

EMPLOYEE BENEFITS SUMMARY

for

Cornish College of the Arts

1000 LENORA
SEATTLE, WA 98121

Presented By:
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Sprague Israel Giles, Inc.

Plan Year October 1, 2009 – September 30, 2010



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MEDICAL POLICY:

Base Plan: Group Health Options – Policy #0614000
Buy-Up Plan: Group Health Alliant Plus – Policy #5096100
Policy Period: 10/01/2009 – 09/30/2010

Cornish offers two Group Health Plans, which are alike in all but one important way. The base plan is a Group Health Options Plan, and the buy up plan is a Group Health Alliant Plus plan. Both plans offer in- and out-of-network benefits, with members sharing more of the costs for services when using providers outside the network.

The only *difference* between these two plans is the provider network, as follows:

	Group Health Options	Group Health Alliant Plus
Providers	In-Network Providers include Group Health providers only. Out-of-network benefits are available if you visit community providers and facilities.	In-Network Providers include Group Health, Virginia Mason, and Everett Clinic Providers. Out-of-network benefits are available if you visit other community providers and facilities.

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Medical Summary of Benefits Group Health Options and Alliant Plus Plans

Benefit	Inside Network	Outside Network
Network	When care is provided or referred by the Managed Health Care Network (MHCN). Benefit allowances utilized inside the Network cannot be duplicated outside the Network.	When care is not provided by or referred by the Managed Health Care Network. Benefit allowances utilized outside the Network cannot be duplicated inside the Network.
Hospital Admission Certification	Not required.	All scheduled inpatient hospital admissions must be authorized by Group Health at least seventy-two (72) hours in advance.
Annual Deductible	No annual deductible.	\$200 per Member or \$400 per family unit per calendar year.
Plan Coinsurance	No plan coinsurance.	80% of the Usual, Customary and Reasonable (UCR) charges are covered.
Lifetime Maximum	none	
Hospital Services Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)	Covered in full.	Covered at the plan coinsurance after the annual deductible is satisfied.
Covered outpatient hospital surgery (including ambulatory surgical centers)	Covered subject to the outpatient services copayment.	\$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Outpatient Services (Office Visits) Covered outpatient medical and surgical services	\$10 copayment per Member per visit.	\$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Allergy testing	Covered subject to the outpatient services copayment.	\$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Oncology (radiation therapy, chemotherapy)	Covered subject to the outpatient services copayment.	\$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Drugs – Outpatient (including mental health drugs, contraceptive drugs and devices and diabetic supplies) Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less when listed in the Group Health Options (GHC) drug formulary	Covered subject to the lesser of the MHCN's charge or a \$10 copayment for generic drugs or a \$20 copayment for brand name drugs.	Covered subject to a \$15 copayment for generic drugs or \$25 copayment for brand name drugs.

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Sprague Israel Giles, Inc.

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Benefit	Inside Network	Outside Network
Over-the-counter drugs and medicines	Not covered.	Not covered.
Allergy serum	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply.	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply.
Injectables	Injections that can be self-administered are subject to the applicable prescription drug cost share.	Injections that can be self-administered are subject to the applicable prescription drug cost share.
Mail order drugs and medicines	Covered subject to a \$5 discount from the applicable prescription drug cost share for each thirty (30) day supply or less.	Not covered.
Growth hormones	Covered in full subject to the applicable pharmacy copayment.	Covered in full subject to the applicable pharmacy copayment.
Out-of-Pocket Limit (Stop Loss)	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> - Inpatient Services - Outpatient Services - Emergency Services at a MHCN Facility - Ambulance Services <p>Limited to an aggregate maximum of \$2,000 per Member and \$4,000 per family per calendar year.</p>	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> - Plan coinsurance - Emergency Services at a non-MHCN Facility <p>Limited to an aggregate maximum of \$2,000 per Member and \$4,000 per family per calendar year.</p>
Acupuncture	Self-referrals to a MHCN Provider covered up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year, subject to the outpatient services copayment. Any additional visits must be approved by Group Health.	\$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Ambulance Services Emergency ground/air transport	Covered at 80%	Covered at 80%
Non-emergent ground/air interfacility transfer	Covered at 80% for HHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full.	When medically necessary and prescribed by the attending physician, transport from one medical facility to the nearest facility equipped to render further Medically necessary treatment is covered at 80%. Services are not subject to annual deductible. Coinsurance does not apply to the out-of-pocket limit.
Chemical Dependency Inpatient Services	Covered subject to the applicable inpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Outpatient Services	Covered subject to the applicable outpatient services copayment.	\$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.

