

Post-Retiree Medical and Life Insurance Coverage Highlights

The Bausch & Lomb Post-Retirement Benefits Plan provides access to medical and life insurance to help you manage costs during your retirement years. It also provides added security and peace of mind in the event of illness or unforeseen events. This section describes the benefits available to you under the Bausch & Lomb Post-Retirement Benefits Plan. It has been designed as a reference, so please review this information carefully to use your benefits more effectively.

For questions about ...	Contact ...
UnitedHealthcare Choice Plus Plan UnitedHealthcare Medicare Supplement Plan UnitedHealthcare Medicare Carve-Out Plan	<ul style="list-style-type: none"> • UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374 866-365-7164 Requests for Review of Denied Claims and Notice of Complaints: <ul style="list-style-type: none"> • UnitedHealthcare P. O. Box 30432 Salt Lake City, UT 84130-0432
HMOs - Rochester area	<ul style="list-style-type: none"> • Blue Choice Value/Medicare Blue Choice 165 Court Street Rochester, NY 14647 585-232-3310 • Preferred Care/Preferred Care Gold 259 Monroe Avenue, Suite A Rochester, NY 14607 585-325-3113 or 800-950-3224
HMOs - outside Rochester (under age 65 only)	<ul style="list-style-type: none"> • CIGNA HealthCare 250 Commonwealth Drive Suite 110 Greenville, SC 29615 800-244-6224 • Piedmont Community Health P.O. Box 2455 Lynchburg, VA 24501 800-400-7247 • BlueChoice Value - Missouri 1831 Chestnut Street St. Louis, MO 63103 800-634-4395

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Eligibility and Enrolling

Effective January 1, 2005, eligibility for post-retirement medical and life insurance became based on your age and total points at retirement. You are eligible for coverage if, on January 1, 2005, you had a total of 55 points and have at least five years of service by December 31, 2005. You also have to be age 55 or older at termination to be considered a retiree.

If you do not meet each of the criteria listed above but are age 55 with 10 years of service or more at the time you leave the company, you are not eligible for company contributions towards post-retirement medical and life insurance. However, you will be eligible for access to post-retirement medical insurance and will be required to pay 100% of the cost.

If you retired before January 1, 2005, the eligibility requirements in effect at the time you retired will apply.

Medical Coverage for Your Dependents

When you enroll for retiree medical coverage, you may also enroll your dependents. Eligible dependents include:

- your spouse to whom you are legally married;
- your eligible children.

Children eligible for coverage include:

- your natural children under age 19 if financially dependent on you and living in your home or living elsewhere in the U.S. or Canada;
- your stepchildren under age 19 if living with you in a regular parent-child relationship;
- legally adopted children under age 19, including any for whom you have started legal adoption proceedings, if they are financially dependent on you;
- your children between the ages of 19 and 25 who are full-time students;
- if an unmarried dependent child with mental retardation or a physical handicap reaches an age when coverage would otherwise end, the Plan will continue to cover the child.

Domestic partners are not eligible for continued medical coverage when you retire.

When Coverage Begins

Retiree medical coverage can begin as early as your retirement date if you are eligible and you enroll within 31 days of retirement. Retiree life insurance begins on your retirement date if you are eligible. See Enrolling for Coverage below for more detail on when coverage begins.

Enrolling for Coverage

You will automatically be enrolled in life insurance coverage if you are an eligible retiree.

You have an opportunity to enroll for medical coverage when you retire so coverage can continue without a break. If you do not enroll when you retire, you may be able to enroll later if:

- you work for another employer that provides medical coverage and that coverage ends when you leave the other company;
- coverage is provided by a spouse's plan and that coverage ends;
- you enroll during an Open Enrollment period.

Generally, to apply you will have to contact the Corporate Benefits Department within 31 days of the date that the other coverage ends. You must also meet the eligibility requirements for retiree medical coverage in effect at the time you left the company.

You have an opportunity to enroll each year during the annual Open Enrollment conducted in late October or early November, with coverage effective the following January 1.

Any new dependents can be added to your coverage within 31 days of becoming your dependent. Failure to enroll new dependents within 31 days may require you to wait until the next Open Enrollment period to enroll them. Contact the Corporate Benefits Department at 588-338-8604 or 866-422-3937, extension 8604 to add eligible dependents to your coverage or to obtain enrollment forms.

Remove your dependent from your coverage in the event of:

- a dependent's death;
- a divorce between you and your spouse;
- a dependent child who no longer qualifies for coverage.

When Coverage Ends

Your coverage for benefits described in this section ends if:

- you stop making the necessary contributions towards the cost of coverage
- the company terminates this plan

Your dependent's benefit coverage ends if:

- your child no longer meets the definition of an eligible dependent;
- you do not make contributions for coverage that may be required;
- both you and your spouse die

If you die, your surviving spouse and eligible children can continue coverage under the retiree medical plan. If your spouse remarries, the new spouse is not eligible for medical coverage from the company.

The Cost of Coverage

Medical Coverage

Your share of the cost of medical coverage will vary depending on when you retired from the company.

