

## 2010 SUMMARY COMPARISON OF MEDICAL BENEFITS

For locations with United Healthcare PPO and United Healthcare EPO Plans

| Medical Plan Features  | ALCON MEDICAL PREMIER PPO PLAN<br>( United Healthcare Choice Plus Network)   |   | UNITED HEALTHCARE<br>PREMIER EPO PLAN   | ALCON MEDICAL BASIC PPO PLAN <sup>†</sup><br>( United Healthcare Choice Plus Network)   |  |
|--|--|---|---|---|--|
|  | PPO Network Provider is used:  | Non-Network Provider is used:   | Must use providers in the United Healthcare Select EPO network to receive benefits (no coverage for out of network providers)   | PPO Network Provider is used:   | Non-Network Provider is used:  |
| <b>ANNUAL DEDUCTIBLE</b>   | \$50 per employee; \$100 family maximum  | \$300 per employee; \$600 family maximum  | None  | \$300 per employee; \$600 family maximum  | \$600 per employee; \$1200 family maximum  |
| <b>ANNUAL OUT-OF-POCKET MAXIMUM</b><br>(includes MH/SA)  | \$1,500 per individual   | \$4,000 per individual  | \$1,500 per individual, \$3,000 per family  | \$2,750 per individual  | \$7,500 per individual   |
| <b>LIFETIME MAXIMUM MEDICAL BENEFIT</b>  | \$3,000,000 maximum  | \$3,000,000 maximum   | \$3,000,000 maximum   | \$3,000,000 maximum   | \$3,000,000 maximum  |
| <b>PRE-EXISTING CONDITIONS EXCLUSION</b>   | None   | None  | None  | None  | None   |
| <b>INPATIENT HOSPITAL SERVICES</b>   | Plan pays 90% after deductible (based on semi-private room rate)   | Plan pays 60% (based on semi-private room rate) after annual deductible *   | \$850 copay per admission then plan pays 100%   | Plan pays 80% after annual deductible (based on semi-private room rate)   | Plan pays 60% (based on semi-private room rate) after annual deductible *  |
| <b>OUTPATIENT SERVICES</b>   |  |   |   |   |  |
| <b>Primary Care Physician Office Visits</b><br>(includes General Practitioners, Family Practitioners, Pediatricians and Internal Medicine doctors) | \$20 copay per visit   | Plan pays 60% after annual deductible   | \$20 copay per visit  | \$30 copay per visit  | Plan pays 60% after annual deductible  |
| <b>Specialist Office Visits*</b>   | \$25 copay per visit   | Plan pays 60% after annual deductible   | \$25 copay per visit  | \$35 copay per visit  | Plan pays 60% after annual deductible  |
| <b>Diagnostic Laboratory Tests due to medical condition</b>  | - Processed in PPO doctor's office or independent PPO lab; plan pays 100%<br>- Outpatient hospital – plan pays 90% after deductible  | Plan pays 60% after annual deductible when test processed by non-network lab or doctor  | Covered in full (100%)  | - Processed in PPO doctor's office or independent PPO lab; plan pays 100%<br>- Outpatient hospital – plan pays 80% after annual deductible  | Plan pays 60% after annual deductible when test processed by non-network lab or doctor   |
| <b>Preventive (Routine) Laboratory Tests</b>   | Covered in-network only: Plan pays 100%  | Not covered   | Covered in full (100%)  | Covered in-network only : Plan pays 100%  | Not covered  |
| <b>Diagnostic X-ray due to a medical condition</b>   | Plan pays 90%, after deductible  | Plan pays 60% after annual deductible   | Covered in full (100%)  | Plan pays 80% after annual deductible   | Plan pays 60% after annual deductible  |
| <b>Allergy Injections in doctor's office</b>   | Plan pays 90%, no deductible   | Plan pays 60% after annual deductible   | No copayment for injection; \$20 (PCP) or \$25 (specialist) copay if accompanied by office visit  | Plan pays 80% after annual deductible   | Plan pays 60% after annual deductible  |
