

# Summary of Optim Energy's Health Care Benefits — Active Employees — 2011

The following charts show deductibles, limits, benefit levels and copay amounts for the Optim Energy medical, dental and vision programs. For more information — including covered services and supplies and expenses not covered — see each individual section.

## Medical Coverage

	Blue Cross and Blue Shield		
	Premium Option	Standard Option	Value Option
<b>Plan Features</b>			
<b>Annual Deductible</b>			
• Individual	\$350	\$500	\$2,100
• Family	\$1,050	\$1,500	\$4,300
<b>Out of Pocket Maximum</b>			
• Individual	\$3,000	\$4,000	\$5,000
• Family	\$6,000	\$8,000	\$10,000
<b>Limitations on Pre-Existing Conditions</b>	None	None	None
<b>Overall Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited
<b>Other Lifetime Maximums</b>			
• Hospice care	• \$7,500/lifetime. Additional max. of 2 benefit periods/lifetime. Respite care limited to 5 consecutive days for each 60 days of hospice care. Additional max. of 2 respite stays.		
• Infertility	• \$5,000 in medical/surgical benefits. Additional \$5,000 in prescription drug benefits.		
• Outpatient physical, speech & occupational therapy (combined)	• \$3,500/condition		
• Skilled Nursing Facilities & inpatient rehabilitation facilities	• 30 days/condition		
<b>Other Maximums</b>			
• Acupuncture	• \$1,500/calendar year — for preferred providers. No coverage/benefits for non-preferred providers.		

**Blue Cross and Blue Shield**

**Premium Option**

**Standard Option**

**Value Option**

**Plan Features (cont'd)**

**Other Maximums**

- Travel related to organ and tissue transplants

- \$10,000/transplant for travel expenses, including meals and lodging. Meals and lodging further limited to \$125/day for recipient and one eligible adult (2 adults if patient is under 18)

- Home health care

- 100 visits/calendar year.

- Medical supplies & durable medical equipment from a non-preferred provider

- \$1,000/calendar year — for supplies from non-preferred providers. Diabetic supplies and oxygen are not subject to max. No annual max for preferred providers. Regardless of provider, mastectomy bras limited to 2/year and support hose limited to 2 pair/year.

- Orthotics & prosthetics from a non-preferred provider (combined)

- \$1,000/calendar year — for non-preferred providers. No annual maximum for preferred providers. Breast prosthetics are not subject to maximum.

- Spinal manipulation/chiropractic

- \$1,500/calendar year — for preferred providers. No coverage/benefits for non-preferred providers.

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**Blue Cross and Blue Shield**

**Premium Option**

**Standard Option**

**Value Option**

**Plan Features (cont'd)**

**Penalties for Failure to Call:**

- For Prior Approval of specific expenses, surgeries & procedures
- For Admission Review of a Hospital admission or other facility admission

- Denial of benefits
- \$300 penalty/admission or denial of benefits if admission is not Medically Necessary

**Services With A Copay**

**For In-Network/  
Preferred Provider Care**

	<b>Preferred Provider</b>	<b>Non-Preferred Provider<sup>1</sup></b>	<b>Preferred Provider</b>	<b>Non-Preferred Provider<sup>1</sup></b>	<b>Preferred Provider</b>	<b>Non-Preferred Provider<sup>1</sup></b>
<p><b>Doctor's Office Visit — PPP &amp; Other Providers</b></p> <ul style="list-style-type: none"> <li>• PPO Primary Provider (PPP)</li> <li>• Other preferred and non-preferred Doctors</li> <li>• Includes regular office visits, as well as covered diabetes education, family planning and gynecological services &amp; prenatal visits</li> </ul> <p><i>A PPP is a BCBS preferred provider in one of the following specialties: Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology, Gynecology and Pediatrics.</i></p>	<p align="center"><i>PPP:</i> 100% after a \$15 copay <i>No deductible</i></p> <p align="center"><i>Other Preferred Providers:</i> 100% after \$30 copay <i>No deductible</i></p>	70%	<p align="center"><i>PPP:</i> 100% after a \$20 copay <i>No deductible</i></p> <p align="center"><i>Other Preferred Providers:</i> 100% after \$40 copay <i>No deductible</i></p>	60%	<p align="center"><i>PPP:</i> 100% after a \$25 copay <i>No deductible</i></p> <p align="center"><i>Other Preferred Providers:</i> 100% after \$50 copay <i>No deductible</i></p>	50%
<p><b>Doctor's Office Visit — Specialist</b></p> <ul style="list-style-type: none"> <li>• Includes regular office visits, as well as covered diabetes education, family planning and gynecological services &amp; prenatal visits</li> </ul>	<p align="center">100% after \$30 copay <i>No deductible</i></p>	70%	<p align="center">100% after \$40 copay <i>No deductible</i></p>	60%	<p align="center">100% after \$50 copay <i>No deductible</i></p>	50%

