no longer enrolled in the Health Care FSA.

If you are enrolled in the Choice Fund Health Savings Account (HSA) or a medical plan that qualifies you to contribute to an HSA, the HealthCare FSA funding of medical or pharmacy expenses is limited.

**Please sign and date this section of the form, to indicate your election:**

I certify that any expenses submitted to the Flexible Spending Account or paid for with the FSA Debit Card on my behalf have been incurred by me or my eligible dependents and have not been reimbursed by any other source, nor do I expect them to be. I agree to notify the CIGNA HealthCare Reimbursement Account Unit immediately if any of these expenses are reimbursed from any other source.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## FOR EMPLOYER USE ONLY *(Required)*

<table>
<thead>
<tr>
<th>EFFECTIVE DATE</th>
<th>ACCOUNT NUMBER</th>
<th>BRANCH NAME</th>
<th>BRANCH CODE</th>
<th>ER AAE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3211716</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*CIGNA* and the "Tree of Life" logo are registered service marks of CIGNA Intellectual Property, Inc. licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

800839b Rev. 12/2008
## Dependent Day Care Flexible Spending Account Enrollment/Change Form

### Employee Information

<table>
<thead>
<tr>
<th>Employee Social Security No.</th>
<th>(Required)</th>
<th>Employer Name</th>
<th>(Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School of Visual Arts</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Last Name</th>
<th>Employee First Name</th>
<th>M.I.</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Address</th>
<th>City</th>
<th>State</th>
<th>Zip/Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Pre-Tax Flexible Spending Account

Choose the annual amount you would like to have withheld from your salary and placed into a Dependent Day Care Flexible Spending Account for reimbursement of eligible dependent day care expenses.

**Annual Amount Elected:**

$\quad$ (not a per pay period amount)

Annual amount elected will be divided by the number of pay periods in the Plan Year.

### Authorization

I hereby authorize my employer to reduce my earnings by the amount stated above for deposit into my Dependent Day Care Flexible Spending Account and to make this money available to me for the reimbursement of dependent day care out-of-pocket expenses as appropriate.

I understand that I will forfeit any unused balance in my account at the end of the Plan Year. I also understand that I cannot change my plan participation during the Plan Year unless I have a change in family status, as defined in the Regulations under Internal Revenue Code Section 125.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### For Employer Use Only (Required)

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Account Number</th>
<th>Branch Name</th>
<th>Branch Code</th>
<th>ER AAE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3211716</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

588561a Rev. 7-06
**Member Claim Form**

Not to be used for Pharmacy or Dental claims

This form can be used for all medical plans.

This form only needs to be completed if the provider is not submitting the claim on your behalf.

Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.

Please refer to reverse side for instructions.

---

**EMPLOYEE INFORMATION:** Employee complete this section

<table>
<thead>
<tr>
<th>A. EMPLOYEE’S NAME (Last Name)</th>
<th>(First Name)</th>
<th>(M.I.)</th>
<th>B. GENDER</th>
<th>C. DATE OF BIRTH MM DD YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Note: address must also be changed with Employer)</td>
<td>(City)</td>
<td>(State)</td>
<td>(Zip Code)</td>
<td>DAYTIME TELEPHONE # ( )</td>
</tr>
<tr>
<td>D. CIGNA ID NUMBER OR EMPLOYEE SOCIAL SECURITY NUMBER</td>
<td>(on the front of your Cigna ID card)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. ACCOUNT NO.</td>
<td>(on the front of your Cigna ID card)</td>
<td>3211716</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**FAMILY/OTHER COVERAGE INFORMATION:** Complete only if claim is for a dependent and/or other coverage in effect

<table>
<thead>
<tr>
<th>A. NAME OF SPOUSE</th>
<th>(Last Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(First Name)</td>
<td>(M.I.)</td>
</tr>
</tbody>
</table>

---

**PAYMENT INSTRUCTIONS**

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s)

<table>
<thead>
<tr>
<th>EMPLOYEE’S SIGNATURE</th>
</tr>
</thead>
</table>

**CERTIFICATION**

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime. For residents in the following states, please see the last page of this form: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas and Virginia.

I certify that the information supplied is true and correct.

X

---

**MEMBER PROVIDER INSTRUCTIONS**

Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.

Please be aware that if the provider of service holds a contract with Cigna, payment will always be made to the provider even if this section is not signed. If the provider is contracted with Cigna, the provider will be paid by Cigna at the contracted rate. If you have already paid for services, you should seek reimbursement directly from the provider.

**NOTE:** The information provided on this form may be disclosed to other persons or entities, including my Plan Sponsor, for the purpose of processing this claim and performing health plan administration.

---

* "Cigna HealthCare" refers to the various HMO subsidiaries of Cigna Health Corporation. If you are enrolled in a Cigna HMO plan, complete details can be found in your plan documents or Evidence of Coverage.

* "Cigna" and the "Tree of Life" logo are registered service marks of Cigna Intellectual Property, Inc. licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Health Management, Inc., and HMO subsidiaries of Cigna Health Corporation.
INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT

1. **This form can be used for all medical plans.** This form only needs to be completed if the provider is not submitting the claim on your behalf. Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.