| <b>Prescription Drugs</b>  | <b>Retail Pharmacy:</b> if UHC network pharmacy IS used; max. 30-day supply<br>• 20% copay, minimum \$12 for Tier 2 & 3 (brand name drugs)<br>• 20% copay, minimum \$5 for Tier 1 (generic drugs)<br><b>UHC Mail Order RX Program:</b> for up to 90 day supply<br>• 20% copay, minimum \$12 for Tier 2 & 3 (brand name drugs)<br>• 20% copay, minimum \$5 for Tier 1 (generic drugs)<br><b>Alcon RX Benefit:</b> 100% coverage for all Alcon-made prescription drugs filled at UHC-participating retail or mail order pharmacy | <b>Retail Pharmacy:</b> if UHC network pharmacy IS NOT used; max. 30-day supply<br>• 25% copay, minimum \$12 for Tier 2 & 3 (brand name drugs)<br>• 25% copay, minimum \$5 for Tier 1 (generic drugs) | <b>Must use UHC network pharmacy:</b><br><b>Retail Pharmacy:</b> 30 day supply:<br>\$7 copay – Tier 1 (generic drugs);<br>\$20 copay – Tier 2 (preferred brand name drugs)<br>\$35 copay – Tier 3 (non-preferred brand name)<br><b>UHC Mail Order RX program:</b> 90-day supply: 2.5 x retail copay<br><b>Alcon RX Benefit:</b> 100% coverage for all Alcon-made prescription drugs filled at UHC-participating retail or mail order pharmacy<br><b>Specialty RX</b> (most Self-Injectables excluding diabetic drugs): \$75 copay per RX; must use UHC mail-order Specialty Pharmacy program. | \$100 annual RX deductible, then employee pays:<br><b>Retail Pharmacy:</b> if UHC network pharmacy IS used; max. 30-day supply<br>• 25% copay, minimum \$12 for Tier 2 & 3 (brand name drugs)<br>• 25% copay, minimum \$5 for Tier 1 (generic drugs)<br><b>UHC Mail Order RX Program:</b> for up to 90 day supply<br>• 25% copay, minimum \$12 for Tier 2 & 3 (brand name drugs)<br>• 25% copay, minimum \$5 for Tier 1 (generic drugs)<br><b>Special Alcon RX Benefit:</b> 100% coverage for all Alcon-made prescription drugs filled at UHC-participating retail or mail order pharmacy (not subject to deductible) | \$100 annual RX deductible, then employee pays:<br><b>Retail Pharmacy:</b> if UHC network pharmacy IS NOT used; max. 30-day supply<br>• 30% copay, minimum \$12 for Tier 2 & 3 (brand name drugs)<br>• 30% copay, minimum \$5 for Tier 1 (generic drugs) |
| <b>Annual Prescription Drug Out of Pocket Maximum</b>  | \$1,500 per individual, in & out of network combined.  | \$1,500 per individual, in & out of network combined.   | \$3,575 per individual per calendar year  | \$1,500 per individual, in & out of network combined.   | \$1,500 per individual, in & out of network combined.  |
| <b>Annual Well-Woman Exam – adult females</b><br>(OB/GYN or Primary care physician)  | - \$20 copay – one exam per calendar year (from PCP or OB/GYN but not both); includes pap smear and other routine lab tests if processed by PPO lab/doctor<br>- Routine Mammogram: plan pays 90% after deductible; limit 1 per cal. year<br>- Bone Density Screening: plan pays 90% after deductible; limit 1 per cal. year<br>- Colonoscopy & Sigmoidoscopy: plan pays 90% after deductible<br><i>coverage provided if test ordered by doctor per UHC preventive care guidelines</i>  | Not Covered   | - \$20 copay per visit – one exam per calendar year (from PCP or OB/GYN but not both); includes routine lab & x-ray tests ordered by doctor<br>- Routine Mammogram: plan pays 100%; limit 1 per cal. year<br>- Bone Density Screening: plan pays 100%; limit 1 per cal. year<br>- Colonoscopy & Sigmoidoscopy: plan pays 100%<br><i>coverage provided if test ordered by doctor per UHC preventive care guidelines</i>  | - \$30 copay - one exam per cal. year (from PCP or OB/GYN but not both); includes pap smear & other routine lab tests if processed by PPO lab/ doctor<br>- Plan pays 80% after annual deductible for 1 mammogram/ yr  | Not covered  |

