



**Your 2011
Benefits Enrollment Guide**



*Look inside to learn about important changes
to your 2011 Capella Healthcare benefits*

Leading the Way to a Brighter Future

Capella Team,

Just as your hospital is vital for the health of your community, you - our employees - are the lifeblood of our hospitals. The health and welfare of our employees as well as your families is essential as we work together, leading the way to a brighter future for the communities we serve together.

Providing a variety of benefits that allow maximum choice is one of the ways we partner with you to help you improve and maintain your health and that of your families. This booklet provides an overview of our 2011 benefits program and points you to additional resources in case you'd like even more information.

While we have expanded services in several areas, most of our benefits will not change in 2011. As you prepare for annual benefits enrollment, please know that Capella is absolutely committed to providing you with benefit options in ways that make the most sense — and to assist you in being able to choose the right coverage for your specific needs. We offer access to a variety of coverage to meet the needs of our diverse population. And, we structure plans that enable us together to get the utmost value for each dollar we spend while being sensitive to the need for benefits to be affordable for everyone.

Even in this difficult economic environment, we are committed to providing you with valuable benefits and paying the majority of the cost. However, it is critical that each of us does everything possible to spend wisely, improve or maintain our health, and keep our costs as low as possible. It's just part of being a responsible healthcare provider, community citizen and caregiver for our own family.

Capella Healthcare is committed to helping you improve and maintain your good health and well-being. When you or your family need care, taking advantage of Capella's outstanding facilities, services and affiliated providers makes sense – for you and your family as well as for our company. Remember, Capella's medical plans are self-funded, which means Capella — not the insurance company — is financially responsible for claims payment. Just as each Capella team member has responsibility to take care of their health and make wise decisions about healthcare purchases, the company has a shared responsibility to provide opportunity for best-in-class service partners and care management.

Thank you for choosing to be a part of our Capella family and for dedicating your life in the service of others. We look forward to working with you as we continue to make progress toward our common goal of building a culture of health and well-being in our hospitals and our communities.

Best Regards,

Dan Slipkovich
Chief Executive Officer

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Not making changes or enrolling in a Flexible Spending Account (FSA) for 2011? You Don't Have to Enroll... You will need to enroll during Annual Enrollment only if you are making changes to your benefit elections or enrolling or re-enrolling in an FSA for 2011. If you do not take action during Annual Enrollment, your 2010 benefit elections (except your FSA elections) will continue into 2011, at 2011 contribution rates.

Health Care Reform Changes for 2011

The Patient Protection and Affordable Care Act (commonly known as “health care reform”) was signed into law March 2010. It impacts ALL health plans, not just our company’s. Below is a summary of the provisions from the health care reform law that will apply to all medical plans in 2011.

- **Children Eligible for Coverage to Age 26:** You can enroll your natural born, adopted, and/or step children up to age 26 for medical, dental and vision coverage under your plan, provided they are not eligible for coverage under another health care plan. Dependents of adult children covered under the plan are not eligible for coverage under health care reform laws.
- **No Reimbursement for Over-the-Counter (OTC) Medicines under the Health Care Flexible Spending Account (FSA):** The legislation eliminated OTC medicines as a reimbursable expense under a Health Care Flexible Spending Account (FSA). Effective January 1, 2011, you will no longer be able to use your Health Care FSA contributions to pay for OTC medicines (except for insulin or OTC medications purchased with a prescription), even if the expense was incurred in the prior year. If you contribute to a Health Care FSA for 2010 and you purchase OTC medications without a prescription in 2010, claims for these medications must be submitted before January 1, 2011 to be eligible for reimbursement.
- **No Lifetime Coverage Limits:** A maximum dollar amount of lifetime expenses will no longer apply to those covered by the Capella Healthcare plan.
- **No Pre-Existing Condition Limits for Children Under Age 19:** The Capella Healthcare plan will not apply pre-existing condition limitations to covered dependents age 19 or under, regardless of whether a Certificate of Creditable Coverage is submitted. Pre-existing coverage limits for primary members and adult dependents over age 19 will still apply unless a Certificate of Creditable Coverage is submitted when newly enrolling in the Plan.



Capella provides great benefits and employee programs...the partnership philosophy really works.

Eligibility

You are eligible for Capella Healthcare benefits the first of the month following 30 days of consecutive service if you are a:

- Full-time employee scheduled to work at least 32 hours a week
- Part-time employee scheduled to work at least 20 hours a week

If you are eligible for coverage, you can also enroll your eligible dependents for:

- Medical
- Dental
- Vision
- Dependent life insurance

NEW FOR 2011

You can enroll your natural born, adopted, and step children up to age 26 under your Capella medical, dental and vision coverage, provided they are not eligible for coverage under another health care plan. Dependents of those adult children covered under the plan are not eligible for coverage under health care reform legislation.

WHO'S ELIGIBLE FOR BENEFITS?

- **Your spouse or domestic partner**
- **Your eligible dependent children**

Eligible dependent children include your natural or adopted or stepchildren who are:

- **With respect to medical, dental and vision coverage,** (a) under age 26 (even if that child is married) and not eligible for coverage through another employer-sponsored plan; or (b) permanently and totally disabled, regardless of age
- **With respect to Dependent Life coverage,** (a) under age 19 (under age 24, if full-time students) and unmarried; or (b) permanently and totally disabled, regardless of age



Enrollment

You enroll for coverage under the Capella plan, as follows:

<p>If you are a new hire or if you are newly eligible for coverage:</p>	<p>You must enroll for coverage within 31 days of becoming eligible. Coverage begins the first of the month following 30 days of employment. If you do not make a medical plan election, coverage will default to the Base Plan (employee only).</p>
<p>During Annual Enrollment:</p>	<p>Each Fall, you can change your benefit elections for the upcoming calendar year during a two-week enrollment period. Please see your Human Resources Department for the Annual Enrollment dates at your location. Your elections will remain in effect through the end of the calendar year unless you experience a qualified life event. See “Changing your benefits” on page 25.</p>
<p>During the year:</p>	<ul style="list-style-type: none"> • If you do not enroll within 31 days of becoming eligible or during Annual Enrollment, <ul style="list-style-type: none"> ○ your medical plan election will default to the Base Plan (employee only), and ○ you will not be enrolled for dental or vision coverage. <p>You will have to wait until the next Annual Enrollment period in the fall to change your elections</p> • If you decline coverage because you are covered elsewhere, you may be able to enroll for coverage under the Capella plan within 31 days after your previous coverage ends • You may change or elect coverage within 31 days of certain qualified life events and status changes. See page 25 for a list of qualified life events • Coverage changes resulting from status changes will take effect the first of the month following the status change, as long as eligibility rules are met



Review your Capella benefits to make sure they continue to meet your and your family's changing needs.