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Benefit	Inside Network	Outside Network
Chemical Dependency Benefit Period Allowance	\$14,500 maximum per Member per any twenty-four (24) consecutive calendar month period. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.	\$14,500 maximum per Member per any twenty-four (24) consecutive calendar month period. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.
Dependent Limiting Age	Dependents can be covered to age 25.	Dependents can be covered to age 25.
Devices, Equipment and Supplies (for home use) Covered items include: <ul style="list-style-type: none"> - Orthopedic appliances - Durable medical equipment - Ostomy supplies - Post-mastectomy bras (limited to two every six months) - Prosthetic devices 	Covered at 80% Covered at 80%	Covered at 80% after the annual deductible is satisfied. Coinsurance does not apply to the out-of-pocket limit. Covered at 80% after the annual deductible is satisfied. Coinsurance does not apply to the out-of-pocket limit.
Diabetic Supplies	Insulin, needles, syringes and lancets – see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies – see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.	Insulin, needles, syringes and lancets – see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies – see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.
Diagnostic Laboratory and Radiology Services	Covered in full.	Covered at the plan coinsurance after the annual deductible is satisfied.
Emergency Services	\$75 copayment per Member per emergency visit to a MHCN Facility. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department.	Covered subject to a \$125 deductible per Member per emergency visit at a non-MHCN Facility (world-wide). Deductible is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. The Member must notify Group Health within twenty-four (24) hours following admission and agree to have care managed by the MHCN in order to have inpatient service covered under the MHCN benefit level. If the Member does not notify Group Health with twenty-four (24) hours following admission, or declines to have care managed by the MHCN, all inpatient services are covered at the plan coinsurance after the annual deductible is satisfied.
Hearing Examinations and Hearing Aids	Hearing examinations to determine hearing loss are covered subject to the outpatient services copayment. Hearing aids, including hearing aid examinations, are not covered.	Hearing examinations to determine hearing loss are subject to a \$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied. Hearing aids, including hearing aid examinations, are not covered.

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Benefit	Inside Network	Outside Network
Home Health Services	Covered in full. No visit limit.	Covered at the plan coinsurance after the annual deductible is satisfied.
Hospice Services	Covered in full.	Covered at the plan coinsurance after the annual deductible is satisfied.
Infertility Services (Including Sterility)	Not covered.	Not covered.
Manipulative Therapy	Self-referrals to a MHCN Provider for manipulative therapy of the spine covered up to a maximum of ten (10) visits per Member per calendar year, subject to the outpatient services copayment.	Manipulative therapy of the spine or extremities is covered up to a maximum of ten (10) visits per Member per calendar year. \$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Maternity and Pregnancy Services Delivery and associated hospital care	Covered subject to the applicable inpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Routine prenatal and postpartum care	Covered subject to the outpatient services copayment.	\$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Mental Health Services Inpatient Services	Covered subject to the applicable inpatient services copayment for up to twelve (12) days per Member per calendar year at a GHO-approved mental health care facility.	Covered at the plan coinsurance after the annual deductible is satisfied for up to twelve (12) days per Member per calendar year at a GHO-approved mental health care facility.
Outpatient Services	Covered subject to the applicable outpatient services copayment for up to twenty (20) visits per Member per calendar year.	\$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied., for up to twenty (20) visits per Member per calendar year.
Naturopathy	Self-referrals to a MHCN Provider covered up to a maximum of three (3) visits per Member per medical diagnosis per calendar year, subject to the outpatient services copayment. Any additional visits must be approved by Group Health.	\$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Optical Services Routine eye examinations	Covered subject to the outpatient services copayment once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the outpatient services copayment as often as Medically Necessary.	Covered up to \$30 once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered at the plan coinsurance after the deductible is satisfied as often as Medically Necessary.
Lenses, including contact lenses and frames	Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting covered up to \$100 per Member per any consecutive twelve (12) month period. Contact lenses following cataract surgery, when in lieu of an intraocular lens, are covered in full provided the Member has been continuously covered by Group Health since such surgery. Contact lenses for eye pathology are covered in full. Replacement of these lenses is covered once within a twelve (12) month period and only when needed due to a change in the Member's medical condition.	Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting covered up to \$100 per Member per any consecutive twelve (12) month period. Contact lenses following cataract surgery, when in lieu of an intraocular lens, are covered in full provided the Member has been continuously covered by Group Health since such surgery. Contact lenses for eye pathology are covered in full. Replacement of these lenses is covered once within a twelve (12) month period and only when needed due to a change in the Member's medical condition.
Benefit	Inside Network	Outside Network