**Blue Cross and Blue Shield**

**Premium Option**

**Standard Option**

**Value Option**

Services With A Copay						
For In-Network/ Preferred Provider Care <i>(cont'd)</i>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>
<b>Emergency Room/ Observation Room – Facility Charges, Emergency Only</b>	100% after \$100 copay <i>No deductible</i>	100% after \$100 copay <i>No deductible</i>	100% after \$125 copay <i>No deductible</i>	100% after \$125 copay <i>No deductible</i>	100% after \$150 copay <i>No deductible</i>	100% after \$150 copay <i>No deductible</i>
<b>Urgent Care</b>	100% after \$20 copay <i>No deductible</i>	70%	100% after \$35 copay <i>No deductible</i>	60%	100% after \$50 copay <i>No deductible</i>	50%
<b>Wellness/Preventive Visits</b> <ul style="list-style-type: none"> <li>• Annual physical</li> <li>• Annual Ob/Gyn</li> <li>• Well-child care</li> <li>• Adult &amp; child immunizations</li> <li>• Mammogram</li> <li>• Colonoscopy</li> <li>• Diabetes management</li> </ul>	100% after \$15 copay <i>No deductible</i>	70%	100% after \$20 copay <i>No deductible</i>	60%	100% after \$25 copay <i>No deductible</i>	50%
Services With Coinsurance						
	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>
<b>Abortion<sup>2</sup></b>	90%	70%	80%	60%	75%	50%
<b>Acupuncture</b> <i>Up to \$1,500/year</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered
<b>Allergy Injections, Tests, Serum</b>	90%	70%	80%	60%	75%	50%
<b>Ambulance<sup>2</sup></b> <ul style="list-style-type: none"> <li>• Ground/Emergency Air</li> <li>• Non-emergency Air</li> </ul>	90% 90%	90% 70%	80% 80%	80% 60%	75% 75%	75% 50%
<b>Cardiac Rehabilitation – Outpatient<sup>2</sup></b>	90%	70%	80%	60%	75%	50%
<b>Cochlear Implants<sup>2</sup></b>	90%	70%	80%	60%	75%	50%

**Blue Cross and Blue Shield**

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**Value Option**

Services With Coinsurance (cont'd)	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>
	<b>Dental Related/TMJ Services &amp; Oral Surgery<sup>2</sup></b> <ul style="list-style-type: none"> <li>• Facility charges for dental services</li> <li>• Oral surgery</li> <li>• Treatment of TMJ</li> </ul> <i>For a non-surgical office visit for treatment of a dental accident, see "Doctor's Office Visit."</i>	90%	70%	80%	60%	75%
<b>Diagnostic Services<sup>2</sup></b> <ul style="list-style-type: none"> <li>• Lab</li> <li>• X-ray</li> <li>• Other diagnostic tests — EKG, EEG, PET &amp; CT scans, ultrasounds, etc.</li> </ul>	90%	70%	80%	60%	75%	50%
<b>Durable Medical Equipment<sup>2</sup></b> <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%
<b>Emergency Room/ Observation Room — Non-Emergency</b>	90%	70%	80%	60%	75%	50%
<b>Emergency Room – Physician &amp; Other Professional Provider Charges</b>	90%	90%	80%	80%	75%	75%
<b>Eyeglasses/Contacts After Cataract Surgery or Keratoconus Correction<sup>2</sup></b> <i>Limitations apply. The durable medical equipment maximum applies — see "Other Maximums."</i>	90%	70%	80%	60%	75%	50%