How to Enroll

If you want to make benefit election changes or enroll in an FSA for 2011, you can do so in just eight easy steps*

1. Go to: www.mycapellabenefits.com

- Enter your User ID and Password
- Note: The first time you use the enrollment system, your User ID will be your last name and the last four digits of your social security number (all lower case).
- Your initial password is your date of birth in the following format (mmddyyyy). You will be required to update your password after your initial log-in and select a password reminder question. Please be sure to reset your password to something that only you will know.



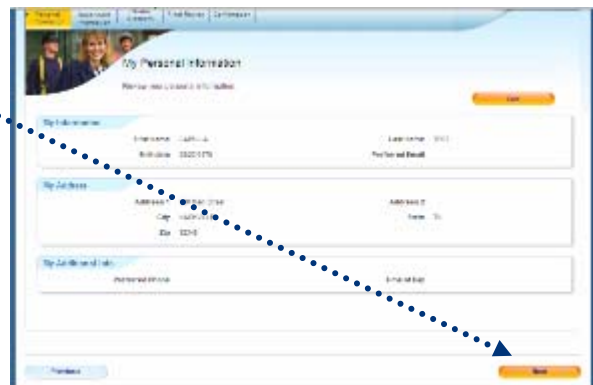
2. Make your elections

- To make your enrollment elections, go to the lower left of the screen to start your election process.
- Click here to view your current elections and make your Annual Enrollment or New Hire elections.



3. Review and update your personal information

- You may update some personal contact information.
- Throughout the process, you will click "Next" as you finish each screen.



4. Review and/or add dependents

- Click the pencil to edit a current dependent's information.
- Click "Add New Dependent" to add eligible dependents that are not shown.



5. Select your specific benefits

- This screen shows the list of benefits for which you are eligible.
- Click "Next Benefit" to move through the list or select specific benefits from the list.



6. Review and/or add beneficiaries

- Click "Add New Beneficiary" to add beneficiaries who are not displayed.
- Add or update the Primary and Secondary Allocations for each benefit in which you are enrolled.



7. Review your benefit choices

Time to review your choices. Review your:

- Benefit elections
- Benefit costs
- Dependent benefits elections
- Beneficiaries

After your Final Review, click "Save Elections" at the bottom of the page.

Benefit	Plan	Selected Plan	Cost per Period
Medical	P.O. Coverage	No Coverage	\$0.00
Dental	P.O. Coverage	No Coverage	\$0.00
Vision	P.O. Coverage	No Coverage	\$0.00
Basic Life Insurance - 10 Year Term B-ABC	10 Year Term Plan	10 Year Term Plan	\$0.00
Supplemental Employee Life Insurance	P.O. Coverage	No Coverage	\$0.00
Disability Life Insurance	P.O. Coverage	No Coverage	\$0.00
Short Term Disability	P.O. Coverage	No Coverage	\$0.00
Long Term Disability	P.O. Coverage	No Coverage	\$0.00
Health Care FSA	P.O. Coverage	\$3.00	\$0.00
Dependent Care FSA	P.O. Coverage	\$3.00	\$0.00
Employee Assisted Plan	P.O. Coverage	No Coverage	\$0.00

	Per Pay Period	Per Year
Total Pre-Tax Deductions	\$3.00	\$0.00
Total Post-Tax Deductions	\$3.00	\$0.00
Total Health	\$3.00	\$0.00
Total Cost of Benefits	\$3.00	\$0.00

Dependent Name	Enroll	Covered
ROBERT YOUNG	ENROLL	NO

8. Print your confirmation

Download or print your benefits enrollment confirmation.

Plan	Selected Plan	My Cost	Effective
Medical	No Coverage	\$0.00	1/01/2011
Dental	No Coverage	\$0.00	1/01/2011
Vision	No Coverage	\$0.00	1/01/2011
Basic Life Insurance - 10 Year Term B-ABC	10 Year Term Plan	\$0.00	09/01/2010
Supplemental Employee Life Insurance	No Coverage	\$0.00	09/01/2010
Disability Life Insurance	No Coverage	\$0.00	09/01/2010
Short Term Disability	No Coverage	\$0.00	1/01/2011
Long Term Disability	No Coverage	\$0.00	09/01/2010
Health Care FSA	No Coverage	\$3.00	1/01/2011
Dependent Care FSA	No Coverage	\$3.00	09/01/2010
Employee Assisted Plan	No Coverage	\$0.00	09/01/2010

	Per Pay Period	Per Year
Total Pre-Tax Deductions	\$3.00	\$0.00

**Remember, you do not have to take action during Annual Enrollment if you are not changing your benefit elections or enrolling in an FSA for 2011.*



If you have any questions about online enrollment, call the Capella Healthcare Benefits Center at 1-866-416-8932.

Medical Plan

Capella's Medical Plan is administered by BlueCross BlueShield (BCBS). The Medical Plan centers around a network of physicians, hospitals and health care providers.

Your benefit election is important.
 Compare the plans in more detail using the Plan Comparison Tool at:
www.mycapellabenefits.com

HOW THE PLAN WORKS


Capella offers two medical options: the Base Plan and the Buy-Up Plan. The Plans cover the same services, but at different benefit levels.

	Base Plan	Buy-Up Plan
Payroll premium deduction	Lower	Higher
Deductible	Higher	Lower
Copay		
Out-of-pocket Maximum		

As a Capella employee, you and your family receive the highest level of benefits from your medical plan when you use a Capella facility. See the charts on pages 10 and 12 for a summary list of covered services and coverage amounts. When you enroll in the Medical Plan, you automatically receive coverage for prescription drugs.

USING THE NETWORK

You have a network (BlueCross BlueShield) of providers from which to choose. When you use network physicians and facilities, you pay less. You may be required to meet an annual deductible before the plan pays anything. Once you meet the deductible, the plan pays a percentage of eligible charges and you pay the rest.

 *From preventive care to hospital services, Capella's Medical Plan is designed to provide quality care and help you save money on medical expenses. You save even more when you receive care through a Capella facility.*



EMERGENCY SERVICES

Emergency situations that are life- or limb-threatening often dictate the use of the nearest medical facility available even when that may not be a Capella or in-network facility. Although hospital services are covered at out of network facilities, you get the highest level of coverage when you can plan to receive care through a network physician at a Capella facility.

PHYSICIAN SERVICES

For physician services, you can see any provider you choose. However, if the physician you choose is **not** in the BCBS network, you will pay more. Out-of-network benefits are also subject to reasonable and customary (R&C) limits. The R&C limit is the maximum a plan will pay for certain services. This limit is based on the usual fees charged by providers with similar training and experience in your geographic area. R&C limits apply only when you receive care from an out-of-network provider. Network providers have already agreed not to exceed R&C limits. If you choose to use an out-of-network provider and the charges exceed R&C limits, you are responsible for paying the difference. See the charts on pages 10 and 12 for specific coverage information.

