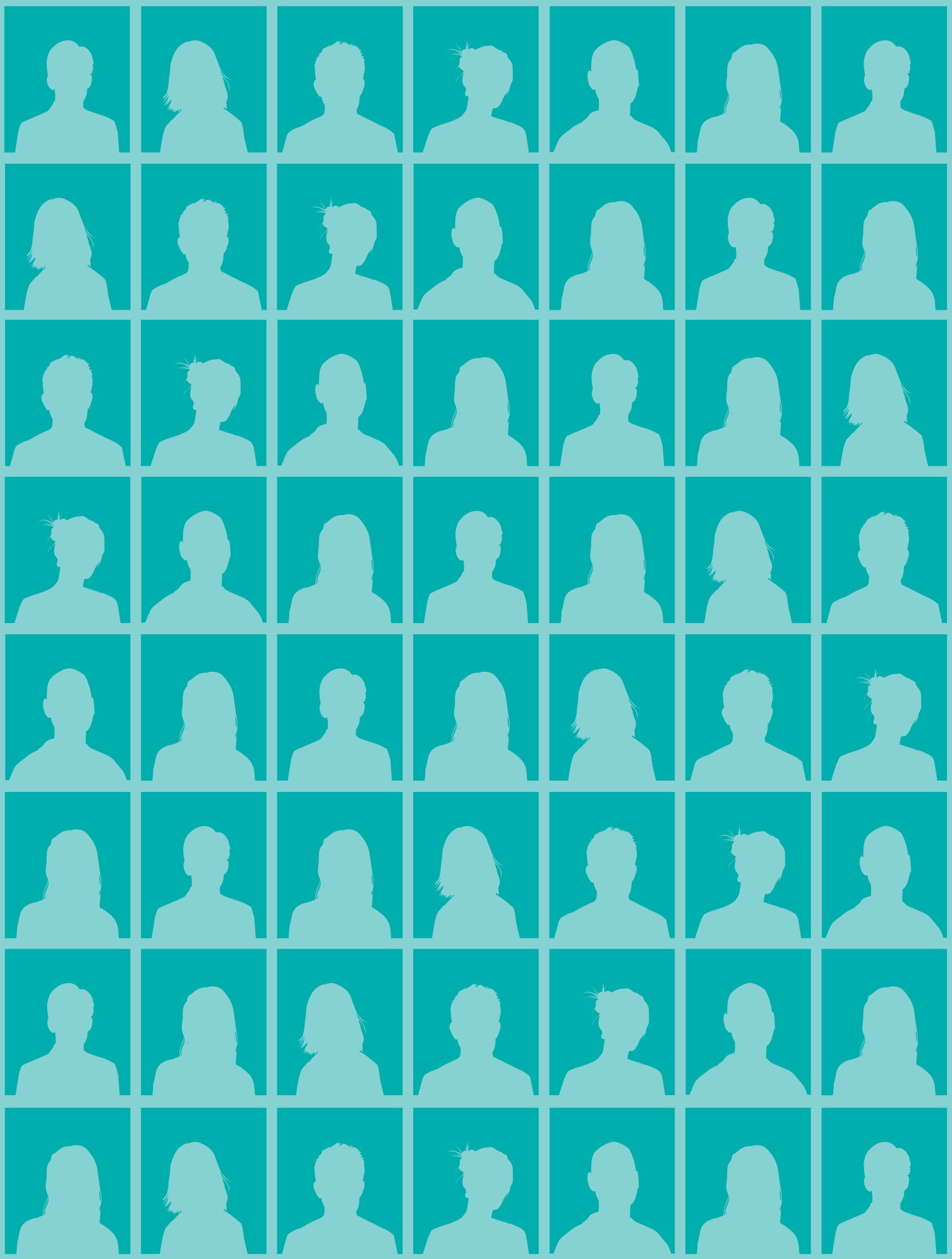
Human Resources
Open Enrollment 2016
Administrative Staff

SVA NYC



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Introduction

David Rhodes, PRESIDENT

For the past decade percentage increases in SVA's healthcare costs have far outpaced percentage increases In SVA's revenues. This trend has shown no sign of slowing and recent increases have been alarming. SVA's healthcare costs have gone from $13.3M in 2014 to $14.8M in 2015 and are projected to increase to $16.5M in 2016, consecutive 11% increases. To contain these cost increases we have had to make changes to our healthcare plans.

The new plans are described in detail in the following pages, but a brief summary is:

1. The Open Access Plan and the Standard Open Access Plan have been consolidated into the Integrated Open Access Plan.
2. Deductibles, co-pays and other out of pocket expenses have been increased.

As a consequence of these increases those of us who will continue in the Integrated Open Access Plan might want to consider opening a Flexible Spending account that can use pre-tax dollars to offset the increase in out of pocket costs.

These changes might also make the High Deductible Plan an option for some of us. Although the deductibles are higher, the premiums are lower. Also, when you enroll in the High Deductible Health Plan you are able to open a Health Saving Account (HSA). Funds put into this account are untaxed at the Federal level and also in most States and can be used to pay for services before the deductible is met. You may also use it for dental and vision expenses not covered by those plans. And unlike the "use it or lose" stipulation of the Flexible Spending Account available to those in the Integrated Open Access Plan, any unused money stays in the account and rolls over from year to year. This is your account and it travels with you even if you leave SVA.

These plans are described in greater detail in the pages that follow. Please review them carefully to determine which option is right for you and your family.

As those of you who have heard me speak about healthcare know, we make these changes reluctantly, but years of sharply increasing costs have left us no alternative.

My best to you and your family in 2016.

David Rhodes

Your Benefits

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 my.sva.edu under the Human Resources tab.

You can view your current benefits, enroll for the first time or terminate benefits offered by SVA by following the steps below.

