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**IASIS Healthcare
Welfare Benefit Plan**

**Summary of Material
Modifications**



Summary of Material Modifications
for the
IASIS Healthcare Welfare Benefit Plan

**WELFARE BENEFIT PLAN
SUMMARY OF PLAN CHANGES EFFECTIVE JANUARY 1, 2011**

Many important changes have been made to the IASIS Healthcare Welfare Benefit Plan as described in the 2010 Summary Plan Description (SPD.) This notice, called a “Summary of Material Modifications,” (SMM) advises you of changes made to your employer-sponsored Welfare Plan.

Please do two things:

1. read the notice carefully, and
2. keep this notice with the SPD that describes your Welfare Benefit Plan.

The IASIS Healthcare Welfare Benefit Plan is identified by both the sponsoring employer’s federal identification number and the plan number.

Sponsoring Employer's Federal Identification Number: -----20-1150104

This is the number used to identify the sponsoring employer with certain government agencies.

Plan Number: -----501

This is the number used to identify the plan in reports to the government.

Several sections throughout the SPD have been changed. Some sections have been changed in their entirety, while other sections have less broad changes. The changes described below follow the order of the SPD. The section that has been changed is labeled in bold type.

Article III. Eligibility and Participation

This section has been changed to include new dependent eligibility information.

In order for your dependents to be covered under the Plan, you must list them on the on-line enrollment, and they must meet all dependent eligibility criteria established by the Employer, and be:

1. Your spouse who is legally married to you and who is considered your spouse for federal income tax purposes. The following are not eligible for coverage under the Plan:
 - a. your spouse if you are legally separated,
 - b. your spouse if you have been physically separated for six months or more,
 - c. your former spouse if you are divorced, even if your divorce decree requires you to cover your former spouse, or
 - d. your common law spouse, civil union spouse, or domestic partner (same sex or opposite sex.)
2. Your or your spouse's (defined above) (1) natural child; (2) legally adopted child (including children placed for adoption); (3) step-child; (4) foster child; or (5) child for whom you or your spouse is the legal guardian; who are:
 - a. less than 26 years old;
 - b. for Optional Dependent Life Insurance and Accidental Death and Dismemberment coverage only, unmarried.

An Incapacitated Child of you or your spouse who is over age 26 is also eligible for medical, dental, and vision coverage under the Plan. See Summary Plan Description Section 11.9 for definition.

The child of your or your spouse's child is not eligible for coverage under the Plan unless you are the legal guardian of that child.

The remainder of this SPD section is unchanged.

Article XII. Benefit Programs and Providers

The Health Care FSA and Employee Assistance Program (EAP) providers have changed.

Provider	Program/ Coverage Type	Require Pre-tax Contributions?	Policy or Group Number	Who is Eligible/When Eligibility for Participation Begins	For Questions, or to File a Claim, Contact:
PBS/ Wage Works	Health Care FSA	Yes	28458	Full time employees (refer to Eligibility and Participation section of SPD)	www.wage works.com or (877) 942-3967
Value Options	Employee assistance program (EAP)	N/A (employer provided)	— —	All employees (refer to Eligibility and Participation section of SPD.)	www.achie vementsolutions. net/IASIS or (877) 798-8793

Medical Plan

The **cover page** is amended as follows:

Deleted: Non-tiered \$250 PPO Plan
 Non-tiered \$500 PPO Plan

Replaced:
 Non-tiered \$500 PPO Plan
 Non-tiered \$750 PPO Plan
 Non-tiered \$1,000 PPO Plan

Lifetime Maximum

This section has been deleted; there is no lifetime benefit maximum under the Plan. Any references to Lifetime Maximum throughout this section are eliminated.

BlueCard/BlueCard PPO Program

The fourth paragraph has been deleted and replaced with the following:

Show Your membership ID card (that has the “PPO in a suitcase” logo) to any BlueCard/BlueCard PPO Participating Provider. The BlueCard/BlueCard PPO Participating Provider can verify Your membership, eligibility and Coverage with Your BlueCross BlueShield Plan. When You visit a BlueCard/BlueCard PPO Participating Provider, You should not have claim forms to file. After You receive services, Your claim is electronically routed to BCBST, which processes it and sends You a detailed explanation of benefits. You are responsible for any applicable Copayments, or Your Deductible and Coinsurance payments (if any). If We pay such amounts to a healthcare provider on your behalf, We may collect those cost-sharing amounts directly from You.

Claims and Payment

Payment

The sixth and seventh paragraphs have been deleted and replaced with the following:

When a claim is paid or denied, in whole or part, We will produce an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The administrator will make the EOB available to you at www.bcbst.com or by calling the customer service department at the number listed on Your membership ID card.

You are responsible for paying any applicable Copayments, Coinsurance or Deductible Amounts to the Provider. If We pay such amounts to a healthcare provider on your behalf, We may collect those cost-sharing amounts directly from You.

Payment for Covered Services is more fully described in Attachment C: Schedule of Benefits.

Grievance Procedure

This section has been deleted and replaced with the following language.

Grievance Procedure

Introduction

Our Grievance procedure (the “Procedure”) is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact the customer service department at the number listed on the membership ID card: (1) to file a Claim; (2) if You have any questions about this EOC or other documents related to Your Coverage (e.g., an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

1. This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this EOC. Any decision to award damages must be based upon the terms of this EOC.
2. The Procedure can only resolve Disputes that are subject to Our control.
3. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
4. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post service claims (“Claims”), that are in the Employee Retirement Income Security Act of 1974 (“ERISA”); Rules and Regulations for Administration and Enforcement; Claims Procedure (the “Claims Regulation”).

An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service.

- If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to Us to obtain a determination concerning whether the Plan will cover that service.
 - Providers may also appeal an Adverse Benefit Determination through Our Provider dispute resolution procedure.
 - A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until a final Adverse Benefit Determination has been rendered in a matter being appealed through the Provider dispute resolution procedure.
5. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
6. We, the Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute.
7. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA and this EOC.