PRE-CERTIFICATION

Pre-certification is required for all inpatient hospital admissions (including mental health and substance abuse). Pre-certification helps ensure that you receive the most appropriate treatment for your condition. It allows you to have your procedure or admission and length of stay approved before entering the hospital. If you don't receive pre-certification at least five days before your admission, or within 48 hours of an emergency admission, a penalty will apply. To pre-certify a procedure or hospital admission, call BCBS at the number listed on the back of your ID card.

WELLNESS — IT'S NOT JUST FOR PATIENTS

Just as you're committed to keeping our patients well, Capella is committed to helping you maintain your health. Making wellness a priority is the key to a healthier, happier life. You can't take care of others — your family and patients — unless you first take care of yourself! Wellness is a shared responsibility. Capella is committed to providing the benefits, tools and resources to help you manage your health. It's up to you to use them to determine the right mix of benefits for you and your family.

ACCESSING YOUR PERSONAL HEALTH ANALYSIS

Taking a health analysis is an important step in evaluating your health and making positive, personal changes toward better health. The analysis identifies risks and promotes early intervention on a variety of health concerns, including weight, stress, tobacco use, fitness, diabetes, and more. An instant feedback report gives each employee a personalized wellness plan with positive action steps. To access the health analysis, go to www.bcbst.com/tools or www.bsbsal.org (for employees in Alabama). Register for your *blueaccess* user ID and password. Once your registration is complete you are ready to begin your health analysis. Completing the health analysis can provide you with a wealth of information. All Capella employees enrolled in company-sponsored medical coverage are encouraged to take the health analysis.

BCBS has online tools and information at www.bcbst.com and www.bcbsal.org (for employees in Alabama) to help you manage your health. Information on the site enables you to better understand the cost of care, make decisions about health care options, and manage plans. You will find links to help you locate a network provider, look up claims and coverage levels, review treatment options and costs, and take a free health analysis.

Summary of Medical Benefits

The charts that follow summarize coverage levels for the Medical Plan. **Remember, you get the highest level of coverage when you receive care through a network physician in a Capella facility.** You can find in-network providers at www.bcbst.com or www.bcbosal.org (for employees in Alabama).

Taking advantage of Capella's best in class facilities and services makes sense — both for you and your family as well as for Capella. When you use a Capella facility, you get access to the best care at the best price. It's up to you to make the most of all that Capella offers. And you should because you deserve the best!



A REMINDER ON HEALTH CARE REFORM

Remember, for 2011, the health care reform law requires the following changes:

- **Children Eligible for Coverage to Age 26:** You can enroll your natural born, adopted, and/or step children up to age 26 for medical, dental and vision coverage under the Capella plan, provided they are not eligible for coverage under another health care plan. Dependents of adult children covered under the plan are not eligible for coverage under the Capella plan.
- **No Reimbursement for Over-the-Counter (OTC) Medicines under the Health Care Flexible Spending Account (FSA):** The legislation eliminates OTC medicines as a reimbursable expense under a Health Care Flexible Spending Account. Effective January 1, 2011, you will no longer be able to use your Health Care FSA contributions to pay for OTC medicines (except for insulin or OTC medications purchased with a prescription), even if the expense was incurred in the prior year. If you contribute to a Health Care FSA for 2010 and you purchase OTC medications without a prescription in 2010, claims for these medications must be submitted before January 1, 2011 to be eligible for reimbursement.
- **No Lifetime Coverage Limits:** A maximum dollar amount of lifetime expenses will no longer apply to those covered by the Capella Healthcare plan.
- **No Pre-Existing Condition Limits for Children Under Age 19:** The Capella Healthcare plan will not apply pre-existing condition limitations to covered dependents age 19 or under, regardless of whether a Certificate of Creditable Coverage is submitted. Pre-existing coverage limits for primary members and adult dependents over age 19 will still apply unless a Certificate of Creditable Coverage is submitted when newly enrolling in the Plan.

The following charts summarize coverage levels for the Medical Plan.

Base Plan Non-Hospital Services	Capella Facility	In-network Facility when Capella Facility IS NOT Available	In-network Facility when Capella Facility IS available	Out-of-network Facility ¹
Annual deductible – Individual/Family	-0-	\$600 Individual \$1,800 Family		\$1,500 Individual \$4,500 Family
Annual out-of-pocket maximum amount excluding any deductibles – Individual/Family	\$2,500 Individual \$5,000 Family	\$2,500 Individual \$5,000 Family	\$7,500 Individual \$15,000 Family	\$10,000 Individual \$20,000 Family
Physician Office Services Office Visits Routine Diagnostic Labs, X-Rays and Injections Non-Routine Diagnostic Services ² Maternity	You pay \$35 copay (Primary Care Physician) You pay \$70 copay (Specialist) No additional copay Plan pays 70% after deductible \$100 copay for all related office visits			Plan pays 50% after deductible
Preventive Health Care Services Well Child Care Extended Well Care for Ages 6 and Up Annual Mammogram Pap Smear Cervical Cancer Test Well Woman Exam PSA test Immunizations (to age 6) Preventive screening colonoscopy	You pay \$20 copay You pay \$20 copay No additional copay No additional copay No additional copay No additional copay No additional copay No additional copay No additional copay			Plan pays 50% after deductible
Dependent age limit	To age 26			
Pre-existing Waiting Period³	12 months			
Medical Equipment Durable Medical Equipment Prosthetic & Orthotic Appliances		Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Therapeutic Services⁴ Therapy (Limited to 30-36 visits per year per therapy type)		Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible

Base Plan Non-Hospital Services	Capella Facility	In-network Facility when Capella Facility IS NOT Available	In-network Facility when Capella Facility IS available	Out-of-network Facility ¹
Skilled Nursing Facility & Rehabilitation Facility Services⁵ Limited to 60 days per calendar year		Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Home Health Services⁶ Limited to 60 days per calendar year		Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Hospice Services⁶		100%	100%	Plan pays 50% after deductible
Ambulance Services		Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 70% after deductible
Mental Health/Substance Abuse		Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 50% after deductible
Hospital Services				
Inpatient Services⁵	Plan pays 90%	Plan pays 70% after deductible	Plan pays 50% after \$2,500 copay	Not Covered
Outpatient Services⁷				
Routine Diagnostic Services – Outpatient Non-Routine Diagnostic Services – Outpatient Other Outpatient Services	Plan pays 90%	Plan pays 70% after deductible	Plan pays 50% after \$2,500 copay	Not covered
Emergency Room⁸ <i>(Facility charges only)</i>	Plan pays 90% after \$175 copay	Plan pays 70% after \$175 copay		

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Includes CAT scans, MRIs, nuclear medicine and other similar technologies as well as chemotherapy, radiation therapy, and renal dialysis.
3. HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'.
4. Physical, speech, manipulative, and occupational therapies are limited to 30 visits per year per therapy type. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per year per therapy type.
5. Services require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.
6. Requires prior approval.
7. Surgeries include diagnostic colonoscopies performed as follow up to a previously diagnosed condition.
8. Copayments are waived if patient is admitted to the hospital.

