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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

Preventive Care

The Preventive Health Care section on pages 47-49 has been deleted and replaced with the following:

The following preventive services are covered:

1. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be “in effect” after it has been adopted by the Director of the Centers for Disease Control and Prevention (CDC). A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the CDC.
2. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the USPSTF).

Examples of general categories of preventive services covered under items 2 through 4 above include, but are not limited to:

- Well-baby and well-child care
- Routine hearing screening and visual acuity screening performed during a well-child checkup
- Annual routine physical examinations
- Cancer screenings

The following sections have been deleted in their entirety and replaced with the Grievance Procedure section below.

Resolving Problems through Appeals
Grievance and Appeals Internal Review Process
Adverse Benefit Determination
Expedited Claims Reviews (72 Hours)
Next Level Grievance Procedure

Grievance Procedure

Introduction

The Altius 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 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 the SPD. Any decision to award damages must be based upon the terms of the SPD.
2. The procedure can only resolve disputes that are subject to the control of Altius.
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 Altius 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. Altius, 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 Utah or Federal laws and regulations, the ASA and the 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 Altius issues 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. Altius is a limited fiduciary for the first level grievance.

Grievance Process

After Altius has 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 of 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 Altius, 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 Altius 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.

Definitions

Changes to the Definitions section beginning on page 66 of the 2010 EOC have been made as specified below.

Lifetime Benefit Maximum

This definition has been deleted. The Plan has no lifetime benefit maximum. Any references to Lifetime Benefit Maximum throughout this section are eliminated.

Out-of-Pocket Maximum

The second bullet has been deleted and replaced with the following:

- Copayments, deductibles or coinsurance amounts that apply to the out-of-pocket maximum are outlined in the Schedule of Benefits.

Schedule of Benefits

This section has been deleted and replaced in its entirety.

ALTIUS CONCENTRIC PLAN				
\$500 Option				
Altius Healthcare January 1, 2011	Level 1 IASIS	Level 2 UUMC, PCMC	Level 3 Altius Contracted Providers (No IHC or HCA)	Level 4 Non-Par Providers (including IHC/HCA)
DEDUCTIBLE, OUT-OF-POCKET & LIMITS				
Calendar Year Deductible – (Individual / Family) Cumulative across benefit levels.	\$500 / \$1,000	\$500 / \$1,000	\$500 / \$1,000	\$1,500 / \$3,000
Out-of-Pocket Maximum – (Individual / Family) Fixed dollar copays do not apply. Cumulative across benefit levels.	\$2,500 / \$5,000	\$2,500 / \$5,000	\$2,500 / \$5,000	\$7,500 / \$15,000
Lifetime Maximum	Unlimited			
YOU PAY				
OUTPATIENT SERVICES				
Preventive Care Services	You Pay Nothing	You Pay Nothing	You Pay Nothing	No Coverage
Preventive Cancer Screenings – including, but not limited to, colonoscopies and sigmoidoscopies.	You Pay Nothing	You Pay Nothing	You Pay Nothing	No Coverage
Office Visits – Primary Care	\$20	\$20	\$20	50%* AD
Office Visits – Specialty Care	\$30	\$30	\$30	50%* AD
After-Hours Care / Urgent Care – Care received in a physician's office.	\$30	\$30	\$30	50%* AD
Chiropractic Office Visits – Limited to 20 visits per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD
Major Diagnostic Laboratory Tests and Radiology – Including, but not limited to CT scans and MRIs.	10%* AD	10%* AD	20%* AD	50%* AD
Minor Diagnostic Laboratory Tests and X-Rays – Including, but not limited to mammograms and chest X-rays.	You Pay Nothing	You Pay Nothing	You Pay Nothing	50%* AD
Physiotherapy Services Physical, occupational and speech therapy provided on an outpatient basis. Limited to a combined benefit of 30 provider's office and/or outpatient facility visits of each type per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD
EMERGENCY CARE				
YOU PAY				
Emergency Room Care – When medically necessary, as determined by Altius. Includes all services provided in an Emergency Room setting. Inpatient benefit applies when admitted. Outpatient hospital benefit applies when transferred to an operating room.	10%* AD	10%* AD	10%* AD	10%* AD
Urgent Care Facility – When medically necessary, as determined by Altius.	\$30	\$30	\$30	50%* AD
Ambulance / Paramedics – (including Air Ambulance) When medically necessary, as determined by Altius.	You Pay Nothing			