To access your current benefits or make changes on-line:

- Go to the Home Page on MySVA and log-in with your username and password
- Click on Employee Info under the Web Advisor section
- Click on Current Benefits to view your current elections
- To make changes Click on Benefit Enrollment and follow the prompts

If you choose to print a copy of your benefit elections for your records, go to Print, Page Layout, and choose Landscape

*Note: If you are accessing the site from a non-SVA computer you will be asked to re-enter your username and password to view the plan descriptions, rates, and beneficiary forms.

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: one referral-free Integrated OAP plan, and a Choice Fund OAP high deductible health plan (HDHP). Employees may also elect coverage for a spouse, children or a domestic partner.

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 $2,550 for healthcare and $5,000 for dependent care), which will be deducted from their paycheck in equal installments throughout the year.

Health Savings Account (HSA)

All eligible administrative employees enrolled in the high deductible health plan can contribute to a special, tax-advantaged account that can be used to pay for qualified medical expenses. Employees contribute money to their HSA, where it earns interest tax-free. Funds are not taxed when withdrawn to pay for qualified medical expenses. Employees determine the amount of their annual deduction (up to $3,350 for single and $6,650 for family), which is deducted electronically from their designated checking account either one time or every month.

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.

Voluntary Vision Care Plan

Eligible administrative employees may enroll in the voluntary VSP Signature Vision Care Plan. This 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.

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 Short-Term Disability Program

Eligible administrative employees may enroll in the enriched voluntary short-term disability program. Employees are able to purchase up to 40%, 50% or 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). New York State short-term disability 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.

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 an OAP 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 an OAP 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 full-time administrative employees (working 35 hours per week) will receive 8 sick days (56 hours) per year. All 8 sick days are provided on February 1 each year. Full-time administrative employees will be permitted to annually "bank" unused sick days (maximum 130 days) for use in a certified short-term disability leave.

*New full-time employees are provided 8 sick days on their first day of employment and may begin to use sick days after 120 days of employment.

All part-time administrative employees (employees regularly scheduled to work less than 35 hours per week) accrue sick leave at the rate of 1 hour for every 30 hours worked, up to a maximum of 40 hours during each year. New part-time employees begin accruing sick days at the commencement of employment and may begin to use their accrued sick days after 120 days of employment. Part-time employees may carry over unused accrued sick time from one year to the next; however part-time employees will not be allowed to take more than 40 hours of sick time in a year.

Paid Parental Leave Policy

The Paid Parental Leave Policy provides qualified employees with up to eight (8) weeks of paid time away from work to assist birth parents,adoptive parents or foster care parents to care for and bond with their child.

Mothers and fathers who are birth parents, adoptive parents or parents of foster children may take Paid Parental Leave. All employees (both staff and faculty) who have been employed at SVA for a minimum of twelve (12) consecutive months are eligible for Paid Parental Leave.

RETIREMENT

401(K)

Regular full-and part-time staff who are at least 21 years of age are eligible to participate in SVA's 401(k) savings plan. Employees may defer up to 75% of their pre-tax compensation through payroll deduction not to exceed the maximum deferment set by the IRS. Budgets permitting, SVA may contribute an amount equal to the sum of 100% of the amount of salary reductions (contributions) that are not in excess of 5% of your compensation. You may choose to invest your account among a variety of carefully selected publicly traded funds. Employees may join or make changes to their plan at the start of every quarter (January 1, April 1, July 1, October 1). The limit on employee elective deferrals (for traditional and safe harbor plans) is: 18,000 per year for employees under the age of 50. Employees 50 years or older, may contribute an additional $6,000 in catch up contributions bringing their total annual contribution limit to $24,000.

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 one guest. 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.
- For more details on museum benefits, visit MySVA/Museum Benefits.
- AMC Loews Theaters: SVA employees can purchase discount movie passes for $8 that can be used at any AMC 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 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 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 at 207 East 23 Street or online at MySVA-campus store.

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 steps on-line located at MySVA. 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-line.

Finally, if you intend to participate in the flexible spending account in 2016, you must complete the Cigna Healthcare Flexible Spending Account Enrollment, regardless of your participation in 2015. This is an annual enrollment and does not automatically carry over.

The due date for all changes is **Monday, November 30, 2015.**

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 2015, 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: Integrated Open Access Plus and a High Deductible OAP Plan. 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 my.sva.edu and clicking on the Benefits: Summary Plan Descriptions section on the Human Resources homepage.

INTEGRATED OAP OPTION

The Integrated Open Access Plus 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 features two co-pay amounts, one for primary care ($25) and another for specialist care ($40), 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.

CHOICE FUND OAP (HDHP)

The Choice Fund OAP (HDHP) offers the convenience of referral-free access to doctors, and the option to select a Primary Care Physician (PCP). The plan also offers the freedom to choose the providers you prefer—even if they aren't part of the network. The Choice Fund OAP features two deductibles, single ($1300) and family ($2600). After the deductible is met the plan pays 100% for in-network.

The plan combines conventional health coverage with a savings account to help you pay for the cost of your health care services.

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- AND THIRD-TIER) DRUGS:** Brand drugs are those which may or may not have an equally effective generic equivalent. These medications are covered at the brand formulary and non-formulary co-payment or co-insurance under a three-tier plan.

PRESCRIPTION DRUG COSTS

Co-payments for prescription drugs vary across the two medical plan choices (Integrated OAP and Choice Fund OAP). 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 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 two 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.

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.

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.myCigna.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.

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-ofnetwork 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 pages[1].

