

Summary of Optim Energy's Health Care Benefits — Active Employees — 2010

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
Plan Features			
Annual Deductible			
• Individual	\$250	\$400	\$2,000
• Family	\$750	\$1,200	\$4,000
Out of Pocket Maximum			
• Individual	\$2,000	\$3,000	\$4,000
• Family	\$4,000	\$6,000	\$8,000
Limitations on Pre-Existing Conditions	None	None	None
Overall Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Other Lifetime Maximums			
• 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		
Other Maximums			
• 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)

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**

	Preferred Provider	Non-Preferred Provider¹	Preferred Provider	Non-Preferred Provider¹	Preferred Provider	Non-Preferred Provider¹
<p>Doctor's Office Visit — PPP & Other Providers</p> <ul style="list-style-type: none"> • PPO Primary Provider (PPP) • Other preferred and non-preferred Doctors • Includes regular office visits, as well as covered diabetes education, family planning and gynecological services & prenatal visits <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 \$20 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 \$25 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>Doctor's Office Visit — Specialist</p> <ul style="list-style-type: none"> • Includes regular office visits, as well as covered diabetes education, family planning and gynecological services & prenatal visits 	<p align="center">100% after \$20 copay <i>No deductible</i></p>	70%	<p align="center">100% after \$25 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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹
Emergency Room/ Observation Room – Facility Charges, Emergency Only	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>
Urgent Care	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%
Wellness Visits – Up to \$800/year • Annual physical • Annual Ob/Gyn • Well-child care • Adult & child immunizations • Mammogram • Colonoscopy (preventive/routine paid at 100% up to a \$1,000 maximum)	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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹
Abortion²	90%	70%	80%	60%	75%	50%
Acupuncture <i>Up to \$1,500/year</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered
Allergy Injections, Tests, Serum	90%	70%	80%	60%	75%	50%
Ambulance² • Ground/Emergency Air • Non-emergency Air	90% 90%	90% 70%	80% 80%	80% 60%	75% 75%	75% 50%
Cardiac Rehabilitation – Outpatient²	90%	70%	80%	60%	75%	50%
Cochlear Implants²	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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹
	Dental Related/TMJ Services & Oral Surgery² <ul style="list-style-type: none"> • Facility charges for dental services • Oral surgery • Treatment of TMJ <i>For a non-surgical office visit for treatment of a dental accident, see "Doctor's Office Visit."</i>	90%	70%	80%	60%	75%
Diagnostic Services² <ul style="list-style-type: none"> • Lab • X-ray • Other diagnostic tests — EKG, EEG, PET & CT scans, ultrasounds, etc. 	90%	70%	80%	60%	75%	50%
Durable Medical Equipment² <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%
Emergency Room/ Observation Room — Non-Emergency	90%	70%	80%	60%	75%	50%
Emergency Room – Physician & Other Professional Provider Charges	90%	90%	80%	80%	75%	75%
Eyeglasses/Contacts After Cataract Surgery or Keratoconus Correction² <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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹
Home Health Care/Home Intravenous Services² <i>Up to 100 visits/year</i>	90%	70%	80%	60%	75%	50%
Hospice Care² <i>Up to \$7,500/lifetime</i>	90%	70%	80%	60%	75%	50%
Hospital Inpatient^{2,3} <ul style="list-style-type: none"> • Medical/surgical, maternity related • Room & board • Covered ancillaries • Routine nursery care for newborns • Intensive care, cardiac care unit 	90%	70%	80%	60%	75%	50%
Infertility^{2,3} — Physician/Facility <i>Up to \$5,000/lifetime</i>	Based on services	70%	Based on services	60%	Based on services	50%
Mastectomy & Reconstructive Surgery^{2,3}	90%	70%	80%	60%	75%	50%
Maternity Services <ul style="list-style-type: none"> • Including delivery & routine pediatrician care for covered newborns • Also see "Hospital" <i>Initial visit may require a copay.</i>	90%	70%	80%	60%	75%	50%
Medical Supplies² <i>Limitations apply. See "Other Maximums."</i>	90%	70%	80%	60%	75%	50%
Mental Health — Outpatient²	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 ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹
Mental Health — Inpatient^{2,3}	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%
Orthotics, Functional² <i>Limitations apply. See “Other Maximums.”</i>	90%	70%	80%	60%	75%	50%
Prosthetics² <i>Limitations apply. See “Other Maximums.”</i>	90%	70%	80%	60%	75%	50%
Pulmonary Rehabilitation — Outpatient²	90%	70%	80%	60%	75%	50%
Short-Term Rehabilitation & Therapy — Outpatient² <ul style="list-style-type: none"> • Physical, occupational & speech therapy & rehabilitation services • Outpatient, office & home-based <i>Limitations apply. See “Other Lifetime Maximums.”</i>	90%	70%	80%	60%	75%	50%
Short-Term Rehabilitation & Therapy — Inpatient^{2,3} <ul style="list-style-type: none"> • Physical, occupational & speech therapy & rehabilitation services • Skilled Nursing Facility or rehabilitation facility <i>Limitations apply. See “Other Lifetime Maximums.”</i>	90%	70%	80%	60%	75%	50%
Spinal Manipulation/ Chiropractic <i>Up to \$1,500/year</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered

Blue Cross and Blue Shield

Premium Option

Standard Option

Value Option

Services With Coinsurance (cont'd)	Premium Option		Standard Option		Value Option	
	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹	Preferred Provider	Non-Preferred Provider ¹
Substance Abuse Treatment — Outpatient² • Includes chemical dependency, drug abuse & alcoholism treatment	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%
Substance Abuse Treatment — Inpatient^{2,3} • Includes chemical dependency, drug abuse & alcoholism treatment	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%
Surgery^{2,3} — Inpatient or Outpatient	90%	70%	80%	60%	75%	50%
Therapy — Chemotherapy, Dialysis & Radiation²	90%	70%	80%	60%	75%	50%
Transplants^{2,3} <i>Limitations apply. See "Other Maximums."</i>	90%	Not Covered	80%	Not Covered	75%	Not Covered

1 Percentages shown for non-preferred providers are the percentage of covered charges payable.
 2 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.
 3 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)
Generic	\$4 copay	\$8 copay
Brand name when generic is available	\$4 copay <i>plus</i> cost difference between brand and generic	\$8 copay plus cost difference between brand and generic
Brand name on Formulary List	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
Brand name not on Formulary list	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
Immunosuppressive drugs & specialty pharmaceuticals*	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>		