– Benefits Continued on Next Page–

INPATIENT / OUTPATIENT HOSPITAL SERVICES		YOU PAY		
Inpatient Hospital / Facility Services	10%* AD	10%* AD	\$500 + 30%* AD	\$500 + 50%* AD
Obesity Surgery – Covered only at an IASIS facility.	\$2,500	No Coverage	No Coverage	No Coverage
Outpatient Hospital / Facility Services – Including, but not limited to, outpatient surgery, observation, cardiovascular services, endoscopy, and pulmonary services.	10%* AD	10%* AD	\$100 + 30%* AD	\$100 + 50%* AD
Outpatient Hospital / Facility Therapy Services – Including, but not limited to, chemotherapy, radiation therapy, dialysis, and infusion therapy.	10%* AD	10%* AD	\$100 + 30%* AD	\$100 + 50%* AD
Additional Professional Services – Anesthesia and facility based professional fees associated with inpatient / outpatient services such as radiologist, pathologist, hospitalist, etc.	10%* AD	10%* AD	10%* AD	50%* AD
Inpatient / Outpatient Physician, Surgeon, Assistant Surgeon	10%* AD	10%* AD	10%* AD	50%* AD
Organ Transplant Services – Organ and tissue transplant services, including, but not limited to, cornea, kidney, heart, lung, heart-lung, liver, pancreas, and bone marrow transplants and related services. Office visits and other services related to organ transplant may have an additional copay.	10%* AD	10%* AD	30%* AD	Participating Providers Only
MATERNITY SERVICES		YOU PAY		
Pre-Natal and Post-Natal Care – Professional Services – Routine pre-natal office visits, delivery (including surgeon and assistant surgeon), and post-natal care. Regular benefits apply for complications of pregnancy.	\$20 1 st visit only	\$20 1 st visit only	\$20 1 st visit only	50%* AD
Inpatient Hospital / Facility Services	10%* AD	10%* AD	\$500 + 30%* AD	\$500 + 50%* AD
INJECTABLE OR IMPLANTABLE MEDICATIONS		YOU PAY		
Injectable or Implantable Medications – Facility – Injectable or implantable medications provided inpatient or outpatient through a hospital, surgical center, skilled nursing facility, other facility setting, or physician's office. Office visits and other services related to injectable or implantable medications may have an additional copay.	10%* AD	10%* AD	20%* AD/ 30%* AD	50%* AD / 60%* AD

– Benefits Continued on Next Page–

ALLERGY CONDITIONS		YOU PAY			
Testing and Treatment – Specialty or After Hours copay may apply.	\$20	\$20	\$20	50%* AD	
Serum	You Pay Nothing	You Pay Nothing	You Pay Nothing	50%* AD	
Injections - Office visits and other services related to Allergy Injections may have an additional copay.	You Pay Nothing	You Pay Nothing	You Pay Nothing	50%* AD	
OTHER BENEFITS		YOU PAY			
Accident Related Dental Services – Dental services required as the result of an accidental injury. Services include, but are not limited to, crowns, caps, bridges, and root canals. Limited to a combined lifetime maximum of \$1,000 per member.	10%* AD	10%* AD	20%* AD	50%* AD	
Durable Medical Equipment (DME) – Including corrective appliances, orthotics and prosthetic devices.	20%* AD	20%* AD	20%* AD	50%* AD	
Home Health Care – Limited to a combined benefit of 60 visits per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD	
Hospice Care – Care for a terminally ill member through a licensed hospice agency.	20%* AD	20%* AD	20%* AD	50%* AD	
Implantable Contraceptives and Intra-Uterine Devices (IUDs) – Includes charges for insertion and removal. Specialty or After Hours copay may apply.	\$20	\$20	\$20	50%* AD	
Infertility Services – Evaluation, testing, and diagnostic services. Includes services that are provided for the purpose of ruling out infertility. Specialty or After Hours copay may apply.	\$20	\$20	\$20	Participating Providers Only	
Medical Supplies – Disposable medical supplies and accessories as determined medically necessary by Altius.	20%* AD	20%* AD	20%* AD	50%* AD	
Neuropsychological Testing	10%* AD	10%* AD	20%* AD	Participating Providers Only	
Skilled Nursing Facility – Limited to a combined benefit of 60 days per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD	
Sterilization Procedures – Services received at a physician's office. Specialty or After Hours copay may apply.	10%* AD	10%* AD	20%* AD	50%* AD	
Sterilization Procedures – Services received at an outpatient facility.	10%* AD	10%* AD	\$100 + 30%* AD	\$100 + 50%* AD	
Temporomandibular Joint Dysfunction (TMJ) – Evaluation, testing and diagnostic services.	Not Covered				

– Benefits Continued on Next Page–

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

Altius Customer Service 1-800-377-4161 www.altiushealthplans.com

Iasis Healthcare January 1, 2011	Level 1 IASIS	Level 2 UUMC, PCMC	Level 3 Altius Contracted Providers (No IHC or HCA)	Level 4 Non-Par Providers (including IHC/HCA)
MENTAL HEALTH / SUBSTANCE ABUSE		YOU PAY		
Inpatient Services	MHNet Providers – 10%* AD		50%* AD	
Partial Hospitalization	MHNet Providers – 10%* AD		50%* AD	
Services at an Outpatient Facility – Includes intensive outpatient services.	MHNet Providers – 10%* AD		50%* AD	
Outpatient Services	MHNet Providers – \$20		50%* AD	
GENERAL INFORMATION				
<p>Calendar Year Deductible – You must satisfy an individual or family deductible each calendar year before certain benefits will be provided under this benefit plan. Deductibles do not apply to benefits with "fixed" copays.</p>				
<p>Lifetime Maximum – The lifetime maximum includes all benefits paid on your behalf under any previous plan, policy, contract, or agreement issued by Altius. Your benefits will be exhausted once this lifetime maximum is met.</p>				
<p>Out-of-Pocket Maximum – Fixed dollar copays do not apply. When you or your family fulfill out-of-pocket maximums during a calendar year, then no further out-of-pocket expenses will be required for the remainder of that calendar year. This provision does not apply to any payments for benefits with fixed copays, prescription drugs, charges that exceed eligible medical expenses, non-covered services, or mental health services (which may have a separate out-of-pocket maximum). You are required to keep receipts for out-of-pocket expenses and furnish such proof to the Altius Claims Department when you reach your maximum.</p>				
<p>Securing Benefits and Payment for Services Through Altius – In order for a medical service to be eligible for coverage, it must be defined as a covered benefit and properly coordinated through Altius. Prior authorization is required for certain services (excluding emergency care) in order to verify that the services to be provided are covered by your benefit plan and are medically necessary and appropriate. It is your responsibility to determine that providers and facilities have obtained prior authorization from Altius prior to receiving care. If prior authorization from Altius is not obtained, coverage may be denied.</p>				