Description of the Review Procedures

Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact the customer service department if You have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

First Level Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that Dispute.

Contact the customer service department at the number listed on Your membership ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory. BCBST is a limited fiduciary for the first level Grievance.

Grievance Process

After We have received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, We will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Plan is not otherwise governed by ERISA.

Written Decision

The committee or reviewers will consider the information presented, and You will receive a written decision concerning Your Grievance as follows:

- For a pre-service claim, within 30 days of receipt of Your request for review;
- For a post-service claim, within 60 days of receipt of Your request for review; and
- For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

The decision of the Committee will be sent to You in writing and will contain:

- A statement of the committee's understanding of Your Grievance;
- The basis of the committee's decision; and
- Reference to the documentation or information upon which the committee based its decision. You may receive a copy of such documentation or information, without charge, upon written request.

Second Level Grievance

Employer does not have a second level Grievance.

Independent Review

If Your Grievance involves a Medical Necessity determination, then after completion of the mandatory first level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by Us, to independently review and resolve such Dispute(s). Your request for independent review must be submitted in writing within 180 days after the date You receive notice of the decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the decision. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under the Plan. If You request independent review of an ERISA Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil action against the Employer or Employer's Plan, until the independent reviewer makes its decision.

The Employer or Employer's Plan will pay the fee charged by the independent review organization and its reviewers if You request that the Plan submit a Dispute to independent review. You will be responsible for any other costs that You incur to participate in the independent review process, including attorney's fees.

We will submit the necessary information to the independent review entity within 5 business days after receiving Your request for review. We will provide copies of Your file, excluding any

proprietary information to You, upon written request. The reviewer may also request additional medical information from You. You must submit any requested information, or explain why that information is not being submitted, within 5 business days after receiving that request from the reviewer.

The reviewer must submit a written determination to Us and We will submit the determination to You within 45 days after receipt of the independent review request. In the case of a life threatening condition, the decision must be issued within 72 hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to 5 business days to issue a determination to consider additional information submitted by Us or You.

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of this EOC and the ASA; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of Coverage of the ASA.

No action at law or in equity shall be brought to recover on this EOC until 60 days after written proof of loss has been furnished as required by this EOC. No such action shall be brought beyond 3 years after the time written proof of loss is required to be furnished.

Eligible Services

Preventive Services

This section has been deleted and replaced in its entirety.

Medically Necessary and Appropriate services for assessing physical status and detecting abnormalities. The frequency of visits is based on guidelines from BCBST's Medical Policy.

Covered

- Well Child Care to age 6 including immunizations and other appropriate diagnostics. Once the member reaches age 6, well care services are provided as described below:
- Well Care Services: Well Care Services are preventive health services for Members ages 6 and older, as recommended by BCBST preventive health care guidelines. Well Care Services include:
 - Annual health care exam including blood pressure screening, cholesterol screening, and vision and hearing screenings performed by a physician during the preventive health exam.
 - Periodic colorectal screening.
 - Immunizations including Tetanus-Diphtheria booster, pneumococcal immunization, other recommended immunizations for ages 6 and older.
 - Prescribed x-ray and lab screenings associated with preventive care.
- A Well Woman Exam every Calendar Year, including any follow-up care. This visit includes mammogram and cervical cancer screenings.
- Prostate screenings
- Influenza immunizations, including nasal spray flu vaccines payable up to the Maximum Allowable Charge for an influenza immunization injection.

Some of these services are not needed every year, or may be appropriate only for people of particular age groups, gender, or those who meet other specific health criteria.

Exclusions

Services not recommended by the guidelines from the administrator's Medical Policy.

Attachment B: Exclusions from Coverage

Item 24 is deleted and replaced in its entirety.

24. Growth Hormone Replacement Therapy is not Covered except for: (1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed and who at initiation of therapy are more than two standard deviations below the mean for chronological age; (2) growth hormone replacement therapy prior to renal transplant in children whose epiphyses have not closed and who also have chronic renal insufficiency (glomerular filtration rate GFR less than 60ml/minute/1.73 squared); (3) Members diagnosed with Turner Syndrome; (4) Members diagnosed with Noonan Syndrome; (5) Members diagnosed with Prader-Willi Syndrome and confirmed by appropriate genetic testing; (6) Members with decreased hypothalamic function due to any of the following reasons: pituitary tumor, pituitary surgical damage, trauma or cranial irradiation; or (7) Members diagnosed with pituitary Dwarfism.

Maternity care	100% after \$20 Copayment (Copayment applies to first visit only)	50% of the Maximum Allowable Charge after Deductible
Injections and Immunizations		
Allergy injections and allergy extract	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
All other injections	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
Diagnostic Services and Preventive Screenings (e.g. x-ray and labwork)		
Allergy Testing	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
<p>Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies</p> <p>Advanced Radiological Imaging services require Prior Authorization. If Prior Authorization is not obtained, benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
All Other Diagnostic Services for illness or injury	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
Other office procedures, services or supplies		
Office Surgery, including anesthesia Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained,	100% after \$20 Copayment 100% after \$30 Copayment	50% of the Maximum Allowable Charge after Deductible 50% of the Maximum Allowable Charge after Deductible

<p>benefits may be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.</p> <p>Surgeries include invasive diagnostic services (e.g., endoscopy).</p> <p>Primary Care Practitioners All other Practitioners</p>		
<p>Therapy Services: Physical, speech, and occupational limited to 30 visits per therapy per Calendar Year; Cardiac and pulmonary rehab limited to 30 visits per Calendar Year Chiropractic care limited to 20 visits per Calendar Year</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
<p>Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions.</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
All Other Office services	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Services Received at a Facility		
<p>Inpatient Hospital Stays, including maternity stays: Prior Authorization required. Benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		