Buy-Up Plan Non-Hospital Services	Capella Facility	In-network Facility when Capella Facility IS NOT Available	In-network Facility when Capella Facility IS available	Out-of-network Facility ¹
Annual deductible – Individual/Family	-0-	\$300 Individual \$900 Family		\$900/\$2,700
Annual out-of-pocket maximum amount excluding any deductibles – Individual/Family	\$2,500 Individual \$5,000 Family	\$2,500 Individual \$5,000 Family	\$6,000 Individual \$12,000 Family	\$10,000 Individual \$20,000 Family
Physician Office Services Office Visits Routine Diagnostic Labs, X-Rays and Injections Non-Routine Diagnostic Services ² Maternity	You pay \$20 copay (Primary Care Physician) You pay \$30 copay (Specialist) No additional copay Plan pays 80% after deductible \$100 copay for all related office visits			Plan pays 50% after deductible
Preventive Health Care Services Well Child Care Extended Well Care for Ages 6 and Up Annual Mammogram Pap Smear Cervical Cancer Test Well Woman Exam PSA test Immunizations (to age 6) Preventive screening colonoscopy	You pay \$15 copay You pay \$15 copay No additional copay No additional copay No additional copay No additional copay No additional copay No additional copay No additional copay			Plan pays 50% after deductible
Dependent age limit	To age 26			
Pre-existing Waiting Period³	12 months			
Medical Equipment Durable Medical Equipment Prosthetic & Orthotic Appliances		Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Therapeutic Services⁴ Therapy (Limited to 30-36 visits per year per therapy type)		Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Skilled Nursing Facility & Rehabilitation Facility Services⁵ Limited to 60 days per calendar year		Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible

Buy-Up Plan Non-Hospital Services	Capella Facility	In-network Facility when Capella Facility IS NOT Available	In-network Facility when Capella Facility IS available	Out-of-network Facility ¹
Home Health Services⁶ Limited to 60 days per calendar year		Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Hospice Services⁶		100%	100%	Plan pays 50% after deductible
Ambulance Services		Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Mental Health/Substance Abuse		Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible
Hospital Services				
Inpatient Services⁵	Plan pays 90%	Plan pays 80% after deductible	Plan pays 50% after \$2,500 copay	Not Covered
Outpatient Services⁷				
Routine Diagnostic Services – Outpatient Non-Routine Diagnostic Services – Outpatient Other Outpatient Services	Plan pays 90%	Plan pays 80% after deductible	Plan pays 50% after \$2,500 copay	Not covered
Emergency Room⁸ (Facility charges only)	Plan pays 90% after \$125 copay	Plan pays 80% after \$125 copay		

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Includes CAT scans, MRIs, nuclear medicine and other similar technologies as well as chemotherapy, radiation therapy, and renal dialysis.
3. HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'.
4. Physical, speech, manipulative, and occupational therapies are limited to 30 visits per year per therapy type. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per year per therapy type.
5. Services require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.
6. Requires prior approval.
7. Surgeries include diagnostic colonoscopies performed as a follow up to a previously diagnosed condition.
8. Copayments are waived if patient is admitted to the hospital.

Prescription Drug Benefits

When you enroll for coverage under the Medical Plan, you automatically receive prescription drug coverage. You have two ways to buy prescription drugs:

- At a network pharmacy
- Through the Rx Home Delivery program

You can buy up to a 30-day supply at a network retail pharmacy or up to a 90-day supply through the Rx Home Delivery program. If you have ongoing prescription needs, the mail order program can save you money.

Prescription drug benefits are administered by Caremark. The plan covers selected brand-name drugs for certain drug classes. For several classes, only generic equivalents or generic alternatives are covered. To minimize your prescription drug costs, review the Limited Formulary Drug List at www.caremark.com. If your medication is not on the list, review the non-covered brands chart to help find lower-cost alternatives that are covered by the plan and discuss these with your doctor. You will find a list of network pharmacies on the website as well.

Some brand name drugs have limits or require a step therapy approach before being prescribed. Step therapy lets you try a less expensive drug — proven to be effective for most people — before you use a similar, more expensive drug. If you’ve already tried the similar, less expensive drugs with no success, or if your doctor believes your medical condition requires the more expensive step therapy drug, ask your doctor to contact Caremark at 1-877-916-2271 to request an exception or prior authorization. If approved, the step therapy drug will be covered by the plan.

You must meet an annual prescription drug deductible before the plan begins paying. After you meet the deductible, you pay a copay each time you fill a generic prescription and a coinsurance percentage each time you fill a brand name prescription.

The following chart summarizes coverage levels for the Prescription Drug Plan.

	Immediate Needs (up to 30-day supply)	Maintenance Medications (up to 90-day supply)
	Network Pharmacy	Rx Home Delivery (mail order)
Annual deductible	\$50/person (does not apply to medical calendar year deductible)	
Generic	\$10 copay after deductible	\$25 copay after deductible
Preferred Brand	30% after deductible (up to \$75 maximum)	\$87.50 copay after deductible
Non-Preferred Brand	40% after deductible (\$55 minimum / \$110 maximum)	\$150 copay after deductible

You generally pay less if your doctor prescribes generic drugs, whether you fill the prescription at a network pharmacy or through the Rx Home Delivery program. If a generic drug is not available, you can ask your doctor to prescribe a brand name drug that is on the Caremark formulary.



New for 2011

Two prescription medicines to help you or a family member stop smoking, Chantix and Zyban, are now covered by our plan. Capella will cover two six-month treatment periods in support of your efforts to quit.

Dental Benefits

Capella's Dental Plan covers a wide range of services. Dental benefits are administered by Delta Dental. Visit their website at www.deltadentaltn.com or call 1-800-223-3104 to locate a Delta Dental provider. You have the freedom to choose any dentist. However, benefits are generally greater when you visit a network dentist.

HOW THE PLAN WORKS

The plan covers:

- Preventive and diagnostic services (routine cleanings and exams)
- Basic services
- Major services
- Orthodontia

DENTAL BENEFITS

The following chart summarizes your coverage levels.