2. If you received this claim form electronically, you can fill in the fields by clicking to the right of the first field (Employee’s Name) and typing in the information. Remember to click on the Clear Fields button on the top of page 1 after printing out the completed claim form.

3. If you are completing this form by hand, use a new printed form rather than a photocopy to ensure the form can be scanned into our system. Also, be sure to print clearly and use black ink when you complete the form.

4. To consider your claim for payment, Cigna must receive it within 180 days of the date you received the service, unless your plan or state law allows more time.

5. Use a separate claim form for each provider and each member of the family. A new form can be obtained from www.cigna.com under HealthCare, Important Forms or by calling Customer Service using the toll-free number on your Cigna ID card.

6. Your claim cannot be processed without your ID Number (Employee Section, Block D). Please reference the front of your Cigna ID card to find this number. Your ID may be the employee’s Social Security Number.

7. You must submit an itemized bill for your claim to be processed. Receipts, balance due statements and cancelled checks are not acceptable replacements for the itemized bill.

8. **ITEMIZED BILLS MUST INCLUDE:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Name</td>
<td>Provider Name/Credentials</td>
</tr>
<tr>
<td>Patient Name</td>
<td>Provider Address</td>
</tr>
<tr>
<td>Type of Service/Procedure Code</td>
<td>Diagnosis Code (ICD-9 format)</td>
</tr>
<tr>
<td>Date of Service (mm/dd/yyyy)</td>
<td>Provider Tax ID Number</td>
</tr>
<tr>
<td>Charge for Service</td>
<td></td>
</tr>
</tbody>
</table>

9. We suggest you make a copy of your bill(s) and your completed claim form for your records. If you are submitting one claim, please do not paper clip or staple your claim form and bill(s). If you are submitting multiple claims in one envelope, please paper clip the appropriate claim form and itemized bill(s) together.

10. Please be aware that payment will be sent to the provider, unless the provider is non-contracted with Cigna and you submit a receipt that shows you paid in full (a zero balance) with your itemized bill and this claim form. Cigna reserves the right to request additional documentation, such as medical records prior to processing your claim.

11. If the patient has coverage through another health insurance carrier which is considered primary (Cigna as secondary), you must submit the Explanation of Benefits (EOB) from the insurance carrier for this service along with this completed form and itemized bill.

EXPLANATION OF BENEFITS

You will receive an Explanation of Benefits (EOB) after your claim is processed explaining the charges applied to your deductible and any charges you owe to the provider. Please keep your EOBs for later reference.

MAILING INSTRUCTIONS

*If you are submitting one claim, please do not paper clip or staple your claim form and bill(s). If you are submitting multiple claims in one envelope, please paper clip the appropriate claim form and itemized bill(s) together.*

Send your **completed claim form** and itemized bill(s) to: CIGNA HealthCare
P.O. Box 182223
Chattanooga, TN 37422-7223

If you have additional questions, please contact Customer Service at: 1.800.CIGNA24
Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

IMPORTANT CLAIM NOTICE

Alaska Residents: A person who knowingly and with intent to injure, defraud or deceive an insurance company or files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona Residents: For your protection, Arizona law requires the following statement to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

California Residents: For your protection, California law requires the following to appear on/with this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and criminal penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.
**Prescription Drug Claim Form**

**PARTICIPANT/PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>PARTICIPANT NAME:</th>
<th>EMPLOYER:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>School of Visual Arts</td>
</tr>
</tbody>
</table>

**CIGNA ID NUMBER** or **PARTICIPANT SOCIAL SECURITY NUMBER** (on the front of your CIGNA ID card):

**PATIENT NAME:**

**PATIENT BIRTHDATE:**

**MO** / **DAY** / **YEAR**

**PATIENT RELATIONSHIP TO PARTICIPANT:**

- SELF (PARTICIPANT)
- SPOUSE
- DEPENDENT

**PATIENT SEX:**

- MALE
- FEMALE

**ACCOUNT NUMBER** (on the front of your CIGNA ID card):

3211716

I represent that the patient information entered on this form is correct, that the patient named is eligible for the benefits and that the patient has received the medication described. I also represent that the medication received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees.

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime. For residents in the following states, please see the last page of this form: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas and Virginia.

**PARTICIPANT SIGNATURE:**

**DATE:**

**DAYTIME PHONE NUMBER:**

**PRESCRIPTION INFORMATION**

*For Health Care Reform related Over-the-Counter reimbursement requests, include your Doctor’s prescription.*

<table>
<thead>
<tr>
<th>1)</th>
<th>2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE FILLED</td>
<td>DATE FILLED</td>
</tr>
<tr>
<td>RX NUMBER</td>
<td>RX NUMBER</td>
</tr>
<tr>
<td>QTY</td>
<td>QTY</td>
</tr>
<tr>
<td>DAY SUPPLY</td>
<td>DAY SUPPLY</td>
</tr>
<tr>
<td>DRUG NAME &amp; STRENGTH</td>
<td>DRUG NAME &amp; STRENGTH</td>
</tr>
<tr>
<td>NDC</td>
<td>NDC</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>AMT. PAID</td>
<td>AMT. PAID</td>
</tr>
</tbody>
</table>