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

Altius Customer Service 1-800-377-4161 www.altiushealthplans.com

ALTIVS CONCENTRIC PLAN

\$750 Option

Altius Healthcare January 1, 2011	Level 1 IASIS	Level 2 UUMC, PCMC	Level 3 Altius Contracted Providers (No IHC or HCA)	Level 4 Non-Par Providers (including IHC/HCA)
DEDUCTIBLE, OUT-OF-POCKET & LIMITS				
Calendar Year Deductible – (Individual / Family) Cumulative across benefit levels.	\$750 / \$1,500	\$750 / \$1,500	\$750 / \$1,500	\$2,250 / \$4,500
Out-of-Pocket Maximum – (Individual / Family) Fixed dollar copays do not apply. Cumulative across benefit levels.	\$4,000 / \$8,000	\$4,000 / \$8,000	\$4,000 / \$8,000	\$12,000 / \$24,000
Lifetime Maximum	Unlimited			
OUTPATIENT SERVICES		YOU PAY		
Preventive Care Services	You Pay Nothing	You Pay Nothing	You Pay Nothing	No Coverage
Preventive Cancer Screenings – including, but not limited to, colonoscopies and sigmoidoscopies.	You Pay Nothing	You Pay Nothing	You Pay Nothing	No Coverage
Office Visits – Primary Care	\$20	\$20	\$20	50%* AD
Office Visits – Specialty Care	\$30	\$30	\$30	50%* AD
After-Hours Care / Urgent Care – Care received in a physician's office.	\$30	\$30	\$30	50%* AD
Chiropractic Office Visits – Limited to 20 visits per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD
Major Diagnostic Laboratory Tests and Radiology – Including, but not limited to CT scans and MRIs.	10%* AD	10%* AD	20%* AD	50%* AD
Minor Diagnostic Laboratory Tests and X-Rays – Including, but not limited to mammograms and chest X-rays.	You Pay Nothing	You Pay Nothing	You Pay Nothing	50%* AD
Physiotherapy Services Physical, occupational and speech therapy provided on an outpatient basis. Limited to a combined benefit of 30 provider's office and/or outpatient facility visits of each type per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD
EMERGENCY CARE		YOU PAY		
Emergency Room Care – When medically necessary, as determined by Altius. Includes all services provided in an Emergency Room setting. Inpatient benefit applies when admitted. Outpatient hospital benefit applies when transferred to an operating room.	10%* AD	10%* AD	10%* AD	10%* AD
Urgent Care Facility – When medically necessary, as determined by Altius.	\$30	\$30	\$30	50%* AD
Ambulance / Paramedics – (including Air Ambulance) When medically necessary, as determined by Altius.	You Pay Nothing			

– Benefits Continued on Next Page–

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

Altius Customer Service 1-800-377-4161 www.altiushealthplans.com

INPATIENT / OUTPATIENT HOSPITAL		YOU PAY		
Inpatient Hospital / Facility Services	10%* AD	10%* AD	\$500 + 30%* AD	\$500 + 50%* AD
Obesity Surgery – Covered only at an IASIS facility.	\$2,500	No Coverage	No Coverage	No Coverage
Outpatient Hospital / Facility Services – Including, but not limited to, outpatient surgery, observation, cardiovascular services, endoscopy, and pulmonary services.	10%* AD	10%* AD	\$100 + 30%* AD	\$100 + 50%* AD
Outpatient Hospital / Facility Therapy Services – Including, but not limited to, chemotherapy, radiation therapy, dialysis, and infusion therapy.	10%* AD	10%* AD	\$100 + 30%* AD	\$100 + 50%* AD
Additional Professional Services – Anesthesia and facility based professional fees associated with inpatient / outpatient services such as radiologist, pathologist, hospitalist, etc.	10%* AD	10%* AD	10%* AD	50%* AD
Inpatient / Outpatient Physician, Surgeon, Assistant Surgeon	10%* AD	10%* AD	10%* AD	50%* AD
Organ Transplant Services – Organ and tissue transplant services, including, but not limited to, cornea, kidney, heart, lung, heart-lung, liver, pancreas, and bone marrow transplants and related services. Office visits and other services related to organ transplant may have an additional copay.	10%* AD	10%* AD	30%* AD	Participating Providers Only
MATERNITY SERVICES		YOU PAY		
Pre-Natal and Post-Natal Care – Professional Services – Routine pre-natal office visits, delivery (including surgeon and assistant surgeon), and post-natal care. Regular benefits apply for complications of pregnancy.	\$20 1 st visit only	\$20 1 st visit only	\$20 1 st visit only	50%* AD
Inpatient Hospital / Facility Services	10%* AD	10%* AD	\$500 + 30%* AD	\$500 + 50%* AD
INJECTABLE OR IMPLANTABLE MEDICATIONS		YOU PAY		
Injectable or Implantable Medications – Facility – Injectable or implantable medications provided inpatient or outpatient through a hospital, surgical center, skilled nursing facility, other facility setting, or physician's office. Office visits and other services related to injectable or implantable medications may have an additional copay.	10%* AD	10%* AD	20%* AD/ 30%* AD	50%* AD / 60%* AD