Wellness Exams and Immunizations

	BIRTH TO 2 YEARS	AGES 3 TO 10	AGES 11 TO 21	AGES 22 AND OLDER
WELL-BABY/WELL-CHILD/ WELL-PERSON EXAMS (includes height, weight, head circumference, BMI, history, anticipatory guidance, education regarding risk reduction, psychosocial/ behavioral assessment)	Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 & 30 months. Additional visit at 2-4 days for infants discharged less than 48 hours after delivery	Well child exams; once a year	Once a year	Applies to all covered dependents through age 26 and includes routine immunizations.
Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP)	2, 4 & 6 months and 15-18 months	Ages 4 -6	Tetanus, diphtheria, acellular pertussis (Tdap) given once, ages 11-64	Tetanus and diphtheria toxoids booster (Td) every 10 years; Tdap given once, ages 11-64
Haemophilus Influenzae type b conjugate (Hib)	2, 4 & 6 months and 12-15 months			
Hepatitis A (HepA)	12-23 months			May be required for persons at risk
Hepatitis B (HepB)	At birth, 1-4 months and 6-18 months	Ages 3-10 if not previously immunized	Ages 11-18 if not previously immunized	May be required for persons at risk
Human Papillomavirus (HPV)[1]		Ages 9-10, as doctor advises	Ages 11-12, catch-up, ages 13-26	Catch-up, through age 26
Influenza Vaccine	Annually 6 months and older	Annually	Annually	Annually
Measles, Mumps and Rubella (MMR)	Ages 12-15 months	Ages 4-6	If not already immune	Rubella for women of childbearing age if not immune
Meningococcal (MCV)			All persons ages 11-18	
Pneumococcal (Pneumonia)	2, 4 & 6 months and 12-15 months			Ages 65 & older, once (or younger than 65 for those with risk factors)
Poliovirus (IPV)	2 & 4 months and 6-18 months	Ages 4-6		
Rotavirus	Ages 6-32 weeks			
Varicella (Chickenpox)	Ages 12-15 months	Ages 4-6	Second dose catch-up or if no evidence of prior immunization or chickenpox	Second dose catch-up or if no evidence of prior immunization or chickenpox
Zoster				Ages 60+

Health Screenings and Interventions

	BIRTH TO 2 YEARS	AGES 3 TO 10	AGES 11 TO 21	AGES 22 AND OLDER
Alcohol misuse				All adults
Aspirin to prevent cardiovascular disease[2]				Men ages 45-79; women ages 55-79
Autism	18, 24 months			
Cholesterol/Lipid Disorders	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)	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)	Ages 20 and older if risk factors	All men ages 35 and older, or ages 20-35 if risk factors All women ages 45 and older, or ages 20-45 if risk factors
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 ▪ Colonoscopy every 10 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)[2] Oral Health Evaluation/ Assess for Dental Referral	Children older than 6 months 12,18, 24 months	Children older than 6 months 30 months, 3, 6 years		

Health Screenings and Interventions

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

Women's Health Screenings and Interventions

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

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.

[1] Gender criteria apply depending on vaccine brand.

[2] 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.

These 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		
	INTEGRATED OAP OPTION	
PLAN HIGHLIGHTS	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	$500/$1,250	$2,000/$5,000
Annual Out-of-Pocket Maximum	$1,000/$2,500	$4,000/$10,000
Co-insurance	90% of R&C* fees after deductible	60% of R&C* fees after deductible
Physician Office Visit	$25 co-pay PCP; $40 co-pay specialist	60% of R&C* fees after deductible
Prescription Drug Card	$5 co-pay generic, $25 co-pay Name Brand Formulary, $40 Name Brand Non Formulary	Not Covered
HOSPITAL/SURGICAL		
Inpatient Surgery	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Inpatient Hospital Facility	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Outpatient Surgery	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Outpatient Hospital Services	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Emergency Room	$25 co-pay (waived if admitted)	$25 co-pay (waived if admitted)
In Patient Professional Services (Radiologists, Pathologists, and Anesthesiologists)	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Out Patient Professional Services (Radiologists, Pathologists, and Anesthesiologists)	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Lab & X-Ray	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
Advanced Radiology (MRI, MRA, CAT Scan, PET Scan, etc.)	90% after deductible to Annual Out of Pocket Maximum	60% of R&C fees after deductible
MENTAL/NERVOUS		
Inpatient Mental/Nervous	90%	60% of R&C fees after deductible
Outpatient Mental/Nervous Facility	90%	60% of R&C fees after deductible
Office Visits	$40 co-pay, then 100%	60% of R&C fees after deductible
ALCOHOL/SUBSTANCE ABUSE		
Inpatient Alcohol/Substance Abuse	90%	60% of R&C fees after deductible
Outpatient Alcohol/Substance Abuse Facility	90%	60% of R&C fees after deductible
Office Visits	$40 co-pay, then 100%	60% of R&C fees after deductible
MISCELLANEOUS		
Chiropractic Care	Not Covered	Not Covered
Massage Therapy	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered
Vision	One exam per calendar year—maximum of $150 per year	One exam per calendar year—maximum of $150 per year
Home Health Care	90%, 120 visits per year	90% 120 visits per year
Skilled Nursing Facility	90%, 100 days per year	90% 100 days per year
Hospice Facility	90%	90%

PLAN PROVISIONS		
	CHOICE FUND OAP (HIGH DEDUCTIBLE HEALTH PLAN)	
PLAN HIGHLIGHTS	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	$1,300/$2,600	$1,300/$2,600
Annual Out-of-Pocket Maximum	$1,300/$2,600	$2,800/$5,600
Co-insurance	N/A	70%
Physician Office Visit	100% after deductible	70%
Prescription Drug Card	100% after deductible	Not Covered
HOSPITAL/SURGICAL		
Inpatient Surgery	100% after deductible	70% after deductible
Inpatient Hospital Services	100% after deductible	70% after deductible
Outpatient Surgery	100% after deductible	70% after deductible
Outpatient Hospital Services	100% after deductible	70% after deductible
Emergency Room	Waived if Admitted	Waived if Admitted
WELLNESS BENEFITS		
Well Baby Care	100%	100%
Annual Physical Exam *(applies to all covered dependents through age 26 and includes routine immunizations)*	100% No Calendar Year Max	100% No Calendar Year Max
Adult Preventive Care for Employee and All Dependents	100% No Calendar Year Max	100% No Calendar Year Max
MENTAL/NERVOUS		
Inpatient Mental/Nervous	100% after deductible	70% after deductible
Outpatient Mental/Nervous Facility	100% after deductible	70% after deductible
Office Visits	100% after deductible	70% after deductible
ALCOHOL/SUBSTANCE ABUSE		
Inpatient Alcohol/Substance Abuse	100% after deductible	70% after deductible
Outpatient Alcohol/Substance Abuse Facility	100% after deductible	70% after deductible
Office Visits	100% after deductible	70% after deductible
MISCELLANEOUS		
Chiropractic Care	Not Covered	Not Covered
Massage Therapy	Not Covered	Not Covered
Acupuncture	Not Covered	Not Covered
Vision	One exam per calendar year—maximum of $150 per year	One exam per calendar year—maximum of $150 per year
Home Health Care	100% after deductible, 120 visits per year	70% after deductible, 120 visits per year
Skilled Nursing Facility	100% after deductible, 100 days per year	70% after deductible, 100 days per year
Hospice Facility	100% after deductible	70% after deductible