**PHARMACY NAME**

**PHARMACY NABP**

**PHARMACY ADDRESS**

<table>
<thead>
<tr>
<th>3)</th>
<th>4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE FILLED</td>
<td>DATE FILLED</td>
</tr>
<tr>
<td>RX NUMBER</td>
<td>RX NUMBER</td>
</tr>
<tr>
<td>QTY</td>
<td>QTY</td>
</tr>
<tr>
<td>DAY SUPPLY</td>
<td>DAY SUPPLY</td>
</tr>
<tr>
<td>DRUG NAME &amp; STRENGTH</td>
<td>DRUG NAME &amp; STRENGTH</td>
</tr>
<tr>
<td>NDC</td>
<td>NDC</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>AMT. PAID</td>
<td>AMT. PAID</td>
</tr>
</tbody>
</table>

**PHARMACY NAME**

**PHARMACY NABP**

**PHARMACY ADDRESS**

<table>
<thead>
<tr>
<th>5)</th>
<th>6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE FILLED</td>
<td>DATE FILLED</td>
</tr>
<tr>
<td>RX NUMBER</td>
<td>RX NUMBER</td>
</tr>
<tr>
<td>QTY</td>
<td>QTY</td>
</tr>
<tr>
<td>DAY SUPPLY</td>
<td>DAY SUPPLY</td>
</tr>
<tr>
<td>DRUG NAME &amp; STRENGTH</td>
<td>DRUG NAME &amp; STRENGTH</td>
</tr>
<tr>
<td>NDC</td>
<td>NDC</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>AMT. PAID</td>
<td>AMT. PAID</td>
</tr>
</tbody>
</table>

**PHARMACY NAME**

**PHARMACY NABP**

**PHARMACY ADDRESS**

583522h  Rev. 12/2010
INSTRUCTIONS

PARTICIPANT/PATIENT INFORMATION  *(To be completed by the Participant)*

1. Complete ALL information on the front side. Claims missing information may be denied, delayed or returned.

2. Sign and date the Certification Statement in the area provided.

3. Complete the RETURN ADDRESS section below.

4. Submit a separate form for each family member.

5. The Prescription Information section must be completed for each prescription for which you are seeking reimbursement. If you need help completing this form, contact your pharmacist. For Health Care Reform related Over-the-Counter reimbursement requests, include your Doctor’s prescription. Please retain a copy of the prescription for your records.

6. Keep a copy for your records.

7. Mail the claim form within 12 months of the prescription fill date, along with original receipts (cash register receipts are not acceptable), to: CIGNA Pharmacy Service Center P.O. Box 3598 Scranton, PA 18505-0598

8. Questions? Please call the CIGNA number located on your ID card.

RETURN ADDRESS

IMPORTANT: PLEASE PRINT. THIS WILL APPEAR IN A WINDOW ENVELOPE FOR RETURNS.
PLEASE PROVIDE CURRENT ADDRESS INFORMATION BELOW:

_________________________________________  PARTICIPANT NAME

_________________________________________  PARTICIPANT STREET ADDRESS

_________________________________________  PARTICIPANT CITY, STATE, ZIP
Please complete this form for NEW and REFILL prescription medication. You can also order refills online at the website on your ID card.

- Print all information clearly as shown in the sample below using BLUE or BLACK ink.

- Fill in the applicable ovals completely (●).

---

**Step 1: Insurance Cardholder Information**  
Complete if above has changed or appears blank

<table>
<thead>
<tr>
<th>CIGNA ID</th>
<th>email</th>
<th>Person completing</th>
<th>Order updates, reminders and other educational information may be sent to the email address above for the following individuals:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Step 2: Allergies & Health Conditions**  
Complete this section every time

New customers must complete this section. If left blank will mean no known drug allergies or no change from information provided previously to Cigna Home Delivery Pharmacy.