– Benefits Continued on Next Page–

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

Altius Customer Service 1-800-377-4161 www.altiushealthplans.com

ALLERGY CONDITIONS		YOU PAY			
Testing and Treatment – Specialty or After Hours copay may apply.	\$20	\$20	\$20	50%* AD	
Serum	You Pay Nothing	You Pay Nothing	You Pay Nothing	50%* AD	
Injections - Office visits and other services related to Allergy Injections may have an additional copay.	You Pay Nothing	You Pay Nothing	You Pay Nothing	50%* AD	
OTHER BENEFITS		YOU PAY			
Accident Related Dental Services – Dental services required as the result of an accidental injury. Services include, but are not limited to, crowns, caps, bridges, and root canals. Limited to a combined lifetime maximum of \$1,000 per member.	10%* AD	10%* AD	20%* AD	50%* AD	
Durable Medical Equipment (DME) – Including corrective appliances, orthotics and prosthetic devices.	20%* AD	20%* AD	20%* AD	50%* AD	
Home Health Care – Limited to a combined benefit of 60 visits per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD	
Hospice Care – Care for a terminally ill member through a licensed hospice agency.	20%* AD	20%* AD	20%* AD	50%* AD	
Implantable Contraceptives and Intra-Uterine Devices (IUDs) – Includes charges for insertion and removal. Specialty or After Hours copay may apply.	\$20	\$20	\$20	50%* AD	
Infertility Services – Evaluation, testing, and diagnostic services. Includes services that are provided for the purpose of ruling out infertility. Specialty or After Hours copay may apply.	\$20	\$20	\$20	Participating Providers Only	
Medical Supplies – Disposable medical supplies and accessories as determined medically necessary by Altius.	20%* AD	20%* AD	20%* AD	50%* AD	
Neuropsychological Testing	10%* AD	10%* AD	20%* AD	Participating Providers Only	
Skilled Nursing Facility – Limited to a combined benefit of 60 days per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD	
Sterilization Procedures – Services received at a physician's office. Specialty or After Hours copay may apply.	10%* AD	10%* AD	20%* AD	50%* AD	
Sterilization Procedures – Services received at an outpatient facility.	10%* AD	10%* AD	\$100 + 30%* AD	\$100 + 50%* AD	
Temporomandibular Joint Dysfunction (TMJ) – Evaluation, testing and diagnostic services.	Not Covered				

– Benefits Continued on Next Page–

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

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Iasis Healthcare January 1, 2011	Level 1 IASIS	Level 2 UUMC, PCMC	Level 3 Altius Contracted Providers (No IHC or HCA)	Level 4 Non-Par Providers (including IHC/HCA)
MENTAL HEALTH / SUBSTANCE ABUSE		YOU PAY		
Inpatient Services	MHNet Providers – 10%* AD		50%* AD	
Partial Hospitalization	MHNet Providers – 10%* AD		50%* AD	
Services at an Outpatient Facility – Includes intensive outpatient services.	MHNet Providers – 10%* AD		50%* AD	
Outpatient Services	MHNet Providers – \$20		50%* AD	
GENERAL INFORMATION				
<p>Calendar Year Deductible – You must satisfy an individual or family deductible each calendar year before certain benefits will be provided under this benefit plan. Deductibles do not apply to benefits with "fixed" copays.</p>				
<p>Lifetime Maximum – The lifetime maximum includes all benefits paid on your behalf under any previous plan, policy, contract, or agreement issued by Altius. Your benefits will be exhausted once this lifetime maximum is met.</p>				
<p>Out-of-Pocket Maximum – Fixed dollar copays do not apply. When you or your family fulfill out-of-pocket maximums during a calendar year, then no further out-of-pocket expenses will be required for the remainder of that calendar year. This provision does not apply to any payments for benefits with fixed copays, prescription drugs, charges that exceed eligible medical expenses, non-covered services, or mental health services (which may have a separate out-of-pocket maximum). You are required to keep receipts for out-of-pocket expenses and furnish such proof to the Altius Claims Department when you reach your maximum.</p>				
<p>Securing Benefits and Payment for Services Through Altius – In order for a medical service to be eligible for coverage, it must be defined as a covered benefit and properly coordinated through Altius. Prior authorization is required for certain services (excluding emergency care) in order to verify that the services to be provided are covered by your benefit plan and are medically necessary and appropriate. It is your responsibility to determine that providers and facilities have obtained prior authorization from Altius prior to receiving care. If prior authorization from Altius is not obtained, coverage may be denied.</p>				

