

EMPLOYEE BENEFITS SUMMARY

for

Cornish College of the Arts

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SEATTLE, WA 98121

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Plan Year October 1, 2011 – September 30, 2012



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MEDICAL POLICY:

Base Plan: Group Health Options – Policy #0614000
Buy-Up Plan: Group Health Alliant Plus – Policy #5096100
Policy Period: 10/01/2011 – 09/30/2012

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.	\$20 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Outpatient Services (Office Visits) Covered outpatient medical and surgical services	\$20 copayment per Member per visit.	\$20 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Allergy testing	Covered subject to the outpatient services copayment.	\$20 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Oncology (radiation therapy, chemotherapy)	Covered subject to the outpatient services copayment.	\$20 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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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.	\$20 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.	\$20 copayment then covered at the plan coinsurance after the annual deductible is satisfied.

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Benefit	Inside Network	Outside Network
Dependent Limiting Age	Dependents can be covered to age 26.	Dependents can be covered to age 26.
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. Pre-authorization must be obtained before coverage will be extended for complex imagining such as CAT and PET scans, or MRIs.
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 \$75 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 \$20 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. \$20 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.	\$20 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 at a GHO-approved mental health care facility.	Covered at the plan coinsurance after the annual deductible is satisfied at a GHO-approved mental health care facility.
Outpatient Services	Covered subject to the applicable outpatient services copayment.	\$20 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
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.	\$20 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.

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Benefit	Inside Network	Outside Network
Organ Transplants	Covered subject to applicable copayments.	Covered at the plan coinsurance after the annual deductible is satisfied. Transplant services must be received at a facility authorized in advance by Group Health.
Pre-Existing Condition Waiting Period	None.	None.
Preventive Services (Well Adult and Well Child Physicals, Immunizations, Pap Smears, Mammograms)	Covered in full when in accordance with the well-care schedule established by Group Health. Excluded are physicals for travel, employment, insurance, license, etc.	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.
Rehabilitation Services Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under	Covered up to sixty (60) days per calendar year, subject to the applicable inpatient services copayment.	Covered up to sixty (60) days per calendar year, at the plan coinsurance after the annual deductible is satisfied.
Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under	Covered up to sixty (60) visits per calendar year, subject to the outpatient services copayment.	Covered up to sixty (60) visits per calendar year. \$20 copayment then covered at the plan coinsurance after the annual deductible is satisfied.
Skilled Nursing Facility (SNF)	Covered in full up to sixty (60) days per Member per calendar year.	Covered up to sixty (60) days per Member per calendar year, at the plan coinsurance after the annual deductible is satisfied.
Sterilization (Vasectomy, Tubal Ligation)	Covered subject to the applicable copayment. Procedures to reverse a sterilization are not covered.	Covered at the plan coinsurance after the annual deductible has been satisfied. Procedures to reverse a sterilization are not covered.
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.

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Benefit	Inside Network	Outside Network
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	<p>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.</p> <p>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).</p>	<p>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.</p> <p>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).</p>

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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 copayment is \$75. 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: 10/01/2011 – 09/30/2012

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
Policy 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 26.		

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LIFE/AD&D POLICY:

Mutual of Omaha – Policy #G000AG9V
 Policy Period: 10/01/2011 – 09/30/2012

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 up to 75% 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 50% 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 3 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:

Mutual of Omaha – Policy #G000AG9V
 Policy Period: 10/01/2011 – 09/30/2012

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 at least one of the substantial and material duties of their own occupation, and they experience at least a 1% income loss. After the first 5 years, an income loss of 15% is required in order to be classified as disabled.
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 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.
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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VOLUNTARY LIFE/AD&D POLICY:

Mutual of Omaha – Policy #G000AG9V
 Policy Period: 10/01/2011 – 09/30/2012

Voluntary Life/AD&D Summary of Benefits

<p>Life Insurance Benefit</p>	<p>For Employees: Voluntary minimum benefit is \$10,000 Benefit amounts may be elected in increments of \$10,000, to a maximum of 5 times your annual salary</p> <p>For Spouses/Domestic Partners: Coverage may be elected in increments of \$5,000. The election may not exceed 50% of the employee’s elected benefit amount</p> <p>For Children: Coverage may be elected in increments of \$2,000. The election may not exceed 50% of the employee’s elected benefit amount</p>
<p>Accidental Death and Dismemberment Benefit</p>	<p>This amount matches your elected life insurance benefit</p> <p>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.</p>
<p>Guaranteed Issue Amount</p>	<p>Newly eligible employees may elect the lesser of 5 times salary or \$100,000 without answering health questions.</p> <p>Newly eligible spouses/Domestic Partners are eligible for \$50,000 without health questions, and children are eligible for \$10,000 without health questions.</p>
<p>Accelerated Death Benefit</p>	<p>Should you become terminally ill, you may be able to access up to 75% of your life insurance benefit.</p>
<p>Benefit Reduction Schedule -Your benefits will be reduced by the following amounts at the appointed age:</p>	<p>25% at age 65 50% at age 70</p>
<p>Coverage During Disability</p>	<p>Should you become totally disabled before age 60, coverage will continue and premium will be waived. You must be totally disabled for 3 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 70, whichever occurs first.</p>
<p>Portability and Conversion Privilege</p>	<p>Upon termination of employment, an individual may continue insurance without having to provide evidence of insurability. In addition, upon termination of employment, you may convert this policy to a permanent policy.</p>

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VOLUNTARY SHORT TERM DISABILITY POLICY:

Mutual of Omaha – Policy #G000AG9V
 Policy Period: 10/01/2011 – 09/30/2012

Voluntary Short Term Disability Summary of Benefits

Short Term Disability Benefit	60% of monthly earnings
Elimination Period	14 days of consecutive disability. Benefits become payable on the 15th day.
Minimum Monthly Benefit	\$25
Maximum Weekly Benefit	\$1,500
Maximum Benefit Duration	Short term disability benefits are available for up to 11 weeks
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 6 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 at least one of the substantial and material duties of their own occupation, and they experience at least a 1% income loss.
Partial Disability Benefits	If you become disabled and can work part-time but not full-time, you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
Disability Benefits When Working	For employees working during the benefit payment period, the monthly benefit payable 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.
Waiver of Premium	Your premium will be waived if you are determined to be disabled under the provisions of the plan.

Note: Participation in this Short Term Disability Plan is voluntary for all eligible employees of Cornish College of the Arts. If you elect coverage, you will pay the premium through payroll deduction with after-tax dollars. Any benefit will be tax-free.

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FLEXIBLE SPENDING PLAN:

Benefit Administration Company
 Plan Year: 10/01/2011 – 09/30/2012

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.</p> <p>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.</p> <p>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.</p> <p>The Health Care plan year election maximum is \$1,500 for an employee who has worked at Cornish less than one year; and \$4,500 for an employee who has worked at Cornish for one or more years.</p>
<p>Convenient Debit Card Option 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.</p> <p>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. As of January 1, 2011, over-the-counter medicines and drugs are reimbursable with a physician's prescription.

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
Phone: (206) 625-1800

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MEDICAID & THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Free Or Low-Cost Health Coverage for Children And Families In Washington State.

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage.

Washington State uses funds from the Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, 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, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

You may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility.

Website: <http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm>

Phone: 1-877-543-7669

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Sprague Israel Giles, Inc.

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

(206) 623-7035



APPLE HEALTH FOR KIDS

If your monthly family income is below the amounts listed on the chart on the below, your children may qualify for Apple Health for Kids - either as free medical coverage or as low-cost health insurance for children under age 19.

Remember to include all adults in the family, and remember that a pregnant woman counts as two people when determining household size.

Calculate your income on this website: http://hrsa.dshs.wa.gov/AppleHealth/am_i_eligible.shtml
 Read the FAQ's: http://hrsa.dshs.wa.gov/AppleHealth/more_information.shtml

Other programs are available for families and pregnant women. Call 1-800-562-3022 toll-free to ask about that coverage or visit your local DSHS Community Service Office to find out more. (A locator is available on line for the addresses and phone numbers of all DSHS offices statewide.)

See income chart below to determine possible program eligibility.