<table>
<thead>
<tr>
<th>Name (start with cardholder)</th>
<th>Date of Birth</th>
<th>Allergies</th>
<th>Health Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST NAME_ _ _ _ _ _ _ _ _ _ _ MM/DD/YY</td>
<td></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>LAST NAME_ _ _ _ _ _ _ _ _ _ _</td>
<td></td>
<td>Penicillin</td>
<td></td>
</tr>
<tr>
<td>FIRST NAME_ _ _ _ _ _ _ _ _ _ _ MM/DD/YY</td>
<td></td>
<td>Sulfa</td>
<td></td>
</tr>
<tr>
<td>LAST NAME_ _ _ _ _ _ _ _ _ _ _</td>
<td></td>
<td>Codeine/Morphine</td>
<td></td>
</tr>
<tr>
<td>FIRST NAME_ _ _ _ _ _ _ _ _ _ _ MM/DD/YY</td>
<td></td>
<td>Aspirin</td>
<td></td>
</tr>
<tr>
<td>LAST NAME_ _ _ _ _ _ _ _ _ _ _</td>
<td></td>
<td>Erythromycin</td>
<td></td>
</tr>
<tr>
<td>FIRST NAME_ _ _ _ _ _ _ _ _ _ _ MM/DD/YY</td>
<td></td>
<td>NSAIDS</td>
<td></td>
</tr>
<tr>
<td>LAST NAME_ _ _ _ _ _ _ _ _ _ _</td>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>FIRST NAME_ _ _ _ _ _ _ _ _ _ _ MM/DD/YY</td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>LAST NAME_ _ _ _ _ _ _ _ _ _ _</td>
<td></td>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>FIRST NAME_ _ _ _ _ _ _ _ _ _ _ MM/DD/YY</td>
<td></td>
<td>GI/GERD</td>
<td></td>
</tr>
<tr>
<td>LAST NAME_ _ _ _ _ _ _ _ _ _ _</td>
<td></td>
<td>High Cholesterol</td>
<td></td>
</tr>
<tr>
<td>FIRST NAME_ _ _ _ _ _ _ _ _ _ _ MM/DD/YY</td>
<td></td>
<td>Other (list below)</td>
<td></td>
</tr>
<tr>
<td>LAST NAME_ _ _ _ _ _ _ _ _ _ _</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please write the individual’s name and list their other allergies and other health conditions referenced above:

---

“Cigna” is a registered service mark, and the “Tree of Life” logo and “Cigna Home Delivery Pharmacy” are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C., and HMO subsidiaries of Cigna Health Corporation.

“Cigna Home Delivery Pharmacy” refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C.
Step 3: Shipping Method

Refrigerated shipments will be expedited at no additional cost. You are responsible for the cost of SPECIAL SHIPPING which expedites carrier delivery time only. Order processing is not affected by SPECIAL SHIPPING. These costs may be subject to change by carrier without prior notification and may vary depending on weight and zone.

- Standard Shipping: $0.00
- USPS Priority Mail: 2 - 3 Days: $9.25
- Overnight Delivery: $17.95

Step 4: Method of Payment

- Check
- Money Order

Total payment enclosed (excluding credit card payment): $________, ________

- VISA
- Discover
- MasterCard
- American Express

Credit / Debit Card #: __________, ________, ________
Expiration Date: ________, ________

I allow Cigna Home Delivery Pharmacy to bill my credit / debit card for this and all future orders. I understand that my credit / debit card will be billed the following amounts in effect at the time my order is filled: any applicable copayment(s), coinsurance and/or deductible(s), payments due for any medications not covered, plus any special shipping costs.

Step 5: Refill Prescriptions

Attach label OR complete requested information

Print Prescription Number Here

- Individual’s Name _______________________
- Date of Birth ___________________________
- Drug Name ____________________________

Print Prescription Number Here

- Individual’s Name _______________________
- Date of Birth ___________________________
- Drug Name ____________________________

Print Prescription Number Here

- Individual’s Name _______________________
- Date of Birth ___________________________
- Drug Name ____________________________

Print Prescription Number Here

- Individual’s Name _______________________
- Date of Birth ___________________________
- Drug Name ____________________________

Step 6: New Prescriptions

Include original written prescription from your doctor

Please write the date of birth and the Cigna ID on the back of each prescription.

<table>
<thead>
<tr>
<th>Check (√) One</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual’s Full Name</td>
<td>Date of Birth</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pharmacy law allows pharmacists to substitute a less expensive generically equivalent medication for a brand name medication unless you or your doctor request the brand. By checking ( √ ) “Brand Only”, you may be responsible for a higher cost.

Remember to include the original prescription(s) from your doctor(s).

You can call us at 1.800.835.3784 or visit the website on your ID card. You can also write to us or mail this order form to Cigna Home Delivery Pharmacy, PO Box 1019, Horsham PA 19044.
Cigna Choice Fund Reimbursement Request Form

Use this form to request payment from your: Health Reimbursement, Health Care Flexible Spending, Healthy Awards or Healthy Future Accounts.

Please follow these steps to ask us for payment. If you don’t fill in all the required information and sign the form, we won’t be able to pay you.

1. Read every box. Fill in all the required information on this form. Required information is marked with *.

## EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>*1. CIGNA ID NUMBER OR SOCIAL SECURITY NUMBER</th>
<th>*2. LAST NAME</th>
<th>*3. FIRST NAME</th>
<th>4. M.I.</th>
<th>*4a. DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>*5. MAILING ADDRESS</td>
<td>*6. CITY</td>
<td>*7. STATE</td>
<td>*8. ZIP CODE</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*9. EMPLOYER NAME</th>
<th>*10. ACCOUNT NUMBER(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School of Visual Arts</td>
<td>3211716</td>
</tr>
</tbody>
</table>

2. Please only use one form for each person’s expenses.

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>*11. PATIENT NAME</th>
<th>*12. PATIENT DATE OF BIRTH</th>
</tr>
</thead>
</table>

3. Important! Please do not write "See attached" or "N/A" in any space.

4. Due to changes in IRS regulations, effective 1/1/2011 Over-the-Counter Drugs require a prescription for reimbursement. Please see page 2 for more information.