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

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ALTIUS CONCENTRIC PLAN

\$1000 Option

Altius Healthcare January 1, 2011	Level 1 IASIS	Level 2 UUMC, PCMC	Level 3 Altius Contracted Providers (No IHC or HCA)	Level 4 Non-Par Providers (including IHC/HCA)
DEDUCTIBLE, OUT-OF-POCKET & LIMITS				
Calendar Year Deductible – (Individual / Family) Cumulative across benefit levels.	\$1,000 / \$2,000	\$1,000 / \$2,000	\$1,000 / \$2,000	\$3,000 / \$6,000
Out-of-Pocket Maximum – (Individual / Family) Fixed dollar copays do not apply. Cumulative across benefit levels.	\$5,000 / \$10,000	\$5,000 / \$10,000	\$5,000 / \$10,000	\$15,000 / \$30,000
Lifetime Maximum	Unlimited			
OUTPATIENT SERVICES		YOU PAY		
Preventive Care Services	You Pay Nothing	You Pay Nothing	You Pay Nothing	No Coverage
Preventive Cancer Screenings – including, but not limited to, colonoscopies and sigmoidoscopies.	You Pay Nothing	You Pay Nothing	You Pay Nothing	No Coverage
Office Visits – Primary Care	\$20	\$20	\$20	50%* AD
Office Visits – Specialty Care	\$30	\$30	\$30	50%* AD
After-Hours Care / Urgent Care – Care received in a physician's office.	\$30	\$30	\$30	50%* AD
Chiropractic Office Visits – Limited to 20 visits per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD
Major Diagnostic Laboratory Tests and Radiology – Including, but not limited to CT scans and MRIs.	10%* AD	10%* AD	20%* AD	50%* AD
Minor Diagnostic Laboratory Tests and X-Rays – Including, but not limited to mammograms and chest X-rays.	You Pay Nothing	You Pay Nothing	You Pay Nothing	50%* AD
Physiotherapy Services Physical, occupational and speech therapy provided on an outpatient basis. Limited to a combined benefit of 30 provider's office and/or outpatient facility visits of each type per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD
EMERGENCY CARE		YOU PAY		
Emergency Room Care – When medically necessary, as determined by Altius. Includes all services provided in an Emergency Room setting. Inpatient benefit applies when admitted. Outpatient hospital benefit applies when transferred to an operating room.	10%* AD	10%* AD	10%* AD	10%* AD
Urgent Care Facility – When medically necessary, as determined by Altius.	\$30	\$30	\$30	50%* AD
Ambulance / Paramedics – (including Air Ambulance) When medically necessary, as determined by Altius.	You Pay Nothing			

– Benefits Continued on Next Page–

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

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SB10/15/10

INPATIENT / OUTPATIENT HOSPITAL		YOU PAY		
Inpatient Hospital / Facility Services	10%* AD	10%* AD	\$500 + 30%* AD	\$500 + 50%* AD
Obesity Surgery – Covered only at an IASIS facility.	\$2,500	No Coverage	No Coverage	No Coverage
Outpatient Hospital / Facility Services – Including, but not limited to, outpatient surgery, observation, cardiovascular services, endoscopy, and pulmonary services.	10%* AD	10%* AD	\$100 + 30%* AD	\$100 + 50%* AD
Outpatient Hospital / Facility Therapy Services – Including, but not limited to, chemotherapy, radiation therapy, dialysis, and infusion therapy.	10%* AD	10%* AD	\$100 + 30%* AD	\$100 + 50%* AD
Additional Professional Services – Anesthesia and facility based professional fees associated with inpatient / outpatient services such as radiologist, pathologist, hospitalist, etc.	10%* AD	10%* AD	10%* AD	50%* AD
Inpatient / Outpatient Physician, Surgeon, Assistant Surgeon	10%* AD	10%* AD	10%* AD	50%* AD
Organ Transplant Services – Organ and tissue transplant services, including, but not limited to, cornea, kidney, heart, lung, heart-lung, liver, pancreas, and bone marrow transplants and related services. Office visits and other services related to organ transplant may have an additional copay.	10%* AD	10%* AD	30%* AD	Participating Providers Only
MATERNITY SERVICES		YOU PAY		
Pre-Natal and Post-Natal Care – Professional Services – Routine pre-natal office visits, delivery (including surgeon and assistant surgeon), and post-natal care. Regular benefits apply for complications of pregnancy.	\$20 1 st visit only	\$20 1 st visit only	\$20 1 st visit only	50%* AD
Inpatient Hospital / Facility Services	10%* AD	10%* AD	\$500 + 30%* AD	\$500 + 50%* AD
INJECTABLE OR IMPLANTABLE MEDICATIONS		YOU PAY		
Injectable or Implantable Medications – Facility – Injectable or implantable medications provided inpatient or outpatient through a hospital, surgical center, skilled nursing facility, other facility setting, or physician's office. Office visits and other services related to injectable or implantable medications may have an additional copay.	10%* AD	10%* AD	20%* AD/ 30%* AD	50%* AD / 60%* AD