RATES EFFECTIVE JANUARY 1, 2016

*High Option and OAP/Out of Network Charges are Subject to Usual and Customary Reimbursement Levels

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

PLAN	COVERAGE	PAYROLL DEDUCTION	
		SEMI-MONTHLY	ANNUALLY
INTEGRATED OAP	Single	$39	$936
	Employee & Child	$70	$1,680
	Employee & Children	$100	$2,400
	Employee & Spouse	$118	$2,832
	Family	$153	$3,672
CHOICE FUND OAP (HDHP)	Single	$26	$624
	Employee & Child	$47	$1,128
	Employee & Children	$67	$1,608
	Employee & Spouse	$78	$1,872
	Family	$102	$2,448

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

DOMESTIC PARTNER TAXATION

If you cover a domestic partner under the medical, dental or vision plan, the following applies to you:

The IRS does not recognize domestic partners as a spouse under federal tax laws. Federal regulations require all domestic partner coverage be deducted on a post-tax basis and that the fair market value of domestic partner coverage must be imputed from the employee's income.

What does this mean?

Your individual employee deduction is deducted on a pre-tax basis, but your domestic partner's portion of the deduction must be deducted on a post-tax basis (i.e. after-tax). You must also pay taxes on the employer's cost of domestic partner coverage.

DOMESTIC PARTNERSHIP POST-TAX DEDUCTION

There will be separate deductions on your paycheck for medical, dental and vision.

HOW WILL THE IMPUTED INCOME AFFECT MY PAYCHECK?

To impute the income is to take the employer cost of the domestic partner's coverage and include it in the employee's paycheck to be taxed. Once the income is entered as earnings (under the earnings section on your paycheck), the same amount is taken out as a post-tax deduction (under the deduction section on your paycheck).

To determine the imputed income portion - we simply take the difference of the employer cost of the employee coverage and the employee's post tax deduction for the dependent coverage and the resulting number is the "fair market value."

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.

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

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 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 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 OAP 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 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 OAP medical plan.

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

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

SEMI-MONTHLY COST

EMPLOYEE: $4.91	**EMPLOYEE + 1:** $9.83	**FAMILY:** $15.82

If you are interested in enrolling in the VSP® Signature Vision care Plan, please complete the appropriate on-line process located at MySVA.

The last day to enroll is Monday, November 30, 2015. Your benefit will become effective on January 1, 2016.

Keep your eyes healthy with School of Visual Arts and VSP® Vision Care.

Why enroll in VSP? Your eyes deserve the best care to keep them healthy year after year. Plus with VSP, you'll get a great value on your eyecare and eyewear.

You'll like what you see with VSP.

- **Personalized Care**. You'll get quality care that focuses on your eyes and overall wellness with VSP. Plus, your satisfaction is guaranteed when you see a VSP doctor.
- **Great Eyewear**. Choose the eyewear that's right for you and your budget.
- **Choice of Providers.** With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor, a retail chain affiliate, or any other provider.

Save with VSP coverage*:	Without VSP Coverage	With VSP Coverage
Eye Exam	$152	$10 Copay
Frame	$150	$25 Copay
Bifocal Lenses	$146	
Progressive Lenses	$144	$90
Transitions® Lenses	$101	$62
Member Only Annual Contribution	N/A	$131
Total	$693	$318

*Comparison based on national averages for comprehensive eye exams and most commonly purchased brands.

Average Annual Savings **$375** with a VSP Doctor

Enrolling in VSP is easy.

Choose one of these convenient options:

- **Online:** Visit VSP at **vsp.com/go/svanonfaculty** and complete the online enrollment form.
- **Phone:** Call VSP at **800.400.4569** and speak with a member services representative, Monday - Friday, 5 a.m. - 8 p.m., or Saturday, 6 a.m. - 5 p.m., Pacific

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. Choose from great brands, like bebe®, Calvin Klein, Nike, and Tommy Bahama®.

Save Big on Hearing Aids

Save up to an average of 50% on all-digital hearing aids through TruHearing®. Visit **specialoffers.vsp.com/truhearing** for details.

Enroll in VSP today.
You'll be glad you did.

vsp.com/go/svanonfaculty
800.400.4569

Your VSP Vision Benefits Summary

As a School of Visual Arts Non-Faculty Employee, VSP provides you with an affordable eyecare plan.

Open Enrollment: November 1 - November 30

Coverage Effective: January 1, 2015

VSP Doctor Network: VSP Signature

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

Benefit	Description	Copay	Frequency
Your Coverage with VSP Doctors or Affiliate Providers*			
WellVision Exam®	Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses			
Frame	• $150 allowance for a wide selection of frames • 20% off amount over your allowance • $80 allowance at Costco®	$25	Every calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children		Every calendar year
Lens Options	• Standard progressive lenses	$55	Every calendar year
	• Premium progressive lenses	$95-$105	
	• Custom progressive lenses	$150-$175	
	• Average 35%-40% off other lens options		
Contacts (instead of glasses)	• $150 allowance for contacts • Contact lens exam (fitting and evaluation)	Up to $60 for fitting & eval	Every calendar year
VSP Diabetic Eyecare Plus Program℠	• Services related to types 1 and 2 diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

Your Coverage with Other Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP doctor.