## ITEMIZED EXPENSES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Only use one date per line)</td>
<td>$</td>
<td>*1 = Medical</td>
<td>44 = Mental Health / Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>35 = Dental</td>
<td>45 = Incentives</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>88 = Pharmacy</td>
<td>30 = Insurance Premiums</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>89 = Over-the-Counter Items</td>
<td>9 = Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>AL = Vision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>81 = Routine Care/Physicals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL: $________

5. Sign your name in Box 19. Without your signature we cannot pay you.

## CERTIFICATION AND SIGNATURE

I certify that all expenses for which reimbursement is requested from the Cigna Flexible Spending Account, Health Reimbursement Account, including Healthy Awards and Healthy Future Accounts, have been incurred and have not been reimbursed and are not reimbursable under any other health plan. I understand that I am required to submit, in addition to this claim form, an itemized receipt from a merchant or an explanation of benefits from the health care professional. I represent that any individual (other than the employee or employee’s spouse) for whom a claim is filed hereunder, qualifies as an eligible dependent of the employee as defined in your FSA plan documents. I further declare that I have not and will not deduct these expenses from my federal, state or local income tax returns.

*19. EMPLOYEE SIGNATURE (Required - unsigned Reimbursement Request Forms will not be processed and will be returned to you) Date

6. Fax the completed and signed form, along with receipts to: 423-553-8953 OR Mail to: Cigna, P.O. Box 182223, Chattanooga, TN 37422-7223

7. If you have any questions, call us at 1.800.Cigna24 (1.800.244.6224) or the toll-free number on the back of your Cigna ID card, 24 hours a day/ 7 days a week.

For more information, see the Frequently Asked Questions on page 2 of this form.
# Cigna Choice Fund Reimbursement Request Form - Frequently Asked Questions

## FILLING OUT THE REIMBURSEMENT REQUEST FORM

1. **How do I know what information is "required"?**
   
   Required information is marked with an *

2. **I'm not sure what my account number is, needed in Box 10. How can I get it?**
   
   Call Customer Service at 1.800.Cigna24 (1.800.244.6224) or the number on the back of your Cigna ID card.

3. **I received services over more than one day, what date do I put in Box 13?**
   
   Write the first date the service was received.

4. **I have payment requests for more than one person, what do I do?**
   
   Use a separate form for each person.

5. **Who signs the form?**
   
   The employee must sign and date the form in Box 19. Without the employee’s signature, we can’t pay you.

## ALL ABOUT RECEIPTS

6. **Must I include a receipt for each service or purchase?**
   
   You must include a receipt or Explanation of Benefits, for each product or service you list in Box 16.

7. **What information must the receipt include?**
   
   - **Date of Service** - The date you received the service or purchased the product.
   - **Type of Service or Purchase** - A detailed description of the service or product you paid for.
   - **Name of the Health Care Professional, Facility, or Store**
   - **Amount** - The dollar amount paid for the services or product.

8. **May I send a photocopy of my receipt or Explanation of Benefits?**
   
   Yes. Both originals and photocopies are acceptable, as long as they include the information listed in Question 7 above.

9. **Are there guidelines I should follow when I prepare and send receipts?**
   
   Please do the following:
   - Tape store receipts smaller than 8.5” x 11” to a blank sheet of paper, so we can scan it easily.
   - On the receipt, circle the expenses you list on the Reimbursement Form.
   - Do not use a highlighter: We can’t see highlighter marks after we scan your receipt.

## OVER-THE-COUNTER DRUGS AND MEDICINES THAT NEED A DOCTOR’S PRESCRIPTION

10. **Are there new rules in 2011 due to Health Care Reform?**
    
    Yes. For most over-the-counter drugs and medicines you buy on or after January 1, 2011, you must include both a doctor's prescription and a receipt. Without both, we can’t pay you. Common items that need a prescription are listed below. For a complete list, go to myCigna.com.

   - Acid Controllers
   - Allergy & Sinus
   - Antibiotic Products
   - Anti-Diarrheals
   - Anti-Gas
   - Anti-Itch and Insect Bite
   - Anti-Parasitic Treatments
   - Baby Rash Ointments/Creams
   - Cold Sore Remedies
   - Cough, Cold & Flu
   - Digestive Aids
   - Feminine Anti-Fungal/Anti-Itch
   - Hemorrhoidal Treatments
   - Laxatives
   - Motion Sickness
   - Pain Relief
   - Respiratory Treatments
   - Sleep Aids & Sedatives
   - Stomach Remedies

   **Note:** Insulin does not require a doctor’s prescription.

## SENDING YOUR REQUEST

11. **Who will receive the payment?**
    
    By using this form, the employee will receive the payment.

12. **Should I save copies of my request?**
    
    Yes. Keep copies of the form, receipts and all other documents you send us. You may need them for tax purposes.

13. **Who can I contact if I have questions or need help filling out this form?**
    
    Please call us at 1.800.Cigna24 (1.800.244.6224) or the number on the back of your Cigna ID card. We’re here 24/7.

Fax the completed and signed Reimbursement Request form, with receipts and any other required documents to:

423-553-8953 OR Mail to: Cigna, P.O. Box 182223, Chattanooga, TN 37422-7223

Please remember to sign this form before you send it in.