Facility charges	90% after Deductible	\$2,500 Copayment per admission, then 50% of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehab Facility stays (Limited to 60 days per Calendar Year) Prior Authorization required. Benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hospital Emergency Care Services		
Emergency Room charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
All Other Hospital charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Practitioner Charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Weight Loss Surgery Limited to 1 surgery per lifetime, unless Medically Necessary Complications covered only if original surgery was performed at an IASIS facility and approved by the Plan Eligibility: Employees: After 1 year of being benefit-eligible under the Plan Spouses: After 2 years of being benefit-eligible under the Plan Dependent Children: Not eligible for Coverage of weight loss surgery or for complications due to weight loss surgery		
Facility charges	IASIS facility: \$2,500 Copayment, then 100% Other facilities: Not Covered	Not Covered
Practitioner Charges	IASIS facility: 100% after facility Copayment Other facilities: Not Covered	Not Covered

Outpatient Facility Services		
Outpatient Surgery		
Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Surgeries include invasive diagnostic services (e.g., endoscopy).		
Facility charges	90% after Deductible	\$500 Copayment per procedure, then 50% of the Maximum Allowable Charge after Deductible
Practitioner charges	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Outpatient Diagnostic Services		
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies. Advanced Radiological Imaging services require Prior Authorization. If Prior Authorization is not obtained, benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
All other Diagnostic Services for illness or injury	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Other Outpatient procedures, services, or supplies		
Therapy Services: Physical, speech, and occupational limited to 30 visits per therapy per Calendar Year; Cardiac and pulmonary	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

rehab limited to 30 visits per Calendar Year Chiropractic care limited to 20 visits per Calendar Year		
DME, Orthotics and Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Other Services		
Ambulance	100%	100% of the Maximum Allowable Charge
Home Health Care Services, including home infusion therapy Prior Authorization is required for skilled nurse visits in the home. Therapy provided in the home does not require Prior Authorization. Limited to 60 visits per Calendar Year	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hospice Care Prior Authorization is required.	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

Organ Transplant Services			
<p>Organ Transplant Services, all transplants except kidney ³</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.</p>	<p>In-Transplant Network</p> <p>benefits:</p> <p>80% after Network Deductible, Network Out-of-Pocket Maximum applies.</p>	<p>Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee): ⁴</p> <p>80% of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered.</p>	<p>Out-of-Network Providers: 50% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not covered.</p>
<p>Organ Transplant Services, kidney transplants ³</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization.</p>	<p>Network Providers: 80% after Network Deductible; Network Out-of-Pocket Maximum applies.</p>	<p>Out-of-Network Providers: 50% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not covered.</p>	

**Schedule of Behavioral Health Services
Inpatient-Only Utilization Review**

<p>Benefit percentages apply to BCBST Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers and Non-Contracted Providers.</p>	<p align="center">Member Payment for Covered Services received from Network Providers</p>	<p align="center">Member Payment for Covered Services received from Out-of-Network Providers</p>
<p>Inpatient Behavioral Health Services: Inpatient Treatment (including Acute care treatment, partial hospital treatment, residential treatment, electro-convulsive therapy (ECT) and intensive outpatient treatment)</p>		
<p>Facility Charges</p>	<p align="center">90% after Deductible</p>	<p>\$2,500 Copayment per admission, then 50% of the Maximum Allowable Charge after Deductible</p>
<p>Practitioner charges</p>	<p align="center">90% after Deductible</p>	<p>50% of the Maximum Allowable Charge after Deductible</p>
<p>Outpatient Behavioral Health Services: Outpatient treatment (outpatient visits to professionals provided in a Practitioner’s office or community mental health center).</p>	<p align="center">100% after \$20 Copayment</p>	<p>50% of the Maximum Allowable Charge after Deductible</p>

Miscellaneous Limits:	In-Network Providers	Out-of-Network Providers
Lifetime Maximum	Unlimited	
	In-Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Deductible		
Individual	\$500	\$1,500
Family	\$1,000	\$3,000
Out-of-Pocket Maximum		
Individual	\$2,500	\$7,500
Family	\$5,000	\$15,000
Pre-existing Condition Waiting Period	None	
4 th Quarter Deductible Carryover	Excluded	

- Benefit percentages apply to BCBST Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Member is responsible for any amount exceeding Maximum Allowable Charge for services received from Non-Contracted Providers.
- Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers.
- All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.
- Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.
- Benefits will be reduced by 30% for Network and Out-of-Network Providers when Prior Authorization is not obtained.

EVIDENCE OF COVERAGE

ATTACHMENT C: PPO SCHEDULE OF BENEFITS—NON-TIERED \$750 PLAN

Group Name: IASIS HEALTHCARE, LLC

Group Number: 82045

Effective Date: January 1, 2011

The Employer has selected the Blue Network P Provider network. To receive the maximum benefit from Your PPO Plan, make sure Your Provider is a member of the Blue Network P Provider network.

Covered Services	Member Payment for Covered Services received from Network Providers ¹	Member Payment for Covered Services received from Out-of-Network Providers ²
Preventive Health Care Services		
Well Child Care (to age 6)	100%	Not Covered
Well Woman Exam	100%	Not Covered
Mammogram, Cervical cancer Screening and Prostate cancer Screening	100%	Not Covered
Immunizations	100%	Not Covered
Well Care Services (ages 6 and up)	100%	Not Covered
Other Well Care Screenings, age 6 and above, including flexible sigmoidoscopy or colonoscopy	100%	Not Covered
Services Received at the Practitioner's office		
Office Exams and Consultations		
Diagnosis and treatment of injury or illness Primary Care Practitioner types Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics & Gynecology, Physician Assistant, Nurse Practitioner All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician.	100% after \$20 Copayment 100% after \$30 Copayment	50% of the Maximum Allowable Charge after Deductible 50% of the Maximum Allowable Charge after Deductible
Maternity care	100% after \$20 Copayment (Copayment applies to first visit only)	50% of the Maximum Allowable Charge after Deductible
Injections and Immunizations		
Allergy injections and allergy extract	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible

All other injections	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
Diagnostic Services and Preventive Screenings (e.g. x-ray and labwork)		
Allergy Testing	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
<p>Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies</p> <p>Advanced Radiological Imaging services require Prior Authorization. If Prior Authorization is not obtained, benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
All Other Diagnostic Services for illness or injury	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
Other office procedures, services or supplies		
<p>Office Surgery, including anesthesia</p> <p>Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in</p>	<p>100% after \$20 Copayment</p> <p>100% after \$30 Copayment</p>	<p>50% of the Maximum Allowable Charge after Deductible</p> <p>50% of the Maximum Allowable Charge after Deductible</p>

<p>Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.</p> <p>Surgeries include invasive diagnostic services (e.g., endoscopy).</p> <p>Primary Care Practitioners All other Practitioners</p>		
<p>Therapy Services: Physical, speech, and occupational limited to 30 visits per therapy per Calendar Year; Cardiac and pulmonary rehab limited to 30 visits per Calendar Year Chiropractic care limited to 20 visits per Calendar Year</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
<p>Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions.</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
All Other Office services	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Services Received at a Facility		
<p>Inpatient Hospital Stays, including maternity stays: Prior Authorization required. Benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		
Facility charges	90% after Deductible	\$2,500 Copayment per admission, then 50% of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	90% after Deductible	50% of the Maximum Allowable Charge after Deductible

<p>Skilled Nursing or Rehab Facility stays (Limited to 60 days per Calendar Year) Prior Authorization required. Benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		
Facility charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
<p>Hospital Emergency Care Services</p>		
Emergency Room charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
All Other Hospital charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Practitioner Charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
<p>Weight Loss Surgery Limited to 1 surgery per lifetime, unless Medically Necessary Complications covered only if original surgery was performed at an IASIS facility and approved by the Plan Eligibility: Employees: After 1 year of being benefit-eligible under the Plan Spouses: After 2 years of being benefit-eligible under the Plan Dependent Children: Not eligible for Coverage of weight loss surgery or for complications due to weight loss surgery</p>		
Facility charges	IASIS facility: \$2,500 Copayment, then 100% Other facilities: Not Covered	Not Covered
Practitioner Charges	IASIS facility: 100% after facility Copayment Other facilities: Not Covered	Not Covered
<p>Outpatient Facility Services Outpatient Surgery Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include invasive diagnostic services (e.g., endoscopy).</p>		

Facility charges	90% after Deductible	\$500 Copayment per procedure, then 50% of the Maximum Allowable Charge after Deductible
Practitioner charges	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Outpatient Diagnostic Services		
<p>Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.</p> <p>Advanced Radiological Imaging services require Prior Authorization. If Prior Authorization is not obtained, benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
All other Diagnostic Services for illness or injury	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Other Outpatient procedures, services, or supplies		
<p>Therapy Services: Physical, speech, and occupational limited to 30 visits per therapy per Calendar Year; Cardiac and pulmonary rehab limited to 30 visits per Calendar Year Chiropractic care limited to 20 visits per Calendar Year</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Other Services		
Ambulance	100%	100% of the Maximum Allowable Charge
Home Health Care Services, including home infusion therapy Prior Authorization is required for skilled nurse visits in the home. Therapy provided in the home does not require Prior Authorization. Limited to 60 visits per Calendar Year	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hospice Care Prior Authorization is required.	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

Organ Transplant Services			
<p>Organ Transplant Services, all transplants except kidney ³</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.</p>	<p>In-Transplant Network benefits:</p> <p>80% after Network Deductible, Network Out-of-Pocket Maximum applies.</p>	<p>Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee): ⁴</p> <p>80% of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered.</p>	<p>Out-of-Network Providers: 50% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not covered.</p>
<p>Organ Transplant Services, kidney transplants ³</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization.</p>	<p>Network Providers:</p> <p>80% after Network Deductible; Network Out-of-Pocket Maximum applies.</p>	<p>Out-of-Network Providers:</p> <p>50% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not covered.</p>	

**Schedule of Behavioral Health Services
Inpatient-Only Utilization Review**

<p>Benefit percentages apply to BCBST Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers and Non-Contracted Providers.</p>	<p align="center">Member Payment for Covered Services received from Network Providers</p>	<p align="center">Member Payment for Covered Services received from Out-of-Network Providers</p>
<p>Inpatient Behavioral Health Services: Inpatient Treatment (including Acute care treatment, partial hospital treatment, residential treatment, electro-convulsive therapy (ECT) and intensive outpatient treatment)</p>		
<p>Facility Charges</p>	<p align="center">90% after Deductible</p>	<p align="center">\$2,500 Copayment per admission, then 50% of the Maximum Allowable Charge after Deductible</p>
<p>Practitioner charges</p>	<p align="center">90% after Deductible</p>	<p align="center">50% of the Maximum Allowable Charge after Deductible</p>
<p>Outpatient Behavioral Health Services: Outpatient treatment (outpatient visits to professionals provided in a Practitioner's office or community mental health center).</p>	<p align="center">100% after \$20 Copayment</p>	<p align="center">50% of the Maximum Allowable Charge after Deductible</p>

Miscellaneous Limits:	In-Network Providers	Out-of-Network Providers
Lifetime Maximum	Unlimited	
	In-Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Deductible		
Individual	\$750	\$2,250
Family	\$1,500	\$4,500
Out-of-Pocket Maximum		
Individual	\$4,000	\$12,000
Family	\$8,000	\$24,000
Pre-existing Condition Waiting Period	None	
4 th Quarter Deductible Carryover	Excluded	

1. Benefit percentages apply to BCBST Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Member is responsible for any amount exceeding Maximum Allowable Charge for services received from Non-Contracted Providers.
2. Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers.
3. All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.
4. Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.
5. Benefits will be reduced by 30% for Network and Out-of-Network Providers when Prior Authorization is not obtained.