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<p>Organ Transplants</p>	<p>Covered up to a lifetime maximum of \$250,000 (including donor costs of \$50,000), subject to applicable copayments. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHO or Group Health Cooperative (Group Health) plan for six (6) months.</p>	<p>Covered up to a lifetime maximum of \$250,000 (including donor costs of \$50,000), at the plan coinsurance after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHO or Group Health Cooperative (GHC) plan for six (6) months. Transplant services must be received at a facility authorized in advance by Group Health.</p>
<p>Pre-Existing Condition</p>	<p>Covered (except as specified) subject to applicable copayments after the Member has been continuously covered under a Group Health plan for three (3) consecutive months, except as described below. Coverage for PKU formula, maternity and breast reconstruction following a mastectomy is not subject to the pre-existing condition waiting period.</p> <p>Pre-existing condition wait will be credited for a Member whose date of application for coverage under this Group Health plan is within ninety (90) days of termination of prior similar coverage, provided the Member has satisfied the pre-existing condition wait under such prior coverage.</p>	<p>Covered (except as specified) at the plan coinsurance after the annual deductible is satisfied after the Member has been continuously covered under a Group Health plan for three (3) consecutive months, except as described below. Coverage for PKU formula, maternity and breast reconstruction following a mastectomy is not subject to the pre-existing condition waiting period.</p> <p>Pre-existing condition wait will be credited for a Member whose date of application for coverage under this Group Health plan is within ninety (90) days of termination of prior similar coverage, provided the Member has satisfied the pre-existing condition wait under such prior coverage.</p>
<p>Preventive Services (Well Adult and Well Child Physicals, Immunizations, Pap Smears, Mammograms)</p>	<p>Covered subject to the outpatient services copayment when in accordance with the well-care schedule established by Group Health. Excluded are physicals for travel, employment, insurance, license, etc.</p>	<p>Not covered, except for routine mammography services covered at the plan coinsurance after the annual deductible is satisfied. Excluded are physicals for travel, employment, insurance, license, etc.</p>
<p>Rehabilitation Services Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under</p>	<p>Covered up to sixty (60) days per calendar year, subject to the applicable inpatient services copayment.</p>	<p>Covered up to sixty (60) days per calendar year, at the plan coinsurance after the annual deductible is satisfied.</p>
<p>Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under</p>	<p>Covered up to sixty (60) visits per calendar year, subject to the outpatient services copayment.</p>	<p>Covered up to sixty (60) visits per calendar year. \$10 copayment then covered at the plan coinsurance after the annual deductible is satisfied.</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>Covered in full up to sixty (60) days per Member per calendar year.</p>	<p>Covered up to sixty (60) days per Member per calendar year, at the plan coinsurance after the annual deductible is satisfied.</p>
<p>Sterilization (Vasectomy, Tubal Ligation)</p>	<p>Covered subject to the applicable copayment. Procedures to reverse a sterilization are not covered.</p>	<p>Covered at the plan coinsurance after the annual deductible has been satisfied. Procedures to reverse a sterilization are not covered.</p>