*Cigna* and "Cigna Choice Fund" are registered service marks and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.
**Dependent Day Care Flexible Spending Account**

**Reimbursement Request Form**

**Instructions:** Complete this form and sign at the bottom in box 22. Your reimbursement request may be denied or payment delayed if this form is not filled out completely. An * indicates required information. Do not write "See Attached" or "N/A" in any space.

**Please see the back of this form for more information.** If you still have questions, please call 1.800.Cigna24 or the toll-free number on the back of your Cigna Identification card.

Fax completed form and receipts to: 423-553-8953 or Mail To: Cigna, PO Box 182223, Chattanooga TN 37422-7223

---

**FOR INTERNAL USE ONLY:**

**CORR CODE:** DC

---

### A. EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>*1. CIGNA ID NUMBER OR SOCIAL SECURITY NUMBER</th>
<th>*2. LAST NAME</th>
<th>*3. FIRST NAME</th>
<th>*4. M.I.</th>
<th>*5. DATE OF BIRTH</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>*5. MAILING ADDRESS</th>
<th>*6. CITY</th>
<th>*7. STATE</th>
<th>*8. ZIP CODE</th>
</tr>
</thead>
</table>

**9. DAYTIME TELEPHONE NUMBER**

**10. E-MAIL ADDRESS**

**11. EMPLOYER NAME**

School of Visual Arts

**12. ACCOUNT NUMBER(S)**

3211716

---

### B. INFORMATION ABOUT THE PEOPLE RECEIVING CARE

*13. NAME* *(If you include expenses for more than one person, please write FAMILY)*

---

### C. DAY CARE EXPENSES

*Please include only covered expenses. For a list of covered/not covered expenses, please see the back of this form.*

**For Dependent Day Care Claims:** I certify that the expenses for which I am requesting reimbursement are for dependent day care services, which qualify for reimbursement under the Internal Revenue Code and are eligible to be excluded from my federal taxable wages. I further certify that these expenses have been incurred by me, they have not been previously submitted for reimbursement, and they have not been reimbursed from any other source, nor do I expect them to be. I agree to notify the Cigna Reimbursement Account Unit immediately if any of these expenses are reimbursed from any other source.

---

### D. CERTIFICATION

*21. CAREGIVER’S SIGNATURE* *(Required only if receipt is not submitted with this form. (If services are provided by more than one caregiver, please use separate forms for each).)*

**DATE**

---

**22. EMPLOYEE SIGNATURE** *(Required - unsigned Reimbursement Request Forms will not be considered for reimbursement)*

**DATE**

---

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

Cat. #589114e  Rev. 11/2011
**COMPLETING THIS REQUEST**

- You must sign and date the form, and certify that the expenses you’ve included on the form are for eligible dependent day care.
- You can use either your Cigna ID number (on the front of your Cigna card), or your social security number in box 2.
- If you’re not sure of your Flexible Spending Account (FSA) number, please call Customer Service at 800-Cigna-24 for help.
- You can use this form for more than one person. If you do, please write "Family" instead of a person's name in box 13.
- Instead of a receipt, you can submit this form with the caregiver's signature in box 21. If you are missing receipts from more than one caregiver, please fill out a separate form and obtain a signature for each caregiver.

**SUBMITTING RECEIPTS**

- All requests should be submitted with itemized receipts. Original receipts or photocopies are acceptable as long as they include:
  - Caregiver’s name and address
  - Date(s) of service
  - Type of service
  - Total amount charged

- If a receipt is smaller than 8-1/2x11", please tape it to a blank sheet of paper so that it can be easily scanned.
- Please circle the expenses you identified on this form if the receipt shows other charges as well. Do not use a highlighter.

**WHAT QUALIFIES AS A DEPENDENT CARE EXPENSE**

- The Internal Revenue Service requires that dependent care expenses:
  - The expense must be for services in the home or at a caregiver for the care of one of the below, so that you can work; and
  - Be incurred by you for a:
    - child under age 13 for whom you are entitled to an income tax deduction; or
    - spouse or other dependent, regardless of age, who is incapable of caring for him/herself; and

**NOTE:** Special rules apply to divorced parents or married individuals living apart. (Internal Revenue Code Section 21(e)).

**WHAT’S COVERED AND NOT COVERED**

- The following expenses can be paid from your FSA:
  - Day care facility, summer day camp, or preschool expenses - the facility must be licensed under state or local law if it cares for seven or more children.
  - Expenses for unlicensed day care centers that care for six or fewer children.
  - Salary you pay to an au pair.
  - Adult day care expenses.
  - Home day care and housekeeping services for a child or other qualifying dependent.
  - Cost of meals, lunches or snacks supplied by a caregiver.