	You Pay
Annual Deductible	\$75 per person \$150 per family
Services	Plan Pays*
Preventive and Diagnostic Services <ul style="list-style-type: none"> • Routine cleanings/examinations (one every six months) • Routine X-rays (one panoramic every 36 months) • One Bitewing (one every 12 months) • Topical application of fluoride (up to age 19) • Space maintainers (children under 14) 	100% (no deductible)
Basic Services (fillings, new extractions, periodontics, oral surgery, sealants for children up to age 16)	80% after deductible
Major Services (crowns, inlays, dentures, partials, bridges)	50% after deductible
Orthodontia (up to \$1,500 lifetime maximum benefit/person)	50% after deductible
Annual maximum benefit (not including orthodontia)	\$1,250/person

*You are responsible for any charges that exceed reasonable and customary (R&C) limits. The R&C limit is the maximum a plan will pay for certain services and is based on the usual fees charged by providers with similar training and experience in your geographic area. R&C limits apply only when you receive care from a non-Delta Dental provider.



New for 2011

Great news! Capella is extending Dental Plan eligibility for dependents to age 26. However, lifetime dental maximums still apply. While this change is not required by health care reform, it is another way in which Capella Healthcare shows our commitment to helping improve and maintain your health and your family's health.

Vision Benefits

Capella's Vision Plan is administered by Vision Service Plan (VSP). The Vision Plan is centered around a network of optometrists, ophthalmologists and optical chains. You can use any provider, but you receive the highest level of benefits when you use one of VSP's network providers. Visit their website at www.vsp.com or call 1-800-877-7195 to locate a VSP provider.



New for 2011
Great news! Capella is extending Vision Plan eligibility for dependents to age 26. While this change is not required by health care reform, it is another way in which Capella Healthcare shows our commitment to helping improve and maintain your health and your family's health.

HOW THE PLAN WORKS

The plan covers the following:

- Eye exams
- Frames
- Lenses
- Contact lenses

USING THE NETWORK

When you use network providers, you generally pay a small copay at the time of service, and the plan pays the rest. If you use an out-of-network provider, your out-of-pocket expenses are generally higher. Also, you may be required to pay the full amount and submit a claim form to receive reimbursement for the portion the plan pays.

VISION BENEFITS

The following chart summarizes coverage levels for the Vision Plan.

	In-Network (VSP providers)	Out-of-Network (non-VSP providers)
Annual deductible	\$0	
Eye Exams (once every 12 months)	You pay a \$10 copay	The plan pays up to \$35
Frames* (one pair every 24 months)	You pay a \$20 copay	The plan pays up to \$45
Lenses** (one pair every 12 months)	You pay a \$20 copay	The plan pays up to:
• Single vision		\$25
• Bifocals		\$40
• Trifocals		\$55
Contact lenses (one pair every 12 months in lieu of eyeglasses)	You pay a \$20 copay	The plan pays up to \$105

*Applies to VSP's selection of frames; the plan offers a discount on non-VSP frames

**Only one copay required when you buy frames and lenses together

Employee Assistance Program

The Employee Assistance Program (EAP) is a free, confidential service designed to help you and your family cope with personal concerns. The EAP is provided by ValueOptions.

COUNSELING ON PERSONAL, FINANCIAL, WORK-LIFE AND LEGAL ISSUES

The EAP offers confidential counseling to help with personal issues you or your dependents may be facing. An experienced clinician will discuss your concerns with you and help develop an action plan that may include referrals to local resources or other expert counselors. The EAP can help you deal with a variety of personal, financial, work-life and legal issues such as:

- Adoption
- Civil lawsuits
- Day care/elder care
- Debt
- Depression
- Divorce
- Family budgeting
- Funeral services
- Grief and loss
- Home purchases
- Relocation services
- Rental cars
- Retirement planning
- Stress and/or anxiety
- Substance abuse
- Traffic violations
- Travel tips
- Tuition planning

ONLINE SERVICES

The EAP lets you use the Internet to find solutions to personal issues. Get trusted, expert information, resources, referrals or answers when you need them.



EAP Services are provided by ValueOptions. Counselors are available 24/7 by phone at 1-877-707-1780. You can also access EAP resources online at www.achievesolutions.net/capella



Flexible Spending Accounts

Flexible Spending Accounts (FSAs) let you pay for eligible out-of-pocket health care expenses for you and your covered dependents, and dependent care expenses for certain dependents, using before-tax payroll contributions. Capella Healthcare offers the following FSA options:

- **Health Care FSA**, which can reimburse you for eligible health care expenses (including medical, prescription drug, dental and vision expenses) not covered or fully reimbursed by your plans.
- **Dependent Day Care FSA**, which can reimburse you for day care, babysitting, pre-school and other qualifying expenses.

You can choose to participate in one FSA, both or neither.

ABOUT THE HEALTH CARE FSA

Your Health Care FSA can be used to cover eligible health care expenses that you, your spouse or Domestic Partner or your eligible dependents incur while you contribute to your account. Examples of eligible expenses include:

- Deductibles, co-insurance or co-pays you pay for medical, mental health and substance abuse, and dental treatment
- Glasses, contacts, contact solution and even vision correction surgery
- Orthodontia
- Weight-loss programs to treat a specific disease such as obesity, hypertension or heart disease, as diagnosed by a physician
- Most health care expenses that qualify for a deduction on your federal income tax return
- Eligible expenses include your own and those of your qualified dependents, even if they're not enrolled in your Capella Healthcare Medical Plan or your spouse's employer-provided plan

Contributing to Your Health Care FSA

You can contribute up to \$5,000 annually, but be sure to plan your contributions carefully because IRS rules require you to "use it or lose it." That means the money in your 2011 Health Care FSA can be used only for expenses you incur by December 31, 2011. You'll have until March 31, 2012 to file your claims for reimbursement. If there's any money left in your Health Care FSA after the claims filing deadline, your remaining balance will be forfeited.



Save Your Receipts

Be sure to keep your medical, prescription drug, dental and vision receipts. The FSA administrator will ask you to substantiate all of your eligible expenses. Retaining your receipts will help ensure that your claims are processed.

A REMINDER ON HEALTH CARE REFORM

No Reimbursement for Over-the-Counter (OTC) Medicines under the Health Care Flexible Spending Account (FSA): The legislation eliminates OTC medicines as a reimbursable expense under a Health Care Flexible Spending Account. Effective January 1, 2011, you will no longer be able to use your Health Care FSA contributions to pay for OTC medicines (except for insulin or OTC medications purchased with a prescription), even if the expense was incurred in the prior year. If you contribute to a Health Care FSA for 2010 and you purchase OTC medications without a prescription in 2010, claims for these medications must be submitted before January 1, 2011 to be eligible for reimbursement.