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Benefit	Inside Network	Outside Network
Temporomandibular Joint (TMJ) Services Inpatient and Outpatient TMJ Services Lifetime Maximum Benefit	Covered subject to the applicable copayment up to a \$1,000 maximum per Member per calendar year. Covered up to \$5,000 per Member.	Covered at the plan coinsurance up to a \$1,000 maximum per Member per calendar year after the annual deductible has been satisfied. Covered up to \$5,000 per Member.
Tobacco Cessation Individual/Group Sessions Approved Pharmacy Products	Covered in full. Covered in full when prescribed and dispensed as part of the GHO-designated tobacco cessation program.	Not covered. Not covered.
Limitations	Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on a non-diseased breast.	Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on a non-diseased breast.
Exclusions	Services or programs not provided or authorized by MHCN staff (except as specified); travel medications; investigational or experimental procedures, drugs and devices; dental care; arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and show inserts for severe diabetic foot disease; convalescent or custodial care; cardiac rehabilitation programs; services covered by first-party insurance; services covered by government and military programs; employment, license, immigration or insurance examinations or reports. Unless otherwise noted as covered, the following services are also excluded: diagnostic testing of sterility, infertility, or sexual dysfunction; work-related conditions (including self-employment, L&I and worker's compensation).	Travel medications; investigational or experimental procedures, drugs and devices; dental care; arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and show inserts for severe diabetic foot disease; convalescent or custodial care; cardiac rehabilitation programs; services covered by first-party insurance; services covered by government and military programs; employment, license, immigration or insurance examinations or reports. Unless otherwise noted as covered, the following services are also excluded: diagnostic testing of sterility, infertility, or sexual dysfunction; work-related conditions (including self-employment, L&I and worker's compensation).

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GROUP HEALTH FREQUENTLY ASKED QUESTIONS:

Do I have to always get a referral from my Group Health primary care doctor to see a specialist?

Not always. You may self-refer for specialty care within a Group Health Facility. If you wish to visit a physician who is contracted with Group Health but does not work in a Group Health facility, you must receive a referral from your primary care physician. You may change your Primary Care Physician at any time. Group Health facilities have the following specialists to whom you can self-refer:

Allergy	Obstetrics/Gynecology
Audiology	Occupational Medicine
Behavioral Health (chemical dependence and mental health)	Oncology
Cardiology	Ophthalmology
Dermatology	Optometry
Free & Clear (tobacco-use cessation)	Orthopedics
Gastroenterology	Otolaryngology
Hematology	Physical Therapy
Hospice	Speech and Language Services
Internal Medicine	Urology
Nephrology	

What is the difference between the Options and the Alliant Plus Plan?

The plan benefits are generally the same. The significant difference is which providers and facilities are considered to be in the network. On the Options plan only Group Health Doctors and Group Health Facilities are part of the network. On the Alliant Plus plan members also receive in-network benefits when they visit Virginia Mason and the Everett Clinic. In order to take advantage of this benefit, one must first choose a Virginia Mason or Everett Clinic primary care physician.

Where is the Everett Clinic?

The Everett Clinic has multiple locations in Snohomish County, including Mukilteo, Marysville, Snohomish, Stanwood, and all over the city of Everett. For detailed information on the Everett Clinic, go to www.everettclinic.com.

Should I Consider Urgent Care?

Sure! Use urgent care when you require prompt attention but your situation does not pose an immediate, serious threat to your health or life. Examples of urgent conditions are increasingly painful ear infections or sprained ankles.

You do not need an appointment for urgent care services. And, going to an urgent care facility can help save you money. The emergency room deductible is \$75 in-network and \$125 out-of network. Urgent care visits are generally treated like a regular office visit.

If you need help finding an urgent care center near you, call GH Consulting Nurse Services toll-free at 1-800-297-6877. Local Group Health urgent care facilities are located at their Capitol Hill, Bellevue, Everett and Tacoma locations, with varying hours of operations. In addition, there are numerous urgent care facilities out-of-network. Check online, or call your nearest urgent care clinic.

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DENTAL POLICY:

Washington Dental Service – Policy #638
 Policy Period: 10/01/2009 – 09/30/2010

Dental Summary of Benefits

WDS Enhanced PPO Plan	Coverage Levels		
Dental Network: To find providers, go to www.deltadentalwa.com	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
Class 1: Preventive and Diagnostic Services -Oral Exams -Cleanings -X-rays	100%	100%	100% of allowable charges
Class 2: Basic Services -Fillings -Simple Extractions -Oral Surgery -Periodontics/Endodontics	90%	80%	80% of allowable charges
Class 3: Major Services -Bridgework -Inlays/Onlays -Crowns -Dentures	50%	50%	50% of allowable charges
Calendar Year Benefit Maximum	\$2,000		
Orthodontia	Adult - 50% to \$1500 lifetime maximum Child - 50% to \$1500 lifetime maximum		
Pre-Determination of Benefits	Before the covered person starts a course of treatment, it may be helpful for that person and his/her dental provider to know in advance, how much of the treatment cost will be covered by the plan and how much will be the responsibility of the covered person. If the course of treatment is expected to be extensive, it is recommended that the covered person obtain a pre-treatment estimate for the insurance company to review. The covered person and his/her provider will be advised of the benefits payable.		
Dependent Limiting Age	Dependents can be covered to age 25.		