– Benefits Continued on Next Page–

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

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ALLERGY CONDITIONS		YOU PAY		
Testing and Treatment – Specialty or After Hours copay may apply.	\$20	\$20	\$20	50%* AD
Serum	You Pay Nothing	You Pay Nothing	You Pay Nothing	50%* AD
Injections - Office visits and other services related to Allergy Injections may have an additional copay.	You Pay Nothing	You Pay Nothing	You Pay Nothing	50%* AD
OTHER BENEFITS		YOU PAY		
Accident Related Dental Services – Dental services required as the result of an accidental injury. Services include, but are not limited to, crowns, caps, bridges, and root canals. Limited to a combined lifetime maximum of \$1,000 per member.	10%* AD	10%* AD	20%* AD	50%* AD
Durable Medical Equipment (DME) – Including corrective appliances, orthotics and prosthetic devices.	20%* AD	20%* AD	20%* AD	50%* AD
Home Health Care – Limited to a combined benefit of 60 visits per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD
Hospice Care – Care for a terminally ill member through a licensed hospice agency.	20%* AD	20%* AD	20%* AD	50%* AD
Implantable Contraceptives and Intra-Uterine Devices (IUDs) – Includes charges for insertion and removal. Specialty or After Hours copay may apply.	\$20	\$20	\$20	50%* AD
Infertility Services – Evaluation, testing, and diagnostic services. Includes services that are provided for the purpose of ruling out infertility. Specialty or After Hours copay may apply.	\$20	\$20	\$20	Participating Providers Only
Medical Supplies – Disposable medical supplies and accessories as determined medically necessary by Altius.	20%* AD	20%* AD	20%* AD	50%* AD
Neuropsychological Testing	10%* AD	10%* AD	20%* AD	Participating Providers Only
Skilled Nursing Facility – Limited to a combined benefit of 60 days per member, per calendar year.	20%* AD	20%* AD	20%* AD	50%* AD
Sterilization Procedures – Services received at a physician's office. Specialty or After Hours copay may apply.	10%* AD	10%* AD	20%* AD	50%* AD
Sterilization Procedures – Services received at an outpatient facility.	10%* AD	10%* AD	\$100 + 30%* AD	\$100 + 50%* AD
Temporomandibular Joint Dysfunction (TMJ) – Evaluation, testing and diagnostic services.	Not Covered			

– Benefits Continued on Next Page–

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

Altius Customer Service 1-800-377-4161 www.altiushealthplans.com

Iasis Healthcare January 1, 2011	Level 1 IASIS	Level 2 UUMC, PCMC	Level 3 Altius Contracted Providers (No IHC or HCA)	Level 4 Non-Par Providers (including IHC/HCA)
MENTAL HEALTH / SUBSTANCE ABUSE		YOU PAY		
Inpatient Services	MHNet Providers – 10%* AD		50%* AD	
Partial Hospitalization	MHNet Providers – 10%* AD		50%* AD	
Services at an Outpatient Facility – Includes intensive outpatient services.	MHNet Providers – 10%* AD		50%* AD	
Outpatient Services	MHNet Providers – \$20		50%* AD	
GENERAL INFORMATION				
<p>Calendar Year Deductible – You must satisfy an individual or family deductible each calendar year before certain benefits will be provided under this benefit plan. Deductibles do not apply to benefits with "fixed" copays.</p>				
<p>Lifetime Maximum – The lifetime maximum includes all benefits paid on your behalf under any previous plan, policy, contract, or agreement issued by Altius. Your benefits will be exhausted once this lifetime maximum is met.</p>				
<p>Out-of-Pocket Maximum – Fixed dollar copays do not apply. When you or your family fulfill out-of-pocket maximums during a calendar year, then no further out-of-pocket expenses will be required for the remainder of that calendar year. This provision does not apply to any payments for benefits with fixed copays, prescription drugs, charges that exceed eligible medical expenses, non-covered services, or mental health services (which may have a separate out-of-pocket maximum). You are required to keep receipts for out-of-pocket expenses and furnish such proof to the Altius Claims Department when you reach your maximum.</p>				
<p>Securing Benefits and Payment for Services Through Altius – In order for a medical service to be eligible for coverage, it must be defined as a covered benefit and properly coordinated through Altius. Prior authorization is required for certain services (excluding emergency care) in order to verify that the services to be provided are covered by your benefit plan and are medically necessary and appropriate. It is your responsibility to determine that providers and facilities have obtained prior authorization from Altius prior to receiving care. If prior authorization from Altius is not obtained, coverage may be denied.</p>				

* Applies to out-of-pocket maximum (OOPM), AD = after deductible

Copays apply to each visit. Medical services with fixed copays are not subject to deductible. Altius pays non-participating providers based on Eligible Medical Expenses. You are responsible for the difference between billed charges and your Eligible Medical Expenses in addition to your share of coinsurance. This difference does not apply to the out-of-pocket maximum. Not all services are available at all levels, based on provider preference and assignment.

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Limitations & Exclusions

The following benefits are limited and/or excluded under the three plan options described above:

- Physiotherapy services (occupational, physical and speech) are limited to services that will significantly improve the member's condition, as determined by Altius.
- Altius reserves the right to include only one manufacturer's product on the Altius formulary when the same or similar drug (that is, a drug with the same active ingredient), supply, or equipment is made by two or more different manufacturers. The product or products not listed on the Altius formulary will be excluded from coverage.
- Altius reserves the right to include only one dosage or form of a drug on the Altius formulary when the same drug is available in different dosages or forms (for example, dissolvable tablets, capsules, etc.), from the same or different manufacturers. The product or products in other forms or dosages that are not listed on the Altius formulary will be excluded from coverage.
- Implantable contraceptive capsules such as Norplant and Implanon are limited to one implantation and removal during the maximum implantation period of the product, as determined by the product manufacturer.
- Neuropsychological evaluation and treatment is limited to those services that diagnose or treat an underlying medical condition and is covered only when there is clinically significant brain dysfunction.
- Accident-related dental services are covered only when required as a result of an accidental injury to sound, natural teeth. Dental services must be received within two years following the accidental injury.
- A determination by Altius that a service is infertility-related may be based on medical records or other documented evidence, and is not dependent on whether Altius actually receives a claim with a diagnosis of infertility.
- Certain injectable or implantable medications, including those that are administered by a medical professional, are covered only when they are purchased through designated vendors. To obtain a current list of these medications and vendors, visit the Altius web site or call customer service.
- Surgical treatment for obesity (including morbid obesity) and/or complications there from, including a reversal of these surgeries except under the following conditions:(1)The surgery must be performed at an IASIS facility, and (2) An employee must have been benefits eligible for one year in order to be eligible for the surgery, and for two years in order for his or her spouse to be eligible for the surgery, and (3) One surgery per lifetime is covered under the plan unless a second surgery is medically necessary, and (4) Complications from surgery for obesity will be covered only if the original surgery was performed in an IASIS facility.