ABOUT THE DEPENDENT DAY CARE FSA

You can use the Dependent Day Care FSA to reimburse yourself for eligible child care expenses or caregiver expenses for an elderly parent or disabled family member. The Dependent Day Care FSA is meant to enable you and your spouse to work outside the home or your spouse to go to school full-time.

To be eligible for reimbursement from the Dependent Day Care FSA, care expenses must be for a dependent who lives with you for more than half the year and who is either (a) your child under age 13 who qualifies as a dependent on your federal income tax return or (b) a family member, including your spouse, who is physically or mentally incapable of self-care and qualifies as a dependent on your federal tax return.

Examples of eligible providers include:

- Caregivers for an elderly parent or disabled family member
- Charges for day care centers for children or adults
- Babysitters
- Nursery schools
- Before- and after-school programs

It's important to note that caregivers and babysitters who are your dependents under age 19 or who you claim on your taxes are not considered eligible providers. For example, if your 16-year-old daughter babysits your 10-year-old son, you cannot be reimbursed from your Dependent Day Care FSA to pay her.

Contributing to Your Dependent Day Care FSA

If you're single, you can contribute up to \$5,000 per year to the Dependent Day Care FSA. If you're married, your maximum contribution may be less than \$5,000, as determined by your tax-filing status and your spouse's status. Remember to plan your contributions carefully, because the IRS "use it or lose it" rule requires that the money in your 2011 Dependent Day Care FSA be used only for expenses you incur by December 31, 2011. You'll have until March 31, 2012 to file your claims for reimbursement. If there's any money left in your Dependent Day Care FSA after the claims filing deadline, your remaining balance will be forfeited.

If you're married and ...	The most you can contribute per year is ...
You or your spouse earns less than \$5,000	The amount the lower-paid person earns
Your spouse also participates in a Dependent Day Care FSA	\$5,000 combined for both accounts (\$416 per month)
Your spouse is a full-time student for at least five months of the year or your spouse is physically or mentally incapable of self-care	\$3,000 if you have one dependent (\$250 per month) — OR — \$5,000 if you have two or more dependents

Note: Your contributions may be reduced based on IRS Non-Discrimination Regulations.



Dependent Day Care, Not Dependent Health Care

The Dependent Day Care FSA is not for payment of your dependents' eligible health care expenses. Those expenses can be paid with your Health Care FSA. If you participate in both the Health Care and the Dependent Day Care FSAs, you cannot transfer money between the two accounts.

DECISION-SUPPORT TOOLS AVAILABLE

Participating in a Health Care FSA and/or Dependent Day Care FSA reduces your taxable income because your FSA contributions are not subject to federal income, Social Security and, in most cases, state and local taxes. Reducing your taxable income lowers your taxes, thus saving you money.

Use the decision support tools on www.mycapellabenefits.com to determine how much to set aside in your FSAs, and to estimate your potential tax-savings.

On the enrollment site, click on “Calculators” in the lower right corner of the Welcome screen.

Enter your personal information and let the calculator help you determine the right amount for your FSA(s).

A screenshot of a web-based calculator titled "Health Care FSA Calculator". The interface includes a header with a logo and a main area with several input fields and a table of results. The table lists various categories with corresponding dollar amounts. At the bottom, there are buttons for "Calculate" and "Reset".

Category	Amount
Medical and dental expenses	\$ 0.00
Dependent day care expenses	\$ 0.00
Prescription medicines	\$ 0.00
Prescription supplies	\$ 0.00
Medical services (e.g., physical therapy)	\$ 0.00
Medical services (e.g., vision care)	\$ 0.00
Medical services (e.g., dental care)	\$ 0.00
Medical services (e.g., home health care)	\$ 0.00
Medical services (e.g., durable medical equipment)	\$ 0.00
Medical services (e.g., long-term care)	\$ 0.00
Medical services (e.g., other qualified expenses)	\$ 0.00
Total FSA contribution	\$ 0.00
Total tax savings	\$ 0.00

MAKE IT EASY ON YOURSELF: PAY WITH YOUR CAPELLA PREPAID BENEFITS CARD

Once you have enrolled in an FSA, you will receive your new Capella Prepaid Benefits Card. Your prepaid benefits card eliminates the need for paper claims. Just use your card to pay your health care provider or pharmacy. Be sure to save your receipts in case you are asked to substantiate your charges as eligible expenses.

Highlights

- Provides instant access to FSA account funds; no need to use out-of-pocket dollars
- No waiting for reimbursement checks or direct deposit transfers
- One card may be used for both the Health Care FSA and the Dependent Day Care FSA
- **Any debit card purchase that is not an insurance plan copayment must be substantiated.** If you use your card at a non-eligible location or an expense is unrecognizable, you may have to submit a paper claim and receipt for reimbursement.

Examples of qualified locations and providers include:

- Hospital pharmacies
- Physician offices
- Dental offices
- Vision service locations
- Dependent care facilities (i.e., day care centers or senior care centers)
- Home health care services
- Durable medical supply location

Important Note: In order for the debit card to work properly, you will need to enter a personal or work e-mail address when enrolling online. If you do not have a secure email address, you always have the option to submit paper forms for claims reimbursement.



Life and AD&D

Life and Accidental Death and Dismemberment (AD&D) insurance provides financial security to you and your family in the event of a serious injury or death. Capella provides a basic level of Life and AD&D insurance for you at no cost. You can also purchase Supplemental Life insurance for yourself and dependent coverage for your family.

BASIC EMPLOYEE LIFE and AD&D

If you are a full-time employee working at least 32 hours a week, Capella will provide basic Life and AD&D coverage in an amount equal to:

- 1 x your annual pay (rounded to the next higher \$1,000, if not a multiple of \$1,000)

AD&D benefits are payable to you if you lose your life, a limb or other serious injury resulting in loss of use as the direct result of an accident. The plan pays a percentage of your coverage based on the severity of your injury. Forms for Life and AD&D insurance are available online at www.mycapellabenefits.com.



OPTIONAL EMPLOYEE TERM LIFE

Important Note: During the annual enrollment period, if you are currently covered, you may elect an additional \$20,000 of Optional Term Life Insurance without proof of good health.

You can buy Optional Term Life Insurance coverage of up to five times your annual pay, not to exceed \$500,000, in \$10,000 increments. You must submit a proof of good health form if you:

- Enroll in supplemental coverage over \$300,000
- Enroll in supplemental coverage more than \$20,000 greater than your current coverage or
- Have previously been denied coverage

SUPPLEMENTAL DEPENDENT LIFE

If you elect Supplemental Life Insurance for yourself, you can also buy Dependent Life Insurance for your spouse and/or your eligible children. Choose from the following amounts:

Spouse*	Up to 100% of your supplemental election in \$5,000 increments, not to exceed \$150,000
Children (14 days – 19 years**)	Up to \$10,000 in \$2,000 increments

*Spouse's coverage cannot exceed amount of employee's supplemental coverage

**Up to age 24 if the child is a full-time student

If you elect spouse coverage over \$25,000, you must submit a proof of good health form.