\*OB/GYN's are considered specialists for all services except the Annual Well-Woman Exam and prenatal visits

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|--|---|---|---|--|---|
|  | PPO Network Provider is used:   | Non-Network Provider is used:   | <i>Must use providers in the United Healthcare Select EPO network to receive benefits (no coverage for out of network providers)</i>  | PPO Network Provider is used:  | Non-Network Provider is used:   |
| <b>Maternity Care</b>  | <b>Outpatient:</b> \$20 copay for initial office visit<br><b>Inpatient:</b> Plan pays 90% after deductible  | Plan pays 60% after annual deductible   | <b>Outpatient:</b> \$20 copay for initial office visit<br><b>Inpatient:</b> \$850 copay, then plan pays 100%  | <b>Outpatient :</b> \$30 copay for initial office visit<br><b>Inpatient:</b> Plan pays 80% after annual deductible                     | Plan pays 60% after annual deductible   |
| <b>Annual Well-Man Exam – adult males</b><br>(Primary care physician)    | - \$20 copay – one exam per calendar year; includes PSA + other routine lab tests if processed by PPO lab/doctor<br>- Colonoscopy & Sigmoidoscopy: plan pays 90% coverage provided if test ordered by doctor per UHC preventive care guidelines | Not covered   | - \$20 copay per visit – one exam per calendar year; includes routine lab & x-ray tests ordered by doctor<br>- Colonoscopy & Sigmoidoscopy: plan pays 100% coverage provided if test ordered by doctor per UHC preventive care guidelines | \$30 copay – one exam per calendar year; includes PSA + other routine lab tests if processed by PPO lab/doctor                         | Not covered   |
| <b>Well Child Care</b><br>(Pediatrician or other primary care physician) | \$20 copay per visit; includes all routine exams tests and immunizations<br>Ages 0-6: Unlimited visits; Children over age 6 limited to 1 routine exam per year  | Not covered   | \$20 copay per visit;<br>Ages 0-6: Unlimited visits; Children over age 6 limited to 1 routine exam per year   | \$30 copay per visit; includes all routine exams, tests and immunizations for children birth to age 2; <b>not covered after age 2</b>  | Not covered   |
| <b>Immunizations</b><br>(adult and children)                             | No copayment for injection; \$20 (PCP) or \$25 (specialist) copay if accompanied by office visit  | Not covered   | No copayment for injection; \$20 (PCP) or \$25 (specialist) copay if accompanied by office visit  | Not covered  | Not covered   |
| <b>Chiropractic Office Visits</b>  | \$20 copay per visit; limit 20 visits per calendar year   | Plan pays 60% after annual deductible; limit 20 visits per calendar year                                  | \$20 copay per visit; limit 20 visits per calendar year   | \$30 copay per visit; limit 20 visits per calendar year  | Plan pays 60% after annual deductible; limit 20 visits per calendar year                                  |
| <b>Out-patient Surgery</b>   | Plan pays 90%, after deductible   | Plan pays 60% after annual deductible   | \$350 copay per surgery then plan pays 100%   | Plan pays 80% after annual deductible  | Plan pays 60% after annual deductible   |
| <b>Home Nursing/Health Care</b>  | Plan pays 90%, after deductible   | Plan pays 60% after annual deductible   | Covered in full; limit 40 visits per calendar year  | Plan pays 80% after annual deductible  | Plan pays 60% after annual deductible   |
| <b>Outpatient Hospital &amp; Facility Services</b>                       | Plan pays 90%, after deductible   | Plan pays 60% after annual deductible   | Covered in full (100%)  | Plan pays 80% after annual deductible  | Plan pays 60% after annual deductible   |
| <b>Physical &amp; Occupational Therapy</b>                               | Plan pays 90%, after deductible   | Plan pays 60% after annual deductible   | \$20 copay per visit; limit 20 visits per calendar year   | Plan pays 80% after annual deductible  | Plan pays 60% after annual deductible   |