Exam.....up to $50	Single Vision Lenses.....up to $50	Lined Trifocal Lenses.....up to $100	Contacts.....up to $105
Frame.....up to $70	Lined Bifocal Lenses.....up to $75	Progressive Lenses.....up to $75	

***Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit vsp.com for details**

VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

JOB#14517CM 10/13

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 of $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: my.sva.edu and clicking on the Benefits: Summary Plan Descriptions section on the Human Resources homepage.

Dental Plan Premiums

	PAYROLL DEDUCTIONS	
LEVEL OF COVERAGE	SEMI-MONTHLY	ANNUALLY
EMPLOYEE	$24.51	$588.24
EMPLOYEE & 1 DEPENDENT	$45.79	$1,099.08
EMPLOYEE & FAMILY	$75.25	$1,806.00

RATES EFFECTIVE JANUARY 1, 2016

	FOC DMO
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	***

**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

Partial List of Services	FOC DMO
Preventive	
Oral examinations (a)	100%
Cleanings (a) Adult/Child	100%
Fluoride (a)	100%
Sealants (permanent molars only) (a)	100%
Bitewing X-rays (a)	100%
Full mouth series X-rays (a)	100%
Basic	
Root canal therapy	
Anterior teeth / Bicuspid teeth	100%
Scaling and root planing (a)	100%
Gingivectomy*	100%
Amalgam (silver) fillings	100%
Composite fillings (anterior teeth only)	100%
Stainless steel crowns	100%
Incision and drainage of abscess*	100%
Uncomplicated extractions	100%
Surgical removal of erupted tooth*	100%
Surgical removal of impacted tooth (soft tissue)*	100%
Major	
Space Maintainers	60%
Inlays	60%
Onlays	60%
Crowns	60%
Full & partial dentures	60%
Pontics	60%
Root canal therapy, molar teeth	60%
Osseous surgery (a)*	60%
Surgical removal of impacted tooth (partial bony/ full bony)*	60%
General anesthesia/intravenous sedation*	60%
Denture repairs	60%

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.

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.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
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.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, 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.

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.

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Dental Benefits Summary

Staff

	Passive PPO With PPOII Network
Annual Deductible*	
Individual	**$50**
Family	**$150**
Preventive Services	**100%**
Basic Services	**80%**
Major Services	**50%**
Annual Benefit Maximum	**$2,000**
Office Visit Copay	**N/A**
Orthodontic Services**	**50%**
Orthodontic Deductible	**None**
Orthodontic Lifetime Maximum	**$1,500**

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

Partial List of Services	Passive PPO With PPOII Network
Preventive	
Oral examinations (a)	100%
Cleanings (a) Adult/Child	100%
Fluoride (a)	100%
Sealants (permanent molars only) (a)	100%
Bitewing X-rays (a)	100%
Full mouth series X-rays (a)	100%
Basic	
Amalgam (silver) fillings	80%
Composite fillings (anterior teeth only)	80%
Stainless steel crowns	80%
Space Maintainers	80%
Uncomplicated extractions	80%
Major	
Inlays	50%
Onlays	50%
Crowns	50%
Full & partial dentures	50%
Pontics	50%
Incision and drainage of abscess*	50%
Surgical removal of erupted tooth*	50%
Surgical removal of impacted tooth (soft tissue)*	50%
Root canal therapy	
Anterior teeth / Bicuspid teeth	50%
Scaling and root planing (a)	50%
Gingivectomy*	50%
Root canal therapy, molar teeth	50%
Osseous surgery (a)*	50%
Surgical removal of impacted tooth (partial bony/ full bony)*	50%
General anesthesia/intravenous sedation*	50%
Denture repairs	50%

***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.

Other Important Information

This Aetna Dental® Preferred Provider Organization (PPO) benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-participating benefits are subject to usual and prevailing charge limits, as determined by Aetna.

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.

When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. 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.
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.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
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.

18. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
19. Services needed solely in connection with non-covered services.
20. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.
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.

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

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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.
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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.

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Dental Benefits Summary

Staff

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 Heath 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 $2,550 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 2015. 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 www.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 2016 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.

COVERED EXPENSE	DESCRIPTION	YOUR ESTIMATE
ANNUAL PLAN DEDUCTIBLES	Applies to both your medical and dental plan deductibles.	$
DOCTOR VISITS	In-network co-pays or other expenses related to doctor visits.	$
ROUTINE PHYSICAL EXAM	In-network co-pays or other expenses related to doctor visits.	$
PRESCRIPTION DRUGS (INCLUDING ORAL CONTRACEPTIVES)	Co-pays for generic and brand name or Tel-Drug 90-day supply.	$
EMERGENCY ROOM	In-network co-pays or other expenses related to hospital visits.	$
DENTAL CARE	Annual deductible for basic and major services in the PPO only; 50% out-of-pocket for orthodontic services DMO and PPO.	$
VISION CARE	In-network co-pays or other expenses for annual eye exam, glasses, LASIK and contact lenses.	$
OTHER PLANNED UNCOVERED EXPENSES	Eligible over the counter medications with a prescription.	$
TOTAL ESTIMATED HEALTH-CARE EXPENSES (Maximum $2,550)		$

Health Savings Account (HSA)

SVA offers employees enrolled in the Choice Fund OAP (HDHP) the option of contributing to a special, tax-advantaged account that can be used to pay for qualified medical expenses. Employees contribute money to their Choice Fund Open Access Plus – HSA, where it earns interest on a Federal level and in most states (NJ for example is not tax free). Funds are not taxed when withdrawn to pay for qualified medical expenses.