DECISION-SUPPORT TOOLS AVAILABLE

Capella's decision support tools can help you determine the appropriate level of life insurance you need.

On the enrollment site, click on "Calculators" in the lower right corner of the Welcome screen.

Enter your personal information and let the calculator help you determine your life insurance needs.



The screenshot shows a web-based "Life Insurance Calculator" interface. It features a header with the Capella logo and a navigation bar. Below the header, there is a form with several input fields and corresponding values:

Field	Value
Final Income (Gross annual salary less taxes)	\$ 0.00
Outstanding Debt (Mortgage, Credit Cards)	\$ 0.00
Annual Debt Service (Annual amount paid for loans or interest of \$1000 a day)	\$ 0.00
Annual Living Expenses (Spending for a dependent)	\$ 0.00
Annual Life Insurance for surviving expenses	\$ 0.00
Health Care (Investments, Savings)	\$ 0.00
Other Life Insurance	\$ 0.00

At the bottom of the form, there are three buttons: "Clear", "Calculate", and "Close".

YOUR BENEFICIARY

A beneficiary is the person you name to receive any benefits that are payable if you die. You are required to designate a beneficiary for Life Insurance and AD&D coverage. The beneficiary you choose for Basic Life Insurance and AD&D will be the same for Supplemental Life unless you name another beneficiary.

Disability Options

SHORT-TERM DISABILITY

Capella offers a Short-Term Disability (STD) Plan that continues a portion of your income if you have to miss work temporarily because of illness, injury or pregnancy.

HOW THE PLAN WORKS

Capella's STD plan:

- Replaces 60% of your weekly salary, up to \$2,500, for up to 22 weeks
- Pays benefits after 14-day waiting period

APPLYING FOR BENEFITS

If you elect STD coverage and become disabled, you can apply for STD benefits. You can use your extended sick leave or paid time off to continue your income during the waiting period, but **not** while you receive STD benefits. You are not required to exhaust your extended sick leave or paid time off before STD benefits begin.

BENEFIT LIMITS

STD benefits may be reduced by other disability benefits you are eligible to receive, such as Social Security. Limits apply for pre-existing conditions. The minimum weekly benefit is \$25, and the maximum weekly benefit is \$2,500. You pay no federal income tax on STD benefits.

Capella's STD Plan does not cover injuries related to Workers' Compensation claims. See your plan booklet for more information.

LONG-TERM DISABILITY

Capella offers a Long-Term Disability (LTD) Plan that pays a portion of your income if an illness or injury keeps you from working for an extended period.

HOW THE PLAN WORKS

Capella offers two Long-Term Disability options from which to choose:

Option 1

- Replaces up to 50% of your monthly pay up to \$10,000
- Pays benefits beginning after five months of disability

Option 2

- Replaces up to 60% of your monthly pay up to \$10,000
- Pays benefits beginning after five months of disability

Generally, if you are under age 63 when your disability begins, benefits are payable until you reach normal retirement age, if you remain disabled. If you are age 63 or older when your disability begins, benefits are payable for a specified period of time.

If your disability is the result of mental illness or substance abuse, benefits are payable for 24 months.

LTD benefits may be reduced by other disability benefits you are eligible to receive, such as Social Security. Limits apply for pre-existing conditions. The minimum monthly benefit is \$100 or 10% of your benefit before it is reduced by other sources.

401(k) Plan

ELIGIBILITY

You are eligible to join the 401(k) Plan during the monthly enrollment period after six months of consecutive service. An enrollment kit will be mailed to your home before your eligibility begins.

HOW THE PLAN WORKS

Decide How Much to Save

You can contribute from 1% to 95% of your pay to the 401(k) — up to a limit specified by the IRS each year. Your contributions are automatically deducted on a pre-tax basis from your paycheck each pay period. By saving with pre-tax dollars, you reduce your taxable income and pay less in taxes.



Capella Healthcare's 401(k)

Plan is administered by Diversified Investment Advisors. For more information, call 1-800-755-5801 or go to www.divinvest.com



Choose Your Investments

The plan offers a variety of investment fund options, each with a different level of risk and return potential. You can obtain information about each fund in your enrollment kit or at the Diversified Investment Advisors website at www.divinvest.com. You can change your investment choices anytime.

Consider the Big Picture

The 401(k) Plan is designed to be a long-term savings vehicle for your retirement. It is not intended to be a short-term savings account. However, Capella Healthcare allows for loans or withdrawals if you have a financial hardship.

Hardship loans and withdrawals will only be allowed in the event of payment of expenses for:

- Un-reimbursable medical care for you or your dependents
- Costs directly related to the purchase of your principal residence (excluding mortgage payments)
- Payment of expenses related to post-secondary education for you or your dependents
- Payments necessary to prevent eviction or foreclosure from your principal residence
- Payment of burial expenses for your dependents
- Payment of expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under IRS Code 165

Matching Contributions

As part of the discretionary match program, Capella can choose to match a specific portion of your salary deferral contributions. The formula for and the amount of any such matching contribution is determined annually by Capella and will be communicated to participants accordingly. The matching contribution will be funded once a year, generally after the close of the plan year. In order to receive the Company match, you must be employed on the last day of the plan year and have worked at least 1,000 hours during the plan year.

It Pays to Stay

You always own 100% of your own contributions to the 401(k) Plan. You earn ownership — or become vested — in Capella's matching contribution over time:

After	You Own
1 year	20% of Capella's contribution
2 years	40% of Capella's contribution
3 years	60% of Capella's contribution
4 years	80% of Capella's contribution
5 years	100% of Capella's contribution

Changing Your Benefits

Because you pay for most of your benefits on a pre-tax basis, the IRS will not allow you to change your benefit elections during the year unless you experience a qualified life event.

Qualified life events include:

- Marriage, divorce or annulment
- Birth, adoption or placement for adoption of a child
- Your spouse's or dependent's gain or loss of a job
- A gain or loss of coverage through your spouse's employer
- A change in work schedule that affects your eligibility
- Your child's gain or loss of eligibility status
- Death of a dependent spouse or child
- A Qualified Medical Child Support Order
- Entitlement to Medicare
- Commencement of, or return from, an unpaid leave of absence



You have **31 days from the date of the qualified life event** to change your coverage. However, the change in coverage must be consistent with the qualified life event. For any questions regarding changing your benefits due to a qualified life event, please contact the *Capella Healthcare Benefits Center at 1-866-416-8932*.