- The following expenses cannot be paid from your FSA:
  - Day care for a child age 13 or older.
  - Overnight summer camp (cannot prorate for the day portion).
  - Kindergarten or school tuition for a child age 5 or older.
  - Expenses for any care provided to a dependent by another dependent or child under age 19.
  - Housekeeping expenses not related to dependent day care.
  - Expenses for which you claim a dependent day care tax credit on your federal income tax return.
  - The registration fees paid for day care, summer camp, kindergarten, preschool, etc. The only exception is day camp or registration fees applied toward the first bill. These are eligible once the first bill has been paid and the service has been provided.
  - The cost of meals while on field trips and outings, or those meals included as part of the cost of such trips.
  - Health care expenses for a dependent.

**GENERAL INFORMATION**

- Expenses can be reimbursed only after the care has been provided, and not when you are billed, are charged for, or pay for care.
- Keep a copy of completed reimbursement request forms and the attached documentation. You may need them for income taxes.
- All reimbursements will be paid to the employee.
- Download reimbursement forms and get general information about flexible spending accounts at [www.myCigna.com](http://www.myCigna.com)
### Dental Benefits Request

#### TO BE COMPLETED BY EMPLOYEE – USE BLACK INK ONLY

<table>
<thead>
<tr>
<th>1. Employer's Name</th>
<th>School of Visual Arts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Policy/Group Number</td>
<td>812285</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Employee's Aetna ID Number</th>
<th>4. Employee's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Employee's Birthdate (MM/DD/YYYY)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Active □ Retired □</th>
<th>7. Employee's Address (include zip code) □ Address is new</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Employee's Daytime Telephone Number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Patient's Name</th>
<th>10. Patient's Aetna ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Patient's Birthdate (MM/DD/YYYY)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. Patient's Relationship to Employee</th>
<th>13. Patient's Address (if different from employee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Self □ Spouse □ Child □ Other</td>
<td>14. Patient's Sex □ Male □ Female</td>
</tr>
<tr>
<td></td>
<td>15. Full Time Student □ Yes □ No</td>
</tr>
<tr>
<td></td>
<td>16. Patient's Expected Graduation Date</td>
</tr>
<tr>
<td></td>
<td>17. Name of School City</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18. Patient's Mental Status</th>
<th>19. Is patient employed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Married □ Single</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>20. Name &amp; Address of Employer</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>21. Is claim related to an accident?</th>
<th>22. Is claim related to employment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No □ Yes</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>If yes, date</td>
<td>□ am □ pm</td>
</tr>
</tbody>
</table>

| 23. Are any family members' expenses covered by another group health plan, group pre-payment plan (Blue Cross-Blue Shield, etc.), no fault auto insurance, Medicare or any federal, state or local government plan? |
|□ No □ Yes |

<table>
<thead>
<tr>
<th>25. Member's ID Number</th>
<th>26. Member's Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Member's Birthdate (MM/DD/YYYY)</td>
<td></td>
</tr>
</tbody>
</table>

28. To all providers of dental care:

You are authorized to provide Aetna Life Insurance Company or one of its affiliated companies ("Aetna"), and any independent claim administrators and consulting dental professionals and utilization review organizations with whom Aetna has contracted, information concerning dental care, advice, treatment or supplies provided the patient. This information will be used to evaluate claims for dental benefits. Aetna may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of the policy or contract under which a claim has been submitted.

I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Patients or Authorized Person's Signature __________________________ Date __________

I authorize payment of dental benefits to the dentist or supplier of service.

Patients or Authorized Person's Signature __________________________ Date __________

### TO BE COMPLETED BY DENTIST – USE BLACK INK ONLY

29. Is treatment result of:

- □ occupational illness or injury?
- □ auto accident?
- □ other accident?
- □ are any services covered by another plan?
- □ If prosthesis, is this the initial placement?
- □ is treatment for orthodontics?
- □ is treatment result of:

<table>
<thead>
<tr>
<th>30. This is a request for:</th>
<th>Pre-Treatment Estimate</th>
<th>Predetermination/Preauthorization Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Statement of Services Rendered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31. Dentist's Name & Address (include zip code)

<table>
<thead>
<tr>
<th>32. National Provider Identifier</th>
<th>33. Dental License No.</th>
<th>34. Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

35. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.

36. First Visit Date Current Series

<table>
<thead>
<tr>
<th>37. Place of Treatment</th>
<th>38. Radiographs or models enclosed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Office □ Hosp. □ ECF □ Other</td>
<td></td>
</tr>
<tr>
<td>□ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>How many?</td>
<td></td>
</tr>
</tbody>
</table>

39. Is treatment result of:

<table>
<thead>
<tr>
<th>40. Yes</th>
<th>No</th>
</tr>
</thead>
</table>

42. If no, date of prior placement and reason for replacement:

<table>
<thead>
<tr>
<th>43. Date appliance placed:</th>
<th>Initial Appliance Fee:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of months of treatment:</td>
<td>Monthly Fee:</td>
</tr>
<tr>
<td>No. of dollars remaining:</td>
<td>Total Fee:</td>
</tr>
</tbody>
</table>

45. To expedite claim handling, identify all missing teeth with "X".

<table>
<thead>
<tr>
<th>Tooth # or Letter</th>
<th>Extracted, Give Date</th>
<th>Surface</th>
<th>Description of Service (x-rays, prophy, materials used, etc.)</th>
<th>Date Service Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

46. Examination and treatment plan. List in order from tooth no. 1 through tooth no. 32. Use charting system shown.

<table>
<thead>
<tr>
<th>Procedure Number</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

47. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.