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LIFE/AD&D POLICY:

Principal Financial Group – Policy #H40770-1
 Policy Period: 10/01/2009 – 09/30/2010

Life/AD&D Summary of Benefits

Life Insurance Benefit	1 X salary up to \$250,000 maximum benefit
Accidental Death and Dismemberment Benefit	1 X salary up to \$250,000 This benefit may be payable for the total loss of eyesight, hearing, or an extremity that occurs within 12 months of an accident. A partial benefit may also be available. Please refer to the schedule of benefits for details.
Accelerated Death Benefit	Should you become terminally ill, you may be able to access a portion of your life insurance benefit.
Benefit Reduction Schedule -Your benefits will be reduced by the following amounts at the appointed age:	25% at age 65 and an additional 25% at age 70
Coverage During Disability	Should you become totally disabled before age 60, coverage will continue and premium will be waived. You must be totally disabled for 9 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 70, whichever occurs first.
Conversion Privilege	Upon termination of employment, an individual may convert this policy to a permanent policy, provided that written application is made, and the first premium is received within 31 days.

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LONG TERM DISABILITY POLICY:

Principal Financial Group – Policy #H40770-1
 Policy Period: 10/01/2009 – 09/30/2010

Long Term Disability Summary of Benefits

Long Term Disability Benefit	60% of monthly earnings
Elimination Period	90 days of consecutive disability. Benefits become payable on the 91 st day.
Minimum Monthly Benefit	The greater of 10% of pre-disability earnings or \$100
Maximum Monthly Benefit	\$10,000
Mental/Nervous Limitation	24 months
Maximum Benefit Duration	To age 65 or Normal Retirement Age
Survivor Benefit	Yes
Pre-existing Condition Limitation	Benefits will not be paid for a total disability caused by or resulting from a Pre-existing Condition unless the Insured has been Actively at Work for one full day following the end of 12 consecutive months from the date he/she became insured under the plan.
Definition of Disability	Employees qualify as disabled during the elimination period and own occupation period if, because of sickness, injury or pregnancy, they cannot perform the majority of the substantial and material duties of their own occupation, or they are performing the duties of their own occupation on a modified basis or performing any other occupation and experience at least a 20% income loss.
Own Occupation Period and Definition	Own occupation is the occupation you are routinely performing at the time of disability. The own occupation period is the period of time you must be unable to perform the duties of your own occupation. The own occupation period is the first 5 years of the benefit payment period.
Disability Benefits When Working	For employees working during the benefit payment period, the monthly benefit payable for the 24 month work incentive period is the lesser of (1) 100% of indexed pre-disability earnings, less income from other sources, less current earnings or (2) your primary monthly benefit, less income from other sources. Thereafter, the monthly benefit equals your primary monthly benefit, less income from other sources, multiplied by your income loss percentage.
Waiver of Premium	Your premium will be waived if you are determined to be disabled under the provisions of the plan.

Note: Participation in the Long Term Disability Plan is mandatory for all eligible employees of Cornish College of the Arts. In order to provide the maximum benefit to an employee in the event of a long term disability claim, Cornish requires eligible employees to pay 100% of the cost of the long term disability coverage. Cornish will reimburse eligible employees for the cost of the long term disability coverage.