EVIDENCE OF COVERAGE

ATTACHMENT C: PPO SCHEDULE OF BENEFITS—NON-TIERED \$1,000 PLAN

Group Name: IASIS HEALTHCARE, LLC

Group Number: 82045

Effective Date: January 1, 2011

The Employer has selected the Blue Network P Provider network. To receive the maximum benefit from Your PPO Plan, make sure Your Provider is a member of the Blue Network P Provider network.

Covered Services	Member Payment for Covered Services received from Network Providers ¹	Member Payment for Covered Services received from Out-of-Network Providers ²
Preventive Health Care Services		
Well Child Care (to age 6)	100%	Not Covered
Well Woman Exam	100%	Not Covered
Mammogram, Cervical cancer Screening and Prostate cancer Screening	100%	Not Covered
Immunizations	100%	Not Covered
Well Care Services (ages 6 and up)	100%	Not Covered
Other Well Care Screenings, age 6 and above, including flexible sigmoidoscopy or colonoscopy	100%	Not Covered
Services Received at the Practitioner's office		
Office Exams and Consultations		
Diagnosis and treatment of injury or illness Primary Care Practitioner types Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics & Gynecology, Physician Assistant, Nurse Practitioner All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician.	100% after \$20 Copayment 100% after \$30 Copayment	50% of the Maximum Allowable Charge after Deductible 50% of the Maximum Allowable Charge after Deductible
Maternity care	100% after \$20 Copayment (Copayment applies to first visit only)	50% of the Maximum Allowable Charge after Deductible

Injections and Immunizations		
Allergy injections and allergy extract	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
All other injections	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
Diagnostic Services and Preventive Screenings (e.g. x-ray and labwork)		
Allergy Testing	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
<p>Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies</p> <p>Advanced Radiological Imaging services require Prior Authorization. If Prior Authorization is not obtained, benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
All Other Diagnostic Services for illness or injury	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	No Additional Copayment	50% of the Maximum Allowable Charge after Deductible
Other office procedures, services or supplies		
<p>Office Surgery, including anesthesia</p> <p>Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained,</p>	<p>100% after \$20 Copayment</p> <p>100% after \$30 Copayment</p>	<p>50% of the Maximum Allowable Charge after Deductible</p> <p>50% of the Maximum Allowable Charge after Deductible</p>

<p>benefits may be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.</p> <p>Surgeries include invasive diagnostic services (e.g., endoscopy).</p> <p>Primary Care Practitioners All other Practitioners</p>		
<p>Therapy Services: Physical, speech, and occupational limited to 30 visits per therapy per Calendar Year; Cardiac and pulmonary rehab limited to 30 visits per Calendar Year Chiropractic care limited to 20 visits per Calendar Year</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
<p>Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions.</p>	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
All Other Office services	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Services Received at a Facility		
<p>Inpatient Hospital Stays, including maternity stays: Prior Authorization required. Benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		

Facility charges	90% after Deductible	\$2,500 Copayment per admission, then 50% of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehab Facility stays (Limited to 60 days per Calendar Year) Prior Authorization required. Benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hospital Emergency Care Services		
Emergency Room charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
All Other Hospital charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Practitioner Charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Weight Loss Surgery Limited to 1 surgery per lifetime, unless Medically Necessary Complications covered only if original surgery was performed at an IASIS facility and approved by the Plan Eligibility: Employees: After 1 year of being benefit-eligible under the Plan Spouses: After 2 years of being benefit-eligible under the Plan Dependent Children: Not eligible for Coverage of weight loss surgery or for complications due to weight loss surgery		
Facility charges	IASIS facility: \$2,500 Copayment, then 100% Other facilities: Not Covered	Not Covered
Practitioner Charges	IASIS facility: 100% after facility Copayment Other facilities: Not Covered	Not Covered

Outpatient Facility Services		
Outpatient Surgery		
Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include invasive diagnostic services (e.g., endoscopy).		
Facility charges	90% after Deductible	\$500 Copayment per procedure, then 50% of the Maximum Allowable Charge after Deductible
Practitioner charges	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Outpatient Diagnostic Services		
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies. Advanced Radiological Imaging services require Prior Authorization. If Prior Authorization is not obtained, benefits will be reduced by 30% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
All other Diagnostic Services for illness or injury	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	90% after Deductible	50% of the Maximum Allowable Charge after Deductible
Other Outpatient procedures, services, or supplies		
Therapy Services: Physical, speech, and occupational limited to 30 visits per therapy per	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

Calendar Year; Cardiac and pulmonary rehab limited to 30 visits per Calendar Year Chiropractic care limited to 20 visits per Calendar Year		
DME, Orthotics and Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Other Services		
Ambulance	100%	100% of the Maximum Allowable Charge
Home Health Care Services, including home infusion therapy Prior Authorization is required for skilled nurse visits in the home. Therapy provided in the home does not require Prior Authorization. Limited to 60 visits per Calendar Year	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hospice Care Prior Authorization is required.	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

Organ Transplant Services			
<p>Organ Transplant Services, all transplants except kidney³</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.</p>	<p>In-Transplant Network</p> <p>benefits:</p> <p>80% after Network Deductible, Network Out-of-Pocket Maximum applies.</p>	<p>Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee):⁴</p> <p>80% of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered.</p>	<p>Out-of-Network Providers:</p> <p>50% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not covered.</p>
<p>Organ Transplant Services, kidney transplants³</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization.</p>	<p>Network Providers:</p> <p>80% after Network Deductible; Network Out-of-Pocket Maximum applies.</p>	<p>Out-of-Network Providers:</p> <p>50% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not covered.</p>	