Dentist's Signature __________________________ Date __________

48. National Provider Identification

<table>
<thead>
<tr>
<th>Total charge $</th>
<th>Amount paid $</th>
<th>Balance due $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulently insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowing in an insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulently insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention California, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulently insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the company, commits a crime and subjects such person to criminal and civil penalties.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulently insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulently insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulently insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulently claim or a claim of another person, or with intent to defraud, files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of not less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years, and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulently insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

NOTE: INCOMPLETE CLAIM FORMS WILL BE RETURNED TO YOU FOR MISSING INFORMATION. THIS WILL DELAY THE PROCESSING OF THE CLAIM. FOR FASTER, EASIER SUBMISSION OF CLAIMS, THE PROVIDER MAY CONTACT THE AETNA CLAIM PROCESSING CENTER FOR INFORMATION REGARDING ELECTRONIC CLAIM SUBMISSIONS.

TO THE EMPLOYEE - USE BLACK INK ONLY
1. Complete blocks 1-22 in full.
2. Complete blocks 23-27 only if other dental coverage exists.
3. Be certain to sign the authorization to release information block 26.
4. If you wish to have your benefits paid directly to your dentist, sign block 29.

If total charges for the planned course of treatment are expected to exceed the minimum Predetermination dollar amount stated in your dental plan booklet, it is suggested you file for Predetermination of Benefits. Aetna Dental will notify your dentist of the benefits payable.

NOTE: YOUR DENTAL COVERAGE IS SUBJECT TO SPECIFIC LIMITATIONS AND EXCLUSIONS. PLEASE REFER TO YOUR DENTAL BOOKLET FOR DESCRIPTION OF COVERAGE EXPENSES, DEDUCTIBLE AND CO-PAYMENT INFORMATION, AND LIMITATIONS AND EXCLUSIONS.

TO THE DENTIST - USE BLACK INK ONLY
1. DATE OF SERVICES - Check the box noted "STATEMENT OF SERVICES RENDERED" and complete blocks 30-48. When entering the treatment plan on the form, please indicate a separate fee for each individual service rendered.
2. PREDETERMINATION OF BENEFITS - If total charges for this claim are to exceed the minimum Predetermination dollar amount indicated in the employee's Dental Plan Booklet (and treatment is not emergency in nature), Predetermination of Benefits is suggested. Check the box marked "PRE-TREATMENT ESTIMATE", and complete blocks 30-48.

NOTE: PREDETERMINATION OF BENEFITS IS ONLY INTENDED TO AVOID MISUNDERSTANDINGS BETWEEN THE EMPLOYEE, DENTIST AND INSURANCE COMPANY CONCERNING BENEFITS PAYABLE. YOU AND YOUR PATIENT ARE, OF COURSE, FREE TO PURSUE ANY TREATMENT PLAN YOU THINK BEST.

3. If the employee indicates that benefits should be paid directly to the dentist, these benefits will be sent directly to you with a copy of the transaction to the employee.

* X-rays taken for metal restorations and crowns should be submitted with treatment plan. They may also be requested for other services. X-rays will be reviewed by practicing Dentists and returned promptly.

TO THE EMPLOYEE & DENTIST
Send the completed benefits request and the bills to: Aetna Dental
P.O. Box 14094
Lexington, KY 40512-4094

GC-6-13 (6-07)
## VISION SERVICE PLAN

**MEMBERSHIP ENROLLMENT FORM**

### 1. Name of Group
- **School of Visual Arts**
- **Department**
- **Effective Date**

### 2. Social Security No. Last Name / First Name / MI

### 3. Date of Birth

### 2. Do you have dependent children - Y □ N □
- Are you enrolling your dependents in the VSP Plan? Y □ N □
- Does your spouse have coverage with VSP? □
  - If Yes, who is covered?

### 4. Coverage Level and Rates

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Semi-Monthly Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$4.62</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$9.24</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$14.87</td>
</tr>
</tbody>
</table>

### 5. Please List All of Your Dependents That Will Be Enrolled in the Program

<table>
<thead>
<tr>
<th>Last Name / First Name / MI</th>
<th>Social Security No.</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Please Return To Your Human Resources Department. Do Not Return To VSP

Signature ____________________________ Date _________________
DECLARATION OF DOMESTIC PARTNERSHIP

We declare, under penalty of perjury, under the laws of the State of ______ that the assertions in this Declaration are true to the best of our knowledge. We understand that this form is not an application for health insurance coverage and that the purpose for this form is to establish the eligibility of persons named herein for the coverage provided under the School of Visual Arts health insurance program.

Employee’s Signature __________________________ Date __________________________

Social Security Number __________________________

Partner’s Signature __________________________ Date __________________________

Social Security Number __________________________

Address of Employee & Partner __________________________

(address line)

(address line)

COUNTY OF )

) SS

STATE OF )

Subscribed and sworn to before me this ________ day of ________, 20__

______________________________
Notary Public

My Commission Expires: ____________