The following are excluded from coverage under this benefit plan:

- Services provided outside the United States of America and its territories, except as required for an emergency or urgent condition.

- New procedures, services, supplies, and medications until they are reviewed for safety, efficacy and cost effectiveness and approved by Altius.
- Experimental or investigational treatment, procedures, tests, equipment, or facilities, or any health care service which is still undergoing evaluation and review.
- Services, drugs, and supplies that are not medically necessary, as determined by Altius.
- Medication amounts in excess of maximum quantity and/or dosage levels indicated by the drug manufacturer and the FDA.
- Experimental medications; medications for non-approved FDA indications or non-approved indications determined by Altius Health Plans; over-the-counter medications and products, except those specifically listed in the Altius formulary and those for which coverage is required by law; prescription medications that have an over-the-counter equivalent, unless otherwise specified in the Altius formulary; medications for athletic and mental performance; compounding fees; non-covered ingredients used in a compounded medication; medications for cosmetic indications; hair growth products and medications; homeopathic medications; hypodermic needles; impotence medications; medications for the treatment of infertility; skin patches for motion sickness; brand name medications for the treatment of nail fungus; progesterone cream and suppositories; smoking cessation products, including any medications prescribed for smoking cessation; medications required exclusively for foreign travel; oral vitamins (except prescription prenatal vitamins); medications or nutritional supplements for weight loss, or for weight gain for non-medical conditions.
- Immunizations required exclusively for foreign travel.
- Food supplements, food substitutes, medical foods, and formulas when taken orally, except when related to inborn errors of amino acid or urea cycle metabolism.
- Infertility treatment.
- In-vitro fertilization, GIFT, ZIFT, artificial insemination, and similar services. This includes any related services such as prescription medications, embryo transport, collection, and preparation costs.
- Reversal of elective sterilization.
- Amniocentesis and ultrasonography for sex determination.
- Predictive genetic testing.
- Predictive diagnostic testing and screenings, and other preventive services performed in the absence of illness or injury, other than those procedures or tests specifically recommended by Altius, the United States Preventive Services Task Force (USPSTF), the Centers for Disease Control (CDC), and local government public health authorities. Preventive services performed more often than, or outside of the guidelines of Altius, the USPSTF, CDC, and local government health authorities, are excluded.
- Elective home delivery for childbirth.
- Procedures, services, drugs, and supplies related to elective abortions, except when the life of the woman would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest, or to prevent the birth of a child that would be born with grave defects.
- Sex change operations or related health care services.
- Treatment, services, devices, and supplies related to sexual dysfunction. This exclusion does not apply to implantation of a penile prosthesis or use of an external device for

impotence caused by an organic disease such as diabetes mellitus or hypertension, or caused by surgery for genitourinary cancer.

- Surgery performed in order to prevent the possible onset of a condition or disease with which the member has not been diagnosed.
- Services, supplies, or treatment in connection with cosmetic or reconstructive procedures which alter appearance but do not restore or improve impaired physical function, or which are performed for psychological or emotional purposes. This exclusion does not apply to: (1) reconstructive surgery required as the result of an accidental injury, infection, or cancer. Services must be rendered (or a planned, staged series of services, as specifically documented in the member's medical record, must be initiated) within 12 months of the cause or onset of the injury, infection, or cancer; (2) circumcision for a newborn child up to three months of age; or (3) reconstruction of the breast(s) following a medically necessary mastectomy.
- Treatment of hyperhidrosis.
- Autopsy procedures.
- Health education services not closely related to the care and treatment of an illness or injury.
- Services provided by an athletic trainer or personal trainer.
- Telephone consultations, electronic mail communication, and communication services that do not require direct face-to-face contact between the patient and the provider.
- Charges for failure to keep a scheduled appointment.
- Interest or finance charges, except as specifically required by law.
- Prolotherapy (the use of injections to strengthen tendons and ligaments).
- Services for crossmatching and/or harvesting organs when the organ recipient is not an Altius member.
- Routine foot care. This exclusion does not apply to members with severe diabetes.
- Treatment of weak, strained or imbalanced feet.
- Foot orthotics, wedges or shoe inserts, unless herein provided. This exclusion does not apply to foot orthotics or shoe inserts for members with severe diabetes.
- Corrective appliances, prostheses, artificial aids and durable medical equipment, including supplies and accessories, are excluded when determined to be primarily for convenience, comfort, non-therapeutic purposes, or in the absence of illness or injury.
- Routine periodic servicing, such as cleaning and regulating, of durable medical equipment, corrective appliances, and prostheses is not covered. Replacement is not covered unless the existing device has become inoperable through normal wear and tear and cannot be repaired, or replacement is prescribed by a physician because of a change in the member's physical condition.
- All shipping, handling, or postage charges, except as incidentally provided without a separate charge.
- Any devices used to aid hearing, including, but not limited to, cochlear implants and hearing aids, including the fitting of such devices and related hearing examinations.
- Routine periodic servicing, repairs, batteries and accessories for any hearing aid device.
- Visual training aids.
- Eyeglasses, contact lenses, and examinations for contact lenses. This exclusion does not apply to: (1) the first pair of contact lenses or eyeglasses following the initial diagnosis of

aphakia or the surgical removal or surgical replacement of an organic lens; or (2) hydrophilic contact lenses used as a corneal bandage to treat conditions involving the cornea.