**Schedule of Behavioral Health Services
Inpatient-Only Utilization Review**

<p>Benefit percentages apply to BCBST Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers and Non-Contracted Providers.</p>	<p align="center">Member Payment for Covered Services received from Network Providers</p>	<p align="center">Member Payment for Covered Services received from Out-of-Network Providers</p>
<p>Inpatient Behavioral Health Services: Inpatient Treatment (including Acute care treatment, partial hospital treatment, residential treatment, electro-convulsive therapy (ECT) and intensive outpatient treatment)</p>		
<p>Facility Charges</p>	<p align="center">90% after Deductible</p>	<p>\$2,500 Copayment per admission, then 50% of the Maximum Allowable Charge after Deductible</p>
<p>Practitioner charges</p>	<p align="center">90% after Deductible</p>	<p>50% of the Maximum Allowable Charge after Deductible</p>
<p>Outpatient Behavioral Health Services: Outpatient treatment (outpatient visits to professionals provided in a Practitioner’s office or community mental health center).</p>	<p align="center">100% after \$20 Copayment</p>	<p>50% of the Maximum Allowable Charge after Deductible</p>

Miscellaneous Limits:	In-Network Providers	Out-of-Network Providers
Lifetime Maximum	Unlimited	
	In-Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Deductible		
Individual	\$1,000	\$3,000
Family	\$2,000	\$6,000
Out-of-Pocket Maximum		
Individual	\$5,000	\$15,000
Family	\$10,000	\$30,000
Pre-existing Condition Waiting Period	None	
4 th Quarter Deductible Carryover	Excluded	

1. Benefit percentages apply to BCBST Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Member is responsible for any amount exceeding Maximum Allowable Charge for services received from Non-Contracted Providers.
2. Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers.
3. All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.
4. Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.
5. Benefits will be reduced by 30% for Network and Out-of-Network Providers when Prior Authorization is not obtained.

Prescription Drug Plan

Prior Authorization

This section is unchanged except the services that require Prior Authorization.

Services that require Prior Authorization include, but are not limited to:

- Specialty Pharmacy Products
- Brand drugs subject to Mandatory Step Therapy.

Appeal Procedure

This section has been deleted and replaced in its entirety.

If you are notified that a claim is wholly or partially denied, you have the right to appeal.

- You will be instructed on how to submit an appeal upon contacting the Caremark Customer Care department.
- Acceptable submission methods include fax or mail. In the case of an Urgent Care appeal, your physician may make the request by phone.
- You must submit an appeal to Caremark in writing no later than 180 days after receiving an adverse benefit determination.
- Appeals will be processed within the following time frames from the date complete information is received:
 - Pre-Service: 15 days
 - Post Service: 30 days
 - Urgent Care: 72 hours.

The appeal process includes the consideration of relevant and supporting documentation you submit. Supporting documentation may include a letter written by your physician in support of the appeal, a copy of the denial letter sent by Caremark, a copy of your payment receipt or medical records, etc.

Non-clinical appeals will be reviewed and determined by an appeals analyst. Clinical appeals will be reviewed and determined by the appeals pharmacist. If the appeal involves a medical necessity determination, then after completion of the mandatory first level appeal, you may request that the dispute be submitted to an external third party or Independent Review Organization (IRO), selected by Caremark, to independently review and resolve such dispute(s). Your request for independent review must be submitted in writing within 4 months after the date you receive notice of adverse determination for your first appeal. Your request should include your name, contact information including mailing address and daytime phone number, member ID number, and a copy of the coverage denial. Your request for external review and supporting documentation may be mailed or faxed to Caremark:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-689-3092

Preliminary Review

Within 5 days of receiving your request for external review, Caremark will conduct a “preliminary review” to ensure that the request qualifies for external review. Within one day after completing this preliminary review, Caremark will notify you, in writing that:

- your request for external review is complete, and may proceed;
- the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or
- the request for external review is complete, but not eligible for review.

Referral to IRO

If your request for external review is complete and your claim is eligible, Caremark will assign the request to one of the IROs with which it has contracted. The IRO will notify you of its acceptance of the assignment. You will then have 10 days to provide the IRO with any additional information you want it to consider.

The IRO will conduct its external review without giving any consideration to any earlier determination made on behalf of the Plan and the Plan Sponsor.

The IRO will provide you with written notice of its final external review decision within 45 days after the IRO receives the request for external review. The reviewer’s decision must state the reasons for the determination based upon: (1) the terms of this SPD; (2) your medical condition; and (3) information submitted to the reviewer. The reviewer’s decision may not expand the terms of coverage of the Plan. If Caremark receives notice from the IRO that it has reversed the prior determination of your claim, Caremark will immediately provide coverage or payment of the claim.

If your claim involves a medical condition for which the timeframe for completion of the standard review process would seriously jeopardize your life or health and/or could result in your failure to regain maximum function, you may request an expedited external review. If Caremark determines you are eligible for an expedited external review, the IRO will provide you with notice of its determination as expeditiously as your medical condition requires, but in no event more than 72 hours after the IRO receives your complete request for external review.

Your decision concerning whether to request independent review has no effect on your rights to any other benefits under the Plan. If you request independent review of an ERISA Action, Caremark will toll any time defenses or restrictions affecting your right to bring a civil action against the Employer or Employer’s Plan, until the independent reviewer makes its decision.

The Employer or Employer's Plan will pay the fee charged by the independent review organization and its reviewers if you request that the Plan submit a dispute to independent review. You will be responsible for any other costs that you incur to participate in the independent review process, including attorney's fees.

If you are not satisfied, you also have the right to bring a civil action against the Plan to obtain the remedies available pursuant to Sec. 502(a) of ERISA ("ERISA Actions") after completing the appeal procedure above.

Attachment A

II. Benefit Payment

This section has been deleted and replaced in its entirety.