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FLEXIBLE SPENDING PLAN:

Benefit Administration Company
 Plan Year: 10/01/2009 – 09/30/2010

Flexible Spending Plan Summary of Benefits

<p>Program Features</p>	<p>The advantage of participating in a Flexible Benefits Plan is to lower your overall taxable income, thereby increasing your net take-home pay. A new Benefit Election Form must be completed each plan year.</p>
<p>Insurance Premium Plan</p>	<p>You may elect to pay for the cost of dependent insurance coverage (as specified by the IRS) with before-tax dollars through monthly payroll deduction. If you believe you will need/want to drop coverage for yourself or a dependent during the plan year, this may not be the best option for you. You may choose to pay for coverage via after-tax payroll deduction. Coverage for domestic partners is available only through after-tax payroll deduction.</p>
<p>Dependent Care Expense Reimbursement Plan</p>	<p>You may elect to set aside money on a pre-tax basis for dependent care expenses (i.e. daycare or eldercare). If you elect to set money aside in the account, your eligibility for a Dependent Care Tax Credit on your tax return will be affected. Please consult your tax advisor or accountant for details. The Dependent Care annual election maximum is \$5,000 per calendar year.</p>
<p>Health Care Expense Reimbursement Plan</p>	<p>You may elect to set aside dollars on a pre-tax basis to fund medical/dental expenses not covered under the group health care plans. The Health Care plan year election maximum is \$1,500 for an employee who has worked at Cornish less than one year; and \$3,500 for an employee who has worked at Cornish for one or more years.</p>
<p>Convenient <u>Debit Card Option</u> for the Health Care Expense Reimbursement Plan</p>	<p>You may elect to use the money in your Health Care Expense Reimbursement Plan by using a debit card. The card is funded with your annual election amount, and may be used at drug stores and doctor's offices for copays and other eligible expenses. BE SURE TO KEEP YOUR RECEIPTS, as you will be required to substantiate your debit card charges. If you make a debit card transaction that you cannot substantiate with a receipt, you must reimburse the plan for the unsubstantiated charge. If you wish to use the debit card, you will need to sign up and check the box authorizing an \$18 deduction from your September paycheck to pay for the card's annual membership fee.</p>

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Flexible Spending Plan Frequently Asked Questions:

What if the plan year ends and I haven't used all the money I have contributed?

In the past, whatever funds had not been used, were forfeited. However, IRS rules have changed, and Cornish has elected to allow a 2.5 month extension of the plan year for the Health Care Expense Reimbursement Plan. This means that if you have not used all the money in your account, you have an additional 2.5 months after the plan year ends during which to incur and be reimbursed for eligible expenses under the plan.

How late can I submit a request for reimbursement from Benefit Administration Company?

You have 90 days after the end of the plan year to submit a reimbursement request of expenses that were incurred during the plan year.

Can I move money from my Health Care Account to my Dependent Care Account?

No. Money cannot be transferred between accounts. Dollars designated for health care can be spent for health care only, and dollars set aside for dependent care can be spent only on dependent care.

When can I change the amount of money I am putting towards my Health Care Account?

After making a salary-reduction election (pre-tax premiums) at the beginning of the Plan Year, no changes may be made unless there is a qualifying change in family status, as defined by the IRS. Examples include: Marriage, divorce, and birth of a child.

When can I change the amount of money I am putting towards my Dependent Care Account?

You may be allowed to change the amount of money you defer to the Dependent Care Account if your daycare expenses change or cease.

What expenses are not eligible for reimbursement?

Dependent Care: Expenses that are not reimbursable include overnight camp, diapers, late payment charges, and care provided while you and your spouse are not working.

Health Care: Examples of expenses that are not eligible for reimbursement include insurance premiums, most cosmetic procedures, and vitamins.

How do I submit for reimbursement?

Claim forms may be obtained from your Benefits Website at www.ourpasswordpage.com (password cca), at Human Resources, or by contacting Benefit Administration Company. Complete a claim form and submit it via mail or fax with your receipt to:

Benefit Administration Company

P.O. Box 550

Seattle, WA 98111-0550

Fax: (206) 682-8016

This Outline is for illustrative purposes only. Actual Claims paid are subject to the terms and conditions of the contract. If there are any discrepancies between this outline and the group contract, the group contract will prevail.



ANNUAL NOTICES

The Women's Health and Cancer Rights Act of 1998

Did you know that your medical plan, as required by the Women's Health and Cancer Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy?

Please refer to your medical plan Summary Plan Description for details, or contact your Plan Administrator for more information.

Newborn Act

Did you know that your medical plan, as required by the Newborns' and Mothers' Health Protection Act, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section?