		Blue Cross and Blue Shield				
		Premium Option	Standard Option		Value Option	
Services With Coinsurance (cont'd)	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>
<b>Home Health Care/Home Intravenous Services<sup>2</sup></b> <i>Up to 100 visits/year</i>	90%	70%	80%	60%	75%	50%
<b>Hospice Care<sup>2</sup></b> <i>Up to \$7,500/lifetime</i>	90%	70%	80%	60%	75%	50%
<b>Hospital Inpatient<sup>2,3</sup></b> <ul style="list-style-type: none"> <li>• Medical/surgical, maternity related</li> <li>• Room &amp; board</li> <li>• Covered ancillaries</li> <li>• Routine nursery care for newborns</li> <li>• Intensive care, cardiac care unit</li> </ul>	90%	70%	80%	60%	75%	50%
<b>Infertility<sup>2,3</sup> — Physician/Facility</b> <i>Up to \$5,000/lifetime</i>	Based on services	70%	Based on services	60%	Based on services	50%
<b>Mastectomy &amp; Reconstructive Surgery<sup>2,3</sup></b>	90%	70%	80%	60%	75%	50%
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>• Including delivery &amp; routine pediatrician care for covered newborns</li> <li>• Also see "Hospital"</li> </ul> <i>Initial visit may require a copay.</i>	90%	70%	80%	60%	75%	50%
<b>Medical Supplies<sup>2</sup></b> <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%
<b>Mental Health — Outpatient<sup>2</sup></b>	100% after \$15 copay <i>No deductible</i>	70%	100% after \$20 copay <i>No deductible</i>	60%	\$100% after \$25 copay <i>No deductible</i>	50%

**Blue Cross and Blue Shield**

**Premium Option**

**Standard Option**

**Value Option**

Services With Coinsurance <i>(cont'd)</i>	Premium Option		Standard Option		Value Option	
	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>
<b>Mental Health — Inpatient<sup>2,3</sup></b>	100% after \$15 copay <i>No deductible</i>	70%	100% after \$20 copay <i>No deductible</i>	60%	100% after \$25 copay <i>No deductible</i>	50%
<b>Orthotics, Functional<sup>2</sup></b> <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%
<b>Prosthetics<sup>2</sup></b> <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%
<b>Pulmonary Rehabilitation — Outpatient<sup>2</sup></b>	90%	70%	80%	60%	75%	50%
<b>Short-Term Rehabilitation &amp; Therapy — Outpatient<sup>2</sup></b> <ul style="list-style-type: none"> <li>• Physical, occupational &amp; speech therapy &amp; rehabilitation services</li> <li>• Outpatient, office &amp; home-based</li> </ul> <i>Limitations apply. See "Other Lifetime Maximums."</i>	90%	70%	80%	60%	75%	50%
<b>Short-Term Rehabilitation &amp; Therapy — Inpatient<sup>2,3</sup></b> <ul style="list-style-type: none"> <li>• Physical, occupational &amp; speech therapy &amp; rehabilitation services</li> <li>• Skilled Nursing Facility or rehabilitation facility</li> </ul> <i>Limitations apply. See "Other Lifetime Maximums."</i>	90%	70%	80%	60%	75%	50%
<b>Spinal Manipulation/ Chiropractic</b> <i>Up to \$1,500/year</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered

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**Value Option**

Services With Coinsurance <i>(cont'd)</i>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>	Preferred Provider	Non-Preferred Provider <sup>1</sup>
<b>Substance Abuse Treatment — Outpatient<sup>2</sup></b> <ul style="list-style-type: none"> <li>Includes chemical dependency, drug abuse &amp; alcoholism treatment</li> </ul>	100% after \$15 copay <i>No deductible</i>	70%	100% after \$20 copay <i>No deductible</i>	60%	100% after \$25 copay <i>No deductible</i>	50%
<b>Substance Abuse Treatment — Inpatient<sup>2,3</sup></b> <ul style="list-style-type: none"> <li>Includes chemical dependency, drug abuse &amp; alcoholism treatment</li> </ul>	100% after \$15 copay <i>Detoxification stays-Deductible Applies.</i> <i>All other stays-No Deductible</i>	70%	100% after \$20 copay <i>Detoxification stays-Deductible Applies.</i> <i>All other stays-No Deductible</i>	60%	100% after \$25 copay <i>Detoxification stays-Deductible Applies.</i> <i>All other stays-No Deductible</i>	50%
<b>Surgery<sup>2,3</sup> — Inpatient or Outpatient</b>	90%	70%	80%	60%	75%	50%
<b>Therapy — Chemotherapy, Dialysis &amp; Radiation<sup>2</sup></b>	90%	70%	80%	60%	75%	50%
<b>Transplants<sup>2,3</sup></b> <i>Limitations apply. See "Other Maximums."</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered

<sup>1</sup> Percentages shown for non-preferred providers are the percentage of covered charges payable.

<sup>2</sup> Certain services are not covered if prior approval is not obtained. See your Summary Plan Description for a complete list of specific expenses, surgeries and procedures that require prior approval.

<sup>3</sup> Admission review is required for inpatient admissions or financial penalty applies. Some services, such as transplants and physical rehabilitation, require additional approval or benefits may be denied entirely. See your Summary Plan Description for details.

Prescription Drugs	You must use Preferred/In-Network pharmacies — All plans No Benefits for Non-preferred/Out-of-Network pharmacies (except emergencies)	
	Retail (up to a 30-day supply)	Mail-order (up to a 90-day supply)
<b>Generic</b>	\$4 copay	\$8 copay
<b>Brand name when generic is available</b>	\$4 copay <i>plus</i> cost difference between brand and generic	\$8 copay plus cost difference between brand and generic
<b>Brand name on Formulary List</b>	You pay 30% of the total cost, Minimum of \$30/Maximum of \$70	You pay 30% of the total, Minimum of \$60/Maximum of \$140
<b>Brand name not on Formulary list</b>	You pay 40% of the total cost, Minimum of \$60/Maximum of \$120	You pay 40% of the total cost, Minimum of \$120/Maximum of \$240
<b>Immunosuppressive drugs &amp; specialty pharmaceuticals*</b>	You pay 15% up to a maximum copay of \$250 per prescription	You pay 15% up to a maximum copay of \$250 per prescription
<p><i>Special Notes for the BCBS program: For covered non-prescription enteral nutritional products and special medical foods, the copay is 50%.</i></p> <p><i>* Includes immunosuppressive drugs following transplant surgery. Specialty pharmaceuticals are a list of drugs including injectibles and oral or inhalation forms. It includes, but is not limited to growth hormones, low molecular weight heparins, interferon, immunologic agents and anti-tumor necrosis factors.</i></p>		

Dental Coverage

	<b>DeltaPremier Dentist (Nationwide)</b>	<b>Non-Participating Dentist (Nationwide)</b>
<b>Plan Features</b>		
<b>Annual Deductible</b>		
<ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$50 \$150	\$50 \$150
<b>Benefit Maximums</b>		
<ul style="list-style-type: none"> <li>• Annual — Per individual; applies to all expenses <i>except</i> orthodontia</li> <li>• Lifetime Orthodontic — Per individual; applies <i>only</i> to orthodontic benefits</li> </ul>	\$1,500 \$2,500	
<b>Covered Expenses</b>		
<b>Preventive Services</b>		
<ul style="list-style-type: none"> <li>• Cleanings (Prophylaxis) or Periodontal Cleaning— Up to twice each calendar year</li> <li>• Fluoride, Topical Application — Only for children under age 19; up to twice each calendar year</li> <li>• Oral Exams, Routine — Up to twice each calendar year</li> <li>• Palliative Treatment (Emergency treatment for pain)</li> <li>• Space Maintainers</li> <li>• X-rays, Bitewing — Up to twice each calendar year</li> <li>• X-rays, Full-Mouth — Once every five years</li> </ul>	100% no deductible applies	100% <sup>1</sup> no deductible applies
<b>Restorative &amp; Basic Services</b>		
<ul style="list-style-type: none"> <li>• Anesthesia, General</li> <li>• Extractions &amp; Other Oral Surgery</li> <li>• Fillings &amp; Regular Restorative Services</li> <li>• Gum Treatments (Periodontics)</li> <li>• Prescription Drugs — Only when Dentally Necessary. You must pay up front and file a claim for reimbursement</li> <li>• Root Canals (Endodontics)</li> <li>• Sealants — Only for children under age 19 and only to unrestored molars and bicuspid. Up to one treatment per tooth per calendar year and no more than two treatments per tooth per lifetime</li> </ul>	80% after deductible	80% <sup>1</sup> after deductible