Benefit payment for Covered Services will be determined as follows:

- Generic Drug. We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the Generic Drug Copayment, and pay the difference up to the Maximum Allowable Charge.
- Preferred Brand Drug. We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the Preferred Brand Drug Copayment, and pay the difference up to the Maximum Allowable Charge.
- Non-preferred Brand Drug. We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the Non-preferred Brand Drug Copayment, and pay the difference up to the Maximum Allowable Charge.

If the Member or the prescribing physician insists on a Brand Drug and a Generic Drug equivalent is available, the Member will be financially responsible for the amount by which the cost of the Brand Drug exceeds the Generic Drug cost plus the required Brand Drug copayment.

Benefits will be provided for up to a 30-calendar day supply of Prescription Drugs or up to a 90-calendar day supply of Maintenance Drugs obtained through mail service or at CVS pharmacies. Coverage for Maintenance Drugs obtained through home delivery and at CVS pharmacies dispensed in quantities greater than a 30-calendar day supply is subject to 2 times the Drug Copayment. Some Prescription Drugs may be subject to additional quantity limitations as adopted by Caremark.

The Plan allows two 30-day fills of Maintenance Drugs at any pharmacy in our network. After that, the Plan will cover Maintenance Drugs only if the Member has 90-day supplies filled through mail service or at a CVS/pharmacy. If the Member continues to have 30-day supplies filled, the Plan will not pay for them.

If a Member has a Prescription filled at a Non-Participating Pharmacy, the Member must pay all expenses and file a claim for reimbursement with Caremark. The Member will be

reimbursed based on the Maximum Allowable Charge, less any applicable Drug Deductible and/or Drug Copayment amount.

Mandatory Generic Drug – Step Therapy

For certain classes of drugs, you must choose a generic drug or approved preferred brand drug (if available) before using other brand drugs. If you instead choose a brand drug first, your prescription will not be covered and you will pay the full drug cost.

If Caremark and your doctor determine that the generic drug does not achieve the results desired, a preferred brand drug may then be covered by the Plan. This change will apply to all prescriptions filled on or after January 1, 2011, and includes (but is not limited to) these drug classes:

- Nasal steroids (asthma and allergy drugs)
- Urinary antispasmodics (drugs for bladder problems)
- Bisphosphonates (drugs to strengthen bones)
- Sleep aids
- Triptans (drugs for migraines and cluster headaches)
- Short-acting beta agonist (SABA) inhalers (asthma drugs)
- Proton pump inhibitors (drugs for stomach acid)
- Non-sedating antihistamines (drugs for allergies)
- Statins (drugs to treat high cholesterol)
- ACE inhibitors/angiotensin II receptor antagonists (ARBs) (drugs to treat high blood pressure)
- COX-2 inhibitors (drugs to treat pain and inflammation)
- Selective serotonin reuptake inhibitors (SSRIs) (drugs to treat depression)

Attachment B: Prescription Drug Schedule of Benefits

This section is deleted and replaced in its entirety.

**Attachment B: Prescription Drug Schedule of Benefits
Effective Date: January 1, 2011**

	Any Network Pharmacy – Up to 30 Day Supply	Home Delivery or CVS Pharmacy – Up to 90 Day Supply
Generic Drugs	\$10.00	\$20.00
Preferred Brand Drugs	\$40.00	\$80.00
Non-preferred Brand Drugs	\$60.00	\$120.00

Flexible Benefits/Cafeteria Plan

Benefit Payments

Item 1 has been deleted and replaced in its entirety.

1. How will I receive payments from my accounts?

Funds in your FSA may be paid in one of two ways during the plan year:

- (a) Manual Submissions. You may submit requests for reimbursement of expenses you have incurred. Expenses are considered “incurred” when the service is performed, not necessarily when it is paid. If the request qualifies as a benefit or expense that the Plan has agreed to pay, (this is an “Approved Claim”), you will receive a reimbursement payment soon after you submit the request. The reimbursements made from the FSA Plans are generally not subject to federal income tax or withholding, nor are they subject to Social security taxes.
- (b) Debit Card. You can use the card at qualified providers (for example, a doctor’s office – but the card will not work at non-qualified providers) for eligible health care services and products. Your debit card transactions still must be substantiated by the claims administrator as having been appropriate. You will be contacted for that purpose and required to provide receipts and/or other documentation to verify that purchases made with your debit card were appropriate.

Item 4 has been deleted and replaced in its entirety.

4. Will I receive any statements of my Accounts?

You will be provided with an Explanation of Benefits (EOB) for each payment that is made from your FSA using a paper claim. Claims paid by your debit card will not result in an EOB. You may also monitor the balance of your FSA on-line at www.wageworks.com. It is important to read your EOBs carefully and monitor your account activity so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

Item 6 has been deleted and replaced in its entirety.

6. What is meant by “substantiation” of claims?

Because the Plan has a pre-tax salary reduction component, the Plan Administrator is required to verify that a claim for reimbursement from an FSA account corresponds to an actual expenditure by the Participant for a qualified benefit. This verification process is also known as “substantiation”. The claims administrator may require that you provide documentation proving the claim is for an eligible healthcare expense. Your documentation must set forth specific information depending upon the type of FSA involved. More specific information about the substantiation process is included in Appendix A.

Administrative Information Attachment

This section has been deleted and replaced in its entirety.

ADMINISTRATIVE INFORMATION ATTACHMENT

The Plan Administrator administers the FSA Plans and has the discretionary authority to interpret all FSA Plan provisions and to determine all issues arising under the FSA Plans, including issues of eligibility, coverage, and benefits. The Plan Administrator's failure to enforce any provision of the FSA Plans shall not affect its right to later enforce that provision or any other provision of the FSA Plans. The Plan Administrator may delegate some of its administrative duties to agents.