- Eye surgeries performed primarily to correct refractive errors. Examples include, but are not limited to: PRK (photorefractive keratectomy), LASIK (laser-assisted in-situ keratomileusis), RL (refractive lensectomy), ICRS (intracorneal ring segments), Intacs, phakic intraocular lenses (unless related to post-cataract surgery), and astigmatism correction (Limbal Relaxing Procedure). This exclusion does not apply to cornea transplants.
- Non-emergency follow-up care provided in an emergency room.
- Charges for transportation, including ambulance, unless determined medically necessary by Altius.
- Travel expenses, including hotel, motel and other non-medical room and board.
- Private hospital rooms, unless medically necessary.
- Hospital take-home drugs and personal, comfort, or convenience items.
- Private duty nursing.
- Custodial care, domiciliary care, rest cures, and independent living training.
- Home health services requested for the convenience of the patient or family that do not require the training and technical skills of a nurse.
- Hospice services that are not reasonable and necessary for palliation or management of a terminal illness.
- Vocational testing and treatment.
- Speech therapy services for psychosocial and/or developmental delays, such as but not limited to, childhood stuttering.
- Services related to the treatment of sensory processing dysfunction or sensory integration disorder. This exclusion does not apply to the initial assessment for diagnosis of the condition or to the medical management of an underlying medical illness which may be contributing to the condition.
- Psychotherapy, counseling or other services in connection with marital or family problems; social maladjustments; conduct disorders; chronic adjustment disorders; psychosexual disorders; chronic organic brain syndromes; personality disorders; developmental disorders; learning disabilities; or mental retardation. This exclusion does not apply to the initial assessment for diagnosis of the condition or to the medical management of an underlying medical illness which may be contributing to the disability.
- Electrosleep or electronarcosis therapy, rapid detoxification programs, and milieu therapy.
- Psychiatric treatments or services performed in the absence of a psychiatric diagnosis.
- Substance abuse maintenance therapy, such as methadone clinics and similar clinics and services.
- Evaluation, testing, and treatment provided by public or private schools.
- Charges in connection with a work-related injury or sickness for which coverage is provided or would be provided under any workers' compensation, employer's liability, or occupational disease law. When the employer is required by law to have such coverage, this exclusion applies whether or not such coverage is in effect.

- Services, supplies, or treatment for which coverage is provided under any motor vehicle no-fault plan. When the member is required by law to have no-fault insurance, this exclusion applies to charges up to the minimum coverage required by law whether or not such coverage is in effect.
- Expenses for which the member has no legal responsibility to pay or for which the member would not ordinarily be charged in the absence of coverage under this benefit plan.
- Care for military service connected disability to which the member is legally entitled, and for which facilities are reasonably available to the member.
- Care or treatment of an illness or injury caused by war or any act of war (whether declared or undeclared), hostilities, or active participation in a riot or civil insurrection.
- Care for conditions which state or local law requires to be treated in a public facility.
- Services and treatments provided in connection with, or to comply with, involuntary admissions, police detentions, and similar arrangements.
- Examinations and services obtained for administrative purposes, such as treatment, care, reports or appearances obtained for, or pursuant to, legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, travel, or military services.
- Oral surgery, including but not limited to orthognathic surgery, and any services related to the treatment of Temporomandibular Joint Syndrome (TMJ), unless determined medically necessary by Altius for direct treatment of an invasive tumor or acute traumatic injury. This exclusion does not apply to diagnosis and evaluation of TMJ dysfunction.
- Dental or orthodontic splints or dental prostheses, unless necessitated by accidental injury.
- Services related to the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth, unless herein provided or necessitated by accidental injury.
- Acupuncture or acupressure.
- Holistic and homeopathic treatments.
- Alternative medicine programs such as hypnosis, massage therapy and biofeedback.
- Recreational therapy, wilderness therapy, or residential treatment programs.
- Injury or illness sustained when in the act of an illegal activity.
- Services for which a provider waives the member's copay, coinsurance, and/or deductible.
- Services provided by a member of the patient's immediate family or household.
- Expenses related to non-covered services, including pre- and post-operative evaluation, diagnostic testing, and complications resulting from non-covered services, supplies, and/or medications. When a non-covered procedure is performed as part of the same operation or process as a covered service, then only eligible charges relating to the covered service will be covered.
- Benefits and services not specified as covered in the Group Service Agreement.

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 EOC; (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 (EOC) 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

	<ul style="list-style-type: none"> • grief issues • parenting • work-related issues • gambling addiction
<i>How do I access the Employee Assistance Program?</i>	<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 can not be resolved within three (3) sessions.</p>
<i>Where are the EAP counseling sites?</i>	<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>
<i>Who pays for the Employee Assistance Program?</i>	<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>
<i>Why use the Employee Assistance Program?</i>	<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**