Family size	THESE INCOME LEVELS QUALIFY FOR: Free health insurance		THESE INCOME LEVELS QUALIFY FOR: \$ 20 monthly premium per child. No family pays more than \$40.		THESE INCOME LEVELS QUALIFY FOR: \$ 30 monthly premium per child. No family pays more than \$60.	
	Monthly Income	Annual Income	Monthly Income	Annual Income	Monthly Income	Annual Income
1	Up to \$1,815	Up to \$21,780	Up to \$2,269	Up to \$27,228	Up to \$2,723	Up to \$32,676
2	Up to \$2,452	Up to \$29,424	Up to \$3,065	Up to \$36,780	Up to \$3,678	Up to \$44,136
3	Up to \$3,089	Up to \$37,068	Up to \$3,861	Up to \$46,332	Up to \$4,633	Up to \$55,596
4	Up to \$3,725	Up to \$44,700	Up to \$4,657	Up to \$55,884	Up to \$5,588	Up to \$67,056
5	Up to \$4,362	Up to \$52,344	Up to \$5,453	Up to \$65,436	Up to \$6,543	Up to \$78,516
6 or more	Add \$627 for each additional child	Add \$7,644 for each additional child	Add \$796 for each additional child	Add \$9,552 for each additional child	Add \$955 for each additional child	Add \$11,460 for each additional child

If your income is close to these amounts but over, you are still encouraged to call 1-877-543-7669. Individuals need to contact their State's Medicaid or CHIP program to determine if they are eligible for Medicaid or CHIP, and to see if their State will subsidize group health plan premiums. If they are eligible for a premium subsidy, they need to contact their plan administrator or employer to take advantage of the new special enrollment opportunity and enroll in the group health plan. Individuals needing assistance or with questions about the application of these provisions to their employment-based group health plan can call toll free 1.866.444.3272 (EBSA) to speak to a Benefits Advisor.

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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 (password: "cca")

Genetic Information Nondiscrimination Act of 2008

Did you know that the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information, and expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)?

GINA provides that group health plans and health insurance issuers cannot base premiums for an employer on genetic information, and generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. GINA generally prohibits employer and insurers from offering rewards in return for collection of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA).

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Planning for Retirement

Cornish College of the Arts has established both a Defined Contribution Retirement Plan for eligible employees, and provides the opportunity for all employees to contribute to an Individual Tax-Deferred Annuity.

Defined Contribution Retirement Plan – For Eligible Employees

Eligible employees will be notified when they become eligible for the Defined Contribution Retirement Plan. The College contributes an amount equal to eight percent of your gross monthly wages to the retirement plan. You will choose how the money is invested in the plan. Please contact HR for information about eligibility and investment options.

Individual Tax-Deferred Annuity – For All Employees

All employees are encouraged to contribute to their retirement. Cornish College of the Arts has made supplemental retirement accounts available through TIAA-CREF and Fidelity Investments. You may choose to contribute to either or both plans. Contributions are made through payroll deduction on a pre-tax basis, thus reducing your current taxable income. You can choose your investment options within the plan. You keep the money invested until retirement. During retirement, withdrawals from the plan are taxable income to you.

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

<u>CONFIDENTIAL</u> 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 User ID: r110 Password: fee-eap</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. User Name: 0770 Password: 0770</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:
10/1/11-9/30/2012**

Group Health Options

	Total Monthly Premium	Monthly Cost to Employee *
Employee Only	\$608.53	\$0.00
Employee & Spouse/Domestic Partner	\$1,217.06	\$608.53
Employee, Spouse, & Child	\$1,564.00	\$955.47
Employee, Spouse, & Children	\$1,843.44	\$1,234.91
Employee & Child	\$955.47	\$346.94
Employee & Children	\$1,234.91	\$626.38

Group Health Alliant Plus

	Total Monthly Premium	Monthly Cost to Employee *
Employee Only	\$625.92	\$17.39
Employee & Spouse/Domestic Partner	\$1,251.84	\$643.31
Employee, Spouse, & Child	\$1,608.31	\$999.78
Employee, Spouse, & Children	\$1,895.76	\$1,287.23
Employee & Child	\$982.39	\$373.86
Employee & Children	\$1,269.84	\$661.31

*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:
10/1/11-9/30/2012**

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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