Claims Administrator: PBS/Wageworks

Claims Administrator's Telephone Number: (877) 942-3967

Maximum Health Care FSA contribution per Plan Year: \$5,000

Type of Plan: The FSA Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§ 105 and 106 and the regulations issued thereunder.

Type of Administration: The Administrator pays applicable benefits from the general assets of the Employer.

Funding: The FSA Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which benefits are paid.

Appendix A: Health Care FSA

This section is deleted and replaced in its entirety.

The Health Care FSA enables you to pay for expenses which are not covered by the medical plan and save taxes at the same time. The account allows you to be reimbursed for out of pocket medical, dental and vision expenses incurred by you and your dependents. The expenses which qualify are those permitted by section 213(d) of the Internal Revenue Code. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses.

1. What is the maximum that I can contribute?

The most that you can contribute to your Health Care FSA each Plan Year is defined by the Employer and IRS guidelines. The maximum Health Care FSA contribution for this plan is set forth in the "Administrative Information Attachment."

2. What expenses qualify for reimbursement from the Health Care FSA?

Expenses that qualify for reimbursement under the Health Care FSA must meet the following requirements:

- The expense must not be covered by a health, dental or vision plan or spouse's plan.

- The expense must be included in the IRS list of eligible tax deductible expenses. A complete list may be found in IRS Publication #502. This is available on-line at <http://www.irs.gov/formspubs/index.html> or by calling the IRS at (800) 829-3676.
- The expenses must be incurred by you or your eligible dependents (spouse, does not include domestic partner, and any children). To qualify, the dependent must be claimed as a tax exemption on the individual's federal income tax return.

Eligible expenses can be taken either as a tax deduction on the annual federal income tax return (IRS form 1040) or used toward Health Care FSA reimbursement. An individual must select one method or the other because a deduction cannot be claimed for an expense that has been reimbursed through the FSA account.

Typically, eligible out-of-pocket health care expenses are expenses incurred for medical care. Such expenses include amounts paid for the diagnosis and treatment of illness or injury including prescription drugs.

Expenses must be for the treatment of an existing disease or to prevent a disease that is likely to occur if the medication is not taken. They do not include toiletries and cosmetics, vitamins and dietary supplements or herbal remedies.

3. What are some examples of ineligible expenses?

- Health insurance premiums;
- Medicare Part B premiums;
- Over-the-counter drugs unless the member has a doctor's written prescription (insulin may be reimbursed without a prescription);
- Vitamins, herbal remedies and other dietary supplements;
- Marriage or family counseling;
- Custodial care in an institution; and
- Health club dues.

4. What is the substantiation process for the Health Care FSA?

The Administrator or the Claims Administrator may require that you provide documentation proving a claim is for an eligible medical care expense. Your documentation must set forth

- The individual(s) on whose behalf eligible medical expenses have been incurred;
- The nature and date of the eligible medical expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such eligible medical expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The documentation must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing

that the eligible expenses have been incurred and the amounts of such eligible expenses, together with any additional documentation that the Administrator or Claims Administrator may request.

Employee Assistance Program

This section has been deleted and replaced in its entirety.

This Coverage Summary is included in the Summary Plan Description document (SPD) created by the Employer as part of its employee welfare benefit plan (the “Plan”), and is subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements.

This Coverage Summary provides information about Employee Assistance Program (EAP) coverage. EAP coverage is provided to all Employees of the Employer. An enrollment election is not made for EAP coverage; rather, all employees and their household members are automatically covered.

<p><i>What is the Employee Assistance Program?</i></p>	<p>The Employee Assistance Program (EAP) is a counseling service available to help resolve problems that may affect a person’s life at home or at work.</p> <p>EAP offers:</p> <ol style="list-style-type: none"> 1. Counseling Services: Assessment, short-term counseling, and referral service for you and your family household members. 2. Legal and financial consultation services 3. Work-life programs via the web.
<p><i>Who is eligible?</i></p>	<p>All IASIS Healthcare LLC employees and household members are eligible for EAP services. The same services are available to everyone.</p>

<p><i>What types of problems does the Employee Assistance Program handle?</i></p>	<p>Professional counselors speak with you in private about concerns such as, but not limited to:</p> <ul style="list-style-type: none"> ▪ marriage/relationship problems ▪ mental health/stress ▪ family issues ▪ legal referrals ▪ elder care ▪ financial issues ▪ alcohol or drug use ▪ grief issues ▪ parenting ▪ work-related issues ▪ gambling addiction
<p><i>How do I access the Employee Assistance Program?</i></p>	<p>First, call the Employee Assistance Program hotline at 1-877-798-8793, to speak directly with a counselor about your issue. The counselor will assess the situation and provide you with options. The EAP is available 24 hours a day – seven days a week.</p> <p>Some problems are resolved over the phone, or you may want to meet at a convenient choice of sites. You and the counselor may find that a referral to ongoing counseling, treatment or other help is needed. If so, referral to qualified resources usually occurs in the first contact, or as soon as the problem is assessed.</p> <p>You can meet again with the same EAP counselor if your problem cannot be resolved within three (3) sessions.</p>
<p><i>Where are the EAP counseling sites?</i></p>	<p>The EAP has offices in your community and throughout the country. The counselor you speak with over the phone will help arrange a meeting in the office most convenient for you.</p>
<p><i>Who pays for the Employee Assistance Program?</i></p>	<p>Your employer has paid for all direct EAP services. There is no cost to you for up to three (3) visits per problem per year. The EAP is <i>separate</i> from the medical plan. If you are referred to resources outside of the EAP, there may be costs for which you or your medical plan are responsible. The EAP counselor can help you understand this.</p>
<p><i>Why use the Employee Assistance Program?</i></p>	<p>When you or any of your dependents have a problem, it can affect how you feel and act. Stress can impair your family life and work, but prompt help can restore your well being, both at home and on the job.</p>

The EAP is confidential to the greatest extent the law allows.

**When you need help, call
1-877-798-8793**