| <b>Durable Medical Equipment</b>   | Plan pays 90%, after deductible   | Plan pays 60% after annual deductible   | Covered in full; must be pre-authorized by UHC  | Plan pays 80% after annual deductible  | Plan pays 60% after annual deductible   |
| <b>EMERGENCY CARE</b>  |   |   |   |  |   |
| <b>Ambulance</b>   | Plan pays 90%, after deductible   | Plan pays 60% after annual deductible   | Covered in full in connection with emergency  | Plan pays 80% after annual deductible  | Plan pays 60% after annual deductible   |
| <b>Emergency Room Care</b>   | Plan pays 90%, after deductible   | Plan pays 60% after annual deductible   | \$50 copay/visit (life or limb threatening emergencies); copay waived if admitted to hospital   | Plan pays 80% after annual deductible  | Plan pays 60% after annual deductible   |
| <b>Urgent Care Center Services</b>                                       | \$20 copay per visit  | Plan pays 60% after annual deductible   | \$25 copay per visit  | \$30 copay per visit   | Plan pays 60% after annual deductible   |
| <b>Out of Area Care</b>  | No restrictions: Must use UHC network provider  | No restrictions   | <i>Non-emergency:</i> can use national UHC EPO network providers if pre-authorized by primary care physician<br><i>Emergency:</i> must notify PCP within 1 business day of admission  | No restrictions: Must use UHC network provider   | No restrictions   |
| <b>MENTAL HEALTH &amp; SUBSTANCE ABUSE</b>                               |   |   |   |  |   |
| <b>Inpatient Care</b>  | <i>All Inpatient mental health &amp; substance abuse treatment must be pre-certified by UBH at 866-319-4478.</i>  |   | <i>All MH/SA care must be pre-authorized by United Behavioral Health, 866-319-4478</i>  | <i>All inpatient mental health &amp; substance abuse treatment must be pre-certified by UBH at 866-319-4478</i>                        |   |
| <b>Mental Health-Hospital &amp; Inpatient Physician</b>                  | Plan pays 90%, after deductible   | Plan pays 60% after annual deductible *   | \$850 copay/admission, then plan pays 100%  | Plan pays 80% after annual deductible  | Plan pays 60% after annual deductible *   |
| <b>Alcohol and Substance Abuse Treatment</b>                             | Plan pays 90%, after deductible   | Plan pays 60% after annual deductible *   | \$850 copay/admission, then plan pays 100%  | Plan pays 80% after annual deductible  | Plan pays 60% after annual deductible *   |
| <b>Outpatient Care</b>   | <i>You must call the UBH Live and Work Well EAP, 866-319-4478, prior to getting all outpatient mental health/substance abuse care.</i>  |   | <i>You must call the UBH Live and Work Well EAP, 866-319-4478, prior to getting outpatient mental health/substance abuse care.</i>  | <i>You must call the UBH Live and Work Well EAP, 866-319-4478, prior to getting all outpatient mental health/substance abuse care.</i> |   |
| <b>Mental Health</b>   | \$25 copay per visit  | Plan pays 60% after annual deductible. Visits must be <u>authorized in advance</u> by UBH or not covered. | \$25 copay per visit  | \$35 copay per visit   | Plan pays 60% after annual deductible. Visits must be <u>authorized in advance</u> by UBH or not covered. |
| <b>Alcohol and Substance Abuse Treatment</b>                             | \$25 copay per visit  | Plan pays 60% after annual deductible. Visits must be <u>authorized in advance</u> by UBH or not covered. | \$25 copay per visit  | \$35 copay per visit   | Plan pays 60% after annual deductible. Visits must be <u>authorized in advance</u> by UBH or not covered. |

This is only a summary of medical plan benefits. Please refer to the Plan's Summary Plan Description for a full description of coverage. In the event of a discrepancy, the Summary Plan Description governs.

(10/21/09)

<sup>†</sup>the Basic PPO applies only to employees who were defaulted to it during the Annual Enrollment Period due to non-participation in the health assessment questionnaire. It is not open to new enrollment during the year.

\* Inpatient benefits are reduced by \$350 if you do not call UBH prior to hospitalization or within 48 hours after emergency admission to a non-network facility.