Please refer to your medical plan Summary Plan Description for details, or contact your Plan Administrator for more information. Please be aware that in order to add a newborn dependant to the plan, you would need to submit your enrollment change application to Human Resources **within 60 days of the event.**

Special Enrollment Rights

Did you know that if your family experiences a qualified change in family status, that you and/or your dependents can enroll in the group insurance plans? Qualified changes include marriage, birth or adoption of a child, or a loss of coverage under another group plan.

Please refer to your medical plan Summary Plan Description for details, or contact your Plan Administrator for more information. Please be aware that in the event of a qualified change in family status, you would need to submit your enrollment change application to Human Resources **within 31 days of the event.**

Notice of Availability & Notice of Privacy Practices

Because Cornish College of the Arts sponsors a Flexible Benefits Plan administered by a Third-Party, we must supply this HIPAA "Notice of Availability" at least every three years.

What is the "Notice of Privacy Practices?" The Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Your plan's Notice of Privacy Practices is available and you can obtain a copy by going to the Benefits Website at www.ourpasswordpage.com (please request password from HR)

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Sprague Israel Giles, Inc.

1501 4th Ave, #2000, Seattle WA 98101-1637

(206) 623-7035



Employee Assistance Plan (EAP) Benefits Summary Fully Effective Employees (FEE)

CONFIDENTIAL EMPLOYEE RESOURCE	
<p>Employee Assistance Line 24-hour toll-free telephone 1.800.648.5834</p>	<p>Direct one-to-one telephone assessment and referral counseling for eligible Cornish employees or their dependents who may be dealing with personal problems and concerns, such as depression, substance abuse, marriage or family problems, stress, grief and conflict. FEE will assess and develop options or alternatives for the resolution of such problems.</p> <p>Includes referrals for up to three (3) visits per incident, with a local counselor.</p>
<p>Self-Help Website: www.fee-eap.com Please ask HR for Password and Login</p>	<p>Access to information on more than 40 topic areas; Links to medication information, self-tests/questionnaires, glossary and newsletters. A great place for employees to begin exploring solutions in difficult times.</p>
<p>Financial and Legal Services Same number and website as above. Special ID and password are required for this portion of the site. Click on the "Legal/Financial" link on the left side of screen. Please ask HR for Password and ID</p>	<p>Provides basic financial and legal advice for common financial and legal problems by telephone.</p> <p>Access to information on many topics from budgeting to divorce mediation. Lists of local attorneys and financial advisors with discounted rates for eligible Cornish employees and their family members.</p>

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**Premium Rates:
10/1/09-9/30/2010**

Group Health Options

	Total Monthly Premium	Monthly Cost to Employee *
Employee Only	\$480.13	\$0.00
Employee & Spouse/Domestic Partner	\$960.26	\$480.13
Employee, Spouse, & Child	\$1,233.99	\$753.86
Employee, Spouse, & Children	\$1,454.47	\$974.34
Employee & Child	\$753.86	\$273.73
Employee & Children	\$974.34	\$494.21

Group Health Alliant Plus

	Total Monthly Premium	Monthly Cost to Employee *
Employee Only	\$494.03	\$13.90
Employee & Spouse/Domestic Partner	\$988.06	\$507.93
Employee, Spouse, & Child	\$1,269.42	\$789.29
Employee, Spouse, & Children	\$1,496.30	\$1,016.17
Employee & Child	\$775.39	\$295.26
Employee & Children	\$1,002.27	\$522.14

*Core and Ranked Adjunct faculty who have chosen an 8-pay option will have payroll deductions higher than those listed above, as twelve months of premiums are divided over eight paychecks. Faculty members may contact HR for specific deduction amounts.

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**Premium Rates:
10/1/09-9/30/2010**

Washington Dental Service

	Total Monthly Premium	Monthly Cost to Employee *
Employee Only	\$60.81	\$0.00
Employee & Spouse/Domestic Partner	\$121.82	\$61.01
Employee, Spouse & Child(ren)	\$215.22	\$154.41
Employee & Child(ren)	\$154.21	\$93.40

*Core and Ranked Adjunct faculty who have chosen an 8-pay option will have payroll deductions higher than those listed above, as twelve months of premiums are divided over eight paychecks. Faculty members may contact HR for specific deduction amounts.

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