TO BE ELIGIBLE FOR AN HSA, EMPLOYEES:

- Must be covered by a High Deductible Health Plan (HDHP)
- Cannot have other health insurance coverage, such as a spouse's plan, that is not an HDHP
- Cannot be claimed as a dependent on another person's tax return
- Cannot open a new HSA or contribute to an existing HSA once enrolled in Medicare

Employees determine the amount of their deduction (up to $3,350 for single and a catch-up contribution of $1,000 for those 55 and older, or $6,650 for family and a catch-up contribution of $1,000 for those 55 and older for 2015), which is deducted from your designated checking account either one time or every month.

The Health Savings Account can be used for qualified medical expenses not covered by the health plan. The following list gives a general overview of qualified expenses. This list is not all-inclusive, and is subject to change by the IRS.

THE HSA MAY BE USED TO COVER MEDICATION EXPENSES IF THE MEDICINE OR DRUG:

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

EXAMPLES OF QUALIFIED MEDICAL EXPENSES THAT CAN BE COVERED BY THE HEALTH SAVINGS ACCOUNT:

- Covered medical services used to satisfy your Cigna deductible
- Acupuncture
- Alcoholism treatment
- Bandages
- Birth Control Pills
- Braces
- Chiropractor
- Eyeglasses

NOTE: Any HSA funds used for non-qualified expenses are taxable. You may also refer to the IRS publication 502—Medical and Dental Expenses, accessible through www.irs.gov or by calling 800.829.3676 for more information and examples of expenses that are covered.

WHAT HAPPENS TO UNUSED FUNDS?

An HSA is generally exempt from tax. Employees are permitted to take a distribution from their HSA at any time; however, only those amounts used exclusively to pay for qualified medical expenses are tax- free. Funds that remain at the end of the year are carried over to the next year.

401 (K) Plan
A tax-deferred retirement savings plan

ELIGIBILITY

All administrative employees who are 21 years of age are eligible to participate in the 401(K) plan. Employees may join the plan on January 1st, April 1st, July 1st and October 1st of each year. Under terms of the plan, an employee can defer a percentage of his/her pre-tax compensation through payroll deductions to the extent allowable by IRS regulations and plan definitions. The School of Visual Arts will make a matching contribution equal to 100% of the first 5% of the employee' salary deferral.

The limit on employee elective deferrals (for traditional and safe harbor plans) is: $18,000 per year for employees under the age of 50. Employees 50 years or older, may contribute an additional $6,000 in catch up con-tributions bringing their total annual contribution limit to $24,000.

HOW TO ENROLL

To enroll for the first-time:

1. Go to enroll.voya.com
2. To log-in to the site you will need the following information:
3. Plan Number; 559685
4. Verification Number: 55968599

To make changes to your current elections/contribution:

1. Go to voyaretirement.voya.com
2. Follow the prompts and enter your username and password.
3. Note: If you are accessing your account for the first time, your username is your SSN and your temporary PIN is the month and year of your date of birth.

Paid Parental Leave Policy

The Paid Parental Leave Policy provides qualified employees with up to eight (8) weeks of paid time away from work to assist birth parents, adoptive parents or foster care parents to care for and bond with their child.

ELIGIBILITY

Mothers and fathers who are birth parents, adoptive parents or parents of foster children[1] may take Paid Parental Leave. All employees (both staff and faculty) who have been employed at SVA for a minimum of twelve (12) consecutive months are eligible for Paid Parental Leave.

LEAVE PROVISIONS

Paid Parental Leave for Staff will be paid at 100 percent of your regular rate of pay for your regularly scheduled workweek as of the time of the leave. Paid Parental Leave for Faculty will be paid based upon the contract in place at the time of the leave or the average weekly payout during the preceding 12-month period, whichever is greater.

Paid Parental Leave is only available within the twelve-month period following the birth, adoption or foster care placement of a child.[2]

Paid Parental Leave may be taken either on a continuous, intermittent or reduced schedule basis.[3] However, Paid Parental Leave on an intermittent or reduced schedule basis is not always compatible with SVA's operational needs. SVA retains the discretion to determine whether, in its judgment, a position is suitable for intermittent or reduced schedule Paid Parental Leave. If an employee wishes to take Paid Parental Leave intermittently or on a reduced schedule basis, then he or she must consult with Human Resources and your Department Chair or supervisor to discuss the leave request and obtain SVA's written approval.

INTERPLAY WITH OTHER TYPES OF PAID AND UNPAID LEAVE

Paid Parental Leave is a new benefit. It can be used separate from, or in combination with, a variety of other types of paid leave or benefits that SVA offers, such as sick days, short-term disability (STD) banked sick days, New York State STD benefits, SVA enhanced STD disability benefits[4], vacation days and personal days, as applicable. You may not use or combine different forms of paid leave to be paid more than your regular rate of pay.

Paid Parental Leave will run simultaneously with FMLA leave, to the extent that you are eligible for FMLA leave during all or any portion of the Paid Parental Leave. See SVA's FMLA Policy in the Handbooks for Administrative Employees and Faculty.

For Staff, this Paid Parental Leave Policy supersedes and replaces the SVA Maternity / Paternity Leave Policy, which is no longer in effect.

Employees who are planning for the birth, adoption or foster care placement of a child are encouraged to consult with Human Resources regarding their options as to paid leave.

APPLICATION AND APPROVAL PROCESS

Employees should notify Human Resources and the Department Chair or supervisor of an intent to take Paid Parental Leave as soon as possible, but must provide at least thirty (30) days' notice before the baby is due or before a scheduled placement of a child for adoption or foster care. If 30 days' notice is not practicable, then notice should be provided as soon as possible. Any changes in the expected date of birth or of the placement of an adoptive or foster child must be communicated promptly to Human Resources and your Department Chair or supervisor.

Employees may be required to provide appropriate documentation for the birth, adoption or foster care placement to Human Resources. Appropriate documentation may include a letter from a physician as proof of birth, a letter from the adoptive or foster care agency, or from a lawyer in private adoption cases.

CONFIDENTIALITY

All medical information relating to Paid Parental Leave, whether verbal or written, including FMLA medical documentation will be kept confidential to the maximum extent possible.