	<b>DeltaPremier Dentist (Nationwide)</b>	<b>Non-Participating Dentist (Nationwide)</b>
<b>Covered Expenses (cont'd)</b>		
<b>Major Services</b> <ul style="list-style-type: none"> <li>• Bridges, Fixed or Removable</li> <li>• Crowns &amp; Cast Restorations</li> <li>• Dentures, Full or Partial</li> <li>• Implants, specified services subject to clinical review</li> </ul>	50% after deductible	50% <sup>1</sup> after deductible
<b>Orthodontic Services</b> <ul style="list-style-type: none"> <li>• For children under age 19</li> <li>• For adults age 19 &amp; over — Only when Dentally Necessary, needed for future dental health and not cosmetic in nature</li> </ul>	50% after deductible	50% <sup>1</sup> after deductible
<i>1 With a non-participating dentist, you are responsible for paying your coinsurance amount, if any, as well as any amount billed by the dentist that is over Delta Dental's Allowable Fee. With a DeltaPremier dentist, you are NOT responsible for paying amounts over the Allowable Fee.</i>		

Vision Coverage

	Vision Service Plan (VSP)	
Plan Features & Covered Expenses	From A VSP Provider	From A Non-VSP Provider
<b>Annual Deductible</b>	None	None
<b>Examinations</b> <i>Once every 12 months</i>	Plan pays: 100% after \$15 copay	Plan pays: up to \$35 after \$15 copay
<b>Lenses</b> <ul style="list-style-type: none"> <li>• Single Vision</li> <li>• Bifocal</li> <li>• Trifocal</li> <li>• Progressive</li> </ul> <i>Once every 12 months. Benefits are per complete set, not per lens.</i>	Plan pays: 100% after \$25 copay <i>(all lens types)</i>	Plan pays: <ul style="list-style-type: none"> <li>• Up to \$25 (after \$25 copay)</li> <li>• Up to \$40 (after \$25 copay)</li> <li>• Up to \$55 (after \$25 copay)</li> <li>• Not available</li> </ul>
<b>Frame</b> <i>Once every 24 months</i>	Plan pays up to \$145 frame allowance <i>(One \$25 copay applies to both lenses &amp; frames)</i>	Plan pays up to \$45 <i>(One \$25 copay applies to both lenses &amp; frames)</i>
<b>Contact Lenses</b> <ul style="list-style-type: none"> <li>• Elective</li> <li>• Medically Necessary</li> </ul> <i>Once every 12 months. Contact lenses are in lieu of all other lens and frame benefits.</i>	Plan pays: <ul style="list-style-type: none"> <li>• Up to \$145</li> <li>• 100% after \$25 copay</li> </ul>	Plan pays: <ul style="list-style-type: none"> <li>• Up to \$105</li> <li>• Up to \$210 after \$25 copay</li> </ul>
<b>Laser Vision Correction</b> <ul style="list-style-type: none"> <li>• Screening</li> <li>• Surgery &amp; pre- and post-operative care</li> </ul>	<ul style="list-style-type: none"> <li>• Plan pays 100%</li> <li>• Plan provides a discount on fees. Discounts vary, but average 15%</li> </ul>	Not available
<b>Low Vision Services &amp; Supplies</b> <i>(must be approved by VSP in advance)</i> <ul style="list-style-type: none"> <li>• Supplemental testing</li> <li>• Supplemental aids</li> </ul> <i>There is a maximum benefit of \$1,000 every 24 months for all low vision services and materials.</i>	Plan pays: <ul style="list-style-type: none"> <li>• 100%</li> <li>• 75% of pre-approved amount</li> </ul>	Plan pays: <ul style="list-style-type: none"> <li>• Up to \$125</li> <li>• Up to 75% of pre-approved amount</li> </ul>