LIFE EVENT CHECKLIST

If you experience a qualified life event, such as marriage, divorce or birth or adoption of an eligible child, use this checklist to make sure you and your family are taking full advantage of your Capella benefits.

Contact your local HR representative to:

- ✓ **Update your personal information** (*name, address, phone number, etc.*).
- ✓ **Review your tax withholding status.**
- ✓ **Request a W-4 form from HR, if you want to make a change.**

Contact the Capella Healthcare Benefits Center to:

- ✓ **Review and update your beneficiary(ies) for:** Life insurance, Supplemental Life insurance, AD&D and 401(k).
- ✓ **Review your medical, dental and vision coverage and make any changes within 31 days of the event. Some rules apply.**
- ✓ **Review your Life insurance and AD&D coverage and make any changes within 31 days of the event.** Proof of good health may be required for some coverage changes; you will be notified if you need to provide proof of good health.
- ✓ **Review your flexible spending account participation and make any contribution changes within 31 days of the event.**

Contact Diversified Investment Advisors to:

- ✓ **Review your 401(k) Plan participation.** Once you become eligible to participate in the 401(k) Plan, you can change your contribution amount monthly and change your investment choices at any time.

Paying For Your Benefits

You and Capella share the cost of your benefits. For medical, dental and vision benefits, you'll pay your share of the cost through pre-tax payroll deductions. Paying for these benefits on a pre-tax basis reduces your taxable income, so you pay less in taxes. As a result, your benefits cost you less than if you paid for them with after-tax dollars. Cost information is included in your enrollment kit and online.

If You Leave Capella

- ✓ Be sure HR has your current mailing address.
- ✓ Any employer paid life and disability benefits will end on the date your employment ends. All other coverage will end on the last day of the month in which your employment ends.
- ✓ You'll be notified through the mail about your options for continuing your medical, dental, and FSA coverage under COBRA.
- ✓ You may be reimbursed for eligible expenses you incurred while contributing to the FSA accounts, as long as you file for reimbursement within 90 days after you leave Capella.
- ✓ Your contributions to the 401(k) Plan will cease. You will receive more information about your account from the plan administrator.

Terms to Know

COPAY

The flat dollar amount you pay for certain services, such as office visits, when you use network providers. The plan pays the remainder of the charges. Some exceptions may apply.

DEDUCTIBLE

The amount you pay each year before a plan (such as the Medical Plan and Dental Plan) begins to pay benefits for covered expenses. An annual deductible can be met by an individual or by a family. You can meet the family deductible with any combination of individual expenses. Once the family deductible has been met, the deductible will be considered met for all family members. **Copay amounts and pharmacy expenses do not count toward the deductible.**

COINSURANCE

The percentage of expenses you are responsible for after any required deductible has been met. For example, assume you need outpatient surgery, and the Buy-Up Plan pays 80% after you meet a deductible. In addition to the deductible, you will be responsible for the other 20% of the charges. The 20% you pay is called coinsurance.

OUT-OF-POCKET MAXIMUM

The most you have to pay out of your own pocket in a given year. When the amount you pay in a year reaches the out-of-pocket maximum, the plan will pay 100% of covered expenses for the rest of that year. Like the deductible, the out-of-pocket maximum can be met by an individual or by a family. Copays do **not** count toward the out-of-pocket maximum.

VESTING

The portion of your 401(k) account that belongs to you and cannot be forfeited. You are always fully vested in your contributions to the plan. You earn ownership (or become vested in) Capella's matching contributions gradually over a five-year period.

Contacts

Benefit Plan	Sponsor	Phone Number / Website
All Benefits	Capella Healthcare Benefits Center	Phone: 1- 866-416-8932 (9am – 6pm CST) Fax: 1- 877-682-4907 www.mycapellabenefits.com
Medical	BlueCross BlueShield of Tennessee	To find a provider: 1-800-810-BLUE(2583) www.bcbst.com To pre-certify a procedure or hospital stay: 1-800-565-9140 Other questions: 1-800-565-9140 www.bcbst.com BlueAccess (member self-service/ claims/personal health assessment): www.bcbst.com/members
	BlueCross BlueShield of Alabama	To find a provider: 1-800-810-BLUE(2583) www.bcbsal.org To pre-certify a procedure or hospital stay: 1-800-248-2342 Other questions: 1-800-846-6765 www.bcbsal.org BlueAccess (member self-service/ claims/personal health assessment): www.behealthy.com “Baby Yourself”: 1-800-222-4379
Prescription Drug Benefits	Caremark	1-888-790-8087 www.caremark.com
Dental Benefits	Delta Dental of Tennessee	1-800-223-3104 www.deltadentaltn.com
Vision Benefits	Vision Service Plan (VSP)	1-800-877-7195 www.vsp.com
Employee Assistance Program	ValueOptions	1-877-707-1780 www.achievesolutions.net/capella
Flexible Spending Accounts	Empyrean Benefit Solutions	1-866-416-8932 www.mycapellabenefits.com
Life and AD&D Short-Term Disability Long-Term Disability	Prudential	1-866-416-8932 (Life Insurance Claims) 1-800-842-1718 (Disability Claims)
401(k) Plan	Diversified Investment Advisors	1-800-755-5801 www.divinvest.com



*We remain committed to being an employer of choice
and to providing valuable benefits.*

Legal Notices

WOMEN'S HEALTH AND CANCER RIGHTS PROTECTIONS

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Contact your plan administrator, Capella Healthcare Director of Benefits for more information.

Capella Healthcare believes this Medical Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Capella Healthcare Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, the Director of Benefits, 615-764-3011. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Effective January 1, 2011, the lifetime limit on the dollar value of benefits under the Capella Healthcare Medical Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to enroll in the plan. Individuals have 30 days from the date Annual Enrollment begins to request enrollment. For more information, contact the Capella Healthcare Benefits Center at 1-866-416-8932.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Capella Healthcare Medical Plan. Individuals may request enrollment for such children for 30 days from the date Annual Enrollment begins. Coverage will be effective January 1, 2011. For more information, contact the Capella Healthcare Benefits Center at 1-866-416-8932.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) MAY OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

Effective January 1, 2011, if you are eligible for health coverage under the Capella Healthcare Plan, but are unable to afford the required contributions, some States have premium assistance programs that may help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Capella Healthcare Plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the plan. This is called a "special enrollment" opportunity, and you must elect coverage within 60 days of being determined eligible for premium assistance.



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This booklet provides only a brief summary of the benefits available under the Capella Healthcare plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Documents govern. The Plan Documents are available for your review online. Capella Healthcare retains the right to modify or eliminate these or any other benefits at any time and for any reason.