QUESTIONS

Questions regarding Paid Parental Leave should be directed to Human Resources.

[1] For purposes of this policy, the Family Medical Leave Act (FMLA) limitations on the age of the child will be applied to determine eligibility for Parental Leave for adoptions and foster care placements.

[2] Eight (8) weeks of Paid Parental Leave is the maximum amount that may be taken in a 12-month period. The 12-month period is measured by looking backward on a rolling basis from the date the employee will be using Paid Parental Leave.

[3] Intermittent leave is leave taken in separate blocks of time. Reduced schedule leave is a schedule that reduces an employee's usual number of hours worked per day or per week. Paid Parental Leave taken intermittently or on a reduced schedule will be prorated based on the staff member's regularly scheduled hours per workweek or the faculty member's average weekly class hours in the preceding 12-month period.

[4] To the extent you have elected to participate in SVA enhanced STD benefits program, then Paid Parental Leave would follow that time period.

Tuition Waiver Benefits for Administrative Employees

CONTINUING EDUCATION

Full-time administrative employees who complete six (6) consecutive months of service and part-time employees who complete one (1) calendar year of service are eligible to enroll in two (2) SVA Continuing Education classes per semester, tuition free. All related course fees, including the registration fee, must be paid. This tuition waiver is subject to space availability and does not apply to the following: Filmmakers Dialogue, Arts Abroad Program, Summer Residency Program, Summer Institute in the Berkshires, Milton Glaser's workshop or any other intensive workshop. Additionally, tuition waivers for undergraduate courses listed in the Division of Continuing Education bulletin are subject to the guidelines for non-degree seeking, undergraduate credits listed below. For the most up-to-date list of these courses please visit the Division of Continuing Education at schoolofvisualarts.edu/ce.

Employees registering for subsequent semesters must be in good academic standing to remain eligible for this benefit. Good academic standing is defined by having successfully completed all previous courses with passing grades. Registration forms and requests for tuition waivers must be submitted to the Division of Continuing Education along with an SVA transcript. You may print an unofficial transcript by accessing your WebAdvisor account at: webadvisor.schoolofvisualarts.edu. This benefit may be applied to members of an employee's immediate family (spouse, domestic partner, or child); however, under no circumstances may the maximum number of courses in any given semester exceed two (2) courses per employee/immediate family member.

PRE-COLLEGE PROGRAM

Family members (child, grandchild, or niece/nephew) of full-time administrative employees who have completed six (6) consecutive months of service or family members of part-time employees who have completed one (1) calendar year of service are eligible to enroll in one (1) pre-college course per semester (including summer). In a given semester, only one (1) family member may receive a waiver for the Pre-College Program and the total number of courses waived (per family) must not exceed three (3).

All related course fees, including the registration fee, must be paid by the employee/family member. Family members registering for subsequent pre-college programs must be in good academic standing to remain eligible for this benefit. Good academic standing is defined by having successfully completed all previous courses with passing grades. Registration forms and requests for tuition waivers must be submitted to the Division of Continuing Education.

NON-DEGREE SEEKING, UNDERGRADUATE ONLY

Full-time administrative employees who complete six (6) consecutive months of service and part-time employees who complete one (1) calendar year of service may be eligible to take 12 SVA undergraduate credits, tuition free. This tuition waiver is subject to the following conditions:

- Employees will be required to go through the admissions process similar to applicants seeking Special Student Status. This requires the submission of an application form, non-refundable application fee, statement of intent in which you should identify yourself as an employee to the Office of Admissions, and official high school and college transcripts. A portfolio will be required for studio courses.
- Upon acceptance, the employee will be permitted to take up to six (6) undergraduate credits per semester for two (2) consecutive semesters only (for a total of 12 credits). In addition, the employee must submit a non-refundable enrollment fee to the Office of Admissions.
- Employees must obtain the approval of their supervisor and Human Resources if the courses they intend to take will in any way interfere with their normal work schedule.
- The registration fee and all departmental fees must be paid by the employee.
- A 3.0 grade point average must be obtained after the 1st semester to remain eligible for the 2nd semester.
- This does not apply to graduate study.

This benefit may be applied to members of an employee's immediate family (spouse, domestic partner, or child); however, under no circumstances may the maximum number of credits in any given semester exceed six (6) credits per employee/immediate family member or 12 credits total.

DEGREE SEEKING, UNDERGRADUATE AND GRADUATE

Full-time and part-time administrative employees who complete at least 18 consecutive months of service may qualify for a tuition waiver towards the completion of a degree at SVA.

This tuition waiver is subject to the following conditions:

- For graduate study, employees must have completed a bachelor's degree at a regionally accredited institution of higher education.
- Employees will be required to go through the normal admissions process. This requires the submission of an application form, non-refundable application fee, statement of intent, of-

ficial high school and college transcripts — and a portfolio to the Office of Admissions.

- Upon acceptance, the employee must submit a non-refundable enrollment fee to the Office of Admissions.
- Employees must obtain the approval of their supervisor and Human Resources if the courses they intend to take will in any way interfere with their normal work schedule.
- The registration fee and all departmental fees must be paid by the employee/family member. Fees include, but are not limited to the enrollment fee, health insurance fee (can be waived), departmental fees, course fees and any late fees.
- A 3.0 grade point average must be maintained for continued eligibility of the benefit.
- Employee Scholarships will only be awarded during the semesters in which the employee/student is receiving credit(s) for his/her work. Thesis extensions and maintenance matriculation are not covered.
- Employee scholarships will only be awarded for the minimum number of credits needed to graduate from the program. The terms and limits of your Employee
- Scholarship will be articulated upon your admission into a program.
- Employee scholarships will be applied towards tuition before any departmental scholarship is applied. The total between both scholarships cannot exceed the total
- cost of tuition and fees.
- Employees are eligible to receive a maximum of 30 credits per academic year.
- Employee must be in good standing to receive the Employee Scholarship.

This benefit may be applied to members of an employee's immediate family (spouse, domestic partner, or child); however, under no circumstances may an employee and a family member or two family members simultaneously receive a waiver for tuition in pursuit of a degree.

All fees are based on the charges in effect at the time of application and registration. This policy is subject to change, revocation, modification, or amendment at any time.

Useful Phone Numbers and Web Sites

HUMAN RESOURCES DEPARTMENT/BENEFITS **DANIELLE WILSON,** Benefits Manager **NICOLE MEDEROS,** Benefits Assistant	212.592.2640 dwilson3@sva.edu 212.592.2691 nmederos@sva.edu
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 OAP members*: www.myCigna.com
CIGNA QUIT TODAY SMOKING CESSATION PROGRAM	1.866.417.QUIT *For Cigna OAP 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/marriage_apply.shtml
CIGNA (VOLUNTARY SHORT-TERM DISABILITY)	1.800.36.CIGNA
LINCOLN FINANCIAL GROUP (NYS DISABILITY)	1.855.546.1445
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
Connecticut General Insurance Company of North America.

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.

High Deductible Health Plan (HDHP)
The High Deductible Health Plan (HDHP) is an alternative option that allows employees to contribute to a special, tax-advantaged Health Savings Account (HSA) that can be used to pay for qualified medical expenses.

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.

Open Access Plus (OAP)
A specific type of health plan with a contracted network of physicians. Within SVA's OAP 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:

Danielle Wilson, Benefits Manager
School of Visual Arts
209 East 23rd Street
New York, NY 10010
(212) 592-2640 / dwilson3@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
- 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.

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.

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 Danielle Wilson, 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 my.sva.edu under the Human Resources tab or, contact a member for the Benefits staff.

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.

ALABAMA — MEDICAID www.medicaid.alabama.gov 855.692.5447	ALASKA — MEDICAID http://health.hss.state.ak.us/dpa/programs/medicaid Outside of Anchorage 888.318.8890 907-269-6529
ARIZONA — CHIP www.azahcccs.gov/applicants 877.764.5437 (Maricopa County): 602.417.5437	COLORADO — MEDICAID www.colorado.gov 800.866.3513 Out of state 800.221.3943
FLORIDA — MEDICAID www.flmedicaidtplrecovery.com 877.357.3268	GEORGIA — MEDICAID Website: http://dch.georgia.gov Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) 800.869.1150
IDAHO — MEDICAID AND CHIP Medicaid: www.accesstohealthinsurance.idaho.gov Medicaid: 800.926.2588 CHIP: www.medicaid.idaho.gov CHIP: 800.926.2588	INDIANA — MEDICAID www.in.gov/fssa 800.889.9949
IOWA — MEDICAID www.dhs.state.ia.us/hipp 888.346.9562	KANSAS — MEDICAID www.kdheks.gov/hcf 800.792.4884
KENTUCKY — MEDICAID http://chfs.ky.gov/dms/default.htm 800.635.2570	LOUISIANA — MEDICAID www.lahipp.dhh.louisiana.gov 888.695.2447
MAINE — MEDICAID www.maine.gov/dhhs/ofi/public-assistance/index.html 800.977.6740 TTY: 800.977.6741	MASSACHUSETTS — MEDICAID AND CHIP www.mass.gov/MassHealth 800.462.1120
MINNESOTA — MEDICAID www.dhs.state.mn.us Click on Health Care, then Medical Assistance 800.657.3629	MISSOURI — MEDICAID www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA — MEDICAID http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml 800.694.3084	NEBRASKA — MEDICAID www.ACCESSNebraska.ne.gov 800.383.4278
NEVADA — MEDICAID http://dwss.nv.gov 800.992.0900	NEW HAMPSHIRE — MEDICAID http://www.dhhs.nh.gov/oii/documents/hippapp.pdf 603.271.5218

NEW JERSEY – MEDICAID AND CHIP Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 800.356.1561 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 800.701.0710	NEW YORK – MEDICAID www.nyhealth.gov/health_care/medicaid 800.541.2831
NORTH CAROLINA – MEDICAID www.ncdhhs.gov/dma 919.855.4100	NORTH DAKOTA – MEDICAID www.nd.gov/dhs/services/medicalserv/medicaid 800.755.2604
OKLAHOMA – MEDICAID AND CHIP www.insureoklahoma.org 888.365.3742	OREGON – MEDICAID AND CHIP www.oregonhealthykids.gov www.hijossaludablesoregon.gov 877.314.5678
PENNSYLVANIA – MEDICAID www.dpw.state.pa.us/hipp 800.692.7462	RHODE ISLAND – MEDICAID www.ohhs.ri.gov 401.462.5300
SOUTH CAROLINA – MEDICAID www.scdhhs.gov 888.549.0820	SOUTH DAKOTA - MEDICAID http://dss.sd.gov 888.828.0059
TEXAS – MEDICAID https://www.gethipptexas.com 800.440.0493	UTAH – MEDICAID AND CHIP http://health.utah.gov/upp 866.435.7414
VERMONT– MEDICAID www.greenmountaincare.org 800.250.8427	VIRGINIA – MEDICAID AND CHIP Medicaid Website: www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 800.432.5924 CHIP Website: www.famis.org CHIP Phone: 866.873.2647
WASHINGTON – MEDICAID http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm 800.562.3022 ext. 15473	WEST VIRGINIA – MEDICAID www.dhhr.wv.gov/bm 877.598.5820 HMS Third Party Liability
WISCONSIN – MEDICAID www.badgercareplus.org/pubs/p-10095.htm 800.362.3002	WYOMING – MEDICAID http://health.wyo.gov/healthcarefin/equalitycare 307.77.7531

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

DECLARATION OF DOMESTIC PARTNERSHIP

We declare, under penalty or 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_____

_____

_____

COUNTY OF)
) SS
STATE OF)

Subscribed and sworn to before me this _____ day of _____, 20___

_____
Notary Public

My Commission Expires: _____