If You Retire on or after January 1, 2005 and You are not Grandfathered for Benefits as of January 1, 2005

You will be able to participate in a group medical plan sponsored by Bausch & Lomb. However, you must pay the full cost of coverage. The advantages of participating in a group plan rather than picking up private coverage are:

- better benefits
- lower group rates

If You Retire on or after January 1, 2000 and You are Grandfathered for Benefits as of January 1, 2005

Your total points – a combination of your age plus years of service – will determine how you and the company share the cost of coverage for yourself and any dependents you choose to cover.

If you are an eligible retiree with:

- 60 to 69 points, you pay the full cost of coverage. While the company does not contribute to your cost for coverage at this level, you will be able to purchase medical coverage at costs that reflect Bausch & Lomb's group buying power. This means the cost will typically be more competitive than what you could otherwise buy on your own.
- 70 to 79 points, the company pays 50% and you pay the balance of a plan the company has determined as most effective in helping manage the cost of health care.
- 80 or more points, the company pays 75% and you pay the balance of a plan the company has determined as most effective in helping manage the cost of health care.

A notice of the change in cost is mailed annually, along with an opportunity to change plans if other plans are available in your area.

If you retired on or after March 1, 1989 and before January 1, 2000

Your share of cost is based on your length of service at your retirement date. The company pays the highest share of cost for retirees with 20 or more years of service.

If You Retired on or after December 1, 1986 and before March 1, 1989

The company pays a percentage of covered costs for you and your dependents regardless of your service.

If You Retired Before December 1, 1986

The company pays the full cost of your coverage. The cost for dependent coverage is based on the age of your spouse. If your spouse is:

- under age 65, you pay \$5.50 a month;
- 65 or older, you pay \$2.75 a month.

There is an additional cost for dependent children and the cost for coverage will not change during the year.

Life Insurance Coverage

Your cost for retiree life insurance coverage depends on when you retired from Bausch & Lomb as an eligible retiree.

If You Retire on or After January 1, 2000

You will retain \$15,000 of coverage. When you reach age 66, the coverage will reduce by \$1,500 at the beginning of each year. When you reach age 70, you will have \$7,500 of coverage. Bausch & Lomb pays the entire cost of your retiree life insurance coverage.

If You Retired on or Before December 31, 1999

If your service at retirement is greater than or equal to 20 years, coverage is provided at no cost.

If you have less than 20 years of service when you retire, your cost for continuing coverage is \$0.30 per \$1,000 of coverage per month. For example, \$10,000 of life insurance would cost you \$3.00 per month. If you retired after January 1, 1993, then each year your total monthly cost will drop as your coverage reduces to \$5,000, finally costing \$1.50 per month (see more detail on page 12-31).

Paying Your Share of the Cost

If you receive a monthly pension check, your retiree medical and/or life insurance payments can be deducted from your check to cover your share of the cost. If the amount of your pension check does not cover the cost of your monthly premium(s), you will be billed for the cost of coverage by an independent agency, Q&F Benefits Administration. You may pay your bill(s) monthly, quarterly or in one annual payment.

If you are currently receiving a bill for coverage and choose to have payments deducted from your pension, contact the Corporate Benefits Department at 585-338-8604 or 866-422-3937, extension 8604.

Because the cost of medical coverage may change from year to year, your cost may change annually. Each year — usually in October or November — you will receive information on retiree medical coverage costs for the next calendar year. If you reside in an area where more than one plan is offered, you will be given an opportunity to change plans during the Open Enrollment period.

About Medical Coverage

Bausch & Lomb provides medical coverage to all eligible retirees. The medical coverage available to you is based on your age and retirement date. The names of the UnitedHealthcare medical plans in which retirees and their dependents participate are as follows:

	Under 65	Over 65
Retired Prior to 1/1/87	Choice Plus Plan	Medicare Supplement Plan
Retired 1/1/87 – 2/28/89	Choice Plus Plan	Medicare Supplement Plan
Retired 3/1/89 – 12/31/99	Choice Plus Plan	Medicare Carve-Out Plan
Retired 1/1/2000 and after	Choice Plus Plan	Medicare Carve-Out Plan

Refer to the appropriate plan relating to your age and date of retirement when reviewing your medical coverage described in this booklet. In addition, there are health maintenance organizations (HMOs) available to some retirees and their dependents that are not detailed in this booklet.

The next section describes coverage under the Choice Plus Plan for retirees under age 65. See pages 12-15 through 12-19 for your benefits under the Medicare Supplement Plan and the Medicare Carve-Out Plan.

Medical Coverage for any Eligible Retiree or Surviving Spouse under Age 65

Retirees and spouses under age 65 have two* choices for retiree medical coverage:

- the UnitedHealthcare Choice Plus plan
- any HMO in their area that is offered by the company

*Under age 65 HMOs are available to retirees in the Rochester, NY. HMOs are available to retirees under age 65 outside of Rochester only if you retired on or after January 1, 2000.

Choice Plus Plan

As a participant in a Choice Plus plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive covered health services.. When enrolled in the Choice Plus plan, you can choose from a group of doctors, hospitals and other providers that participate in the UnitedHealthcare network, or go outside the network for care. After you meet an annual deductible, the plan pays a percentage of the covered cost for services. When you use network providers, you receive a higher level of benefit than you would for non-network care. The benefits of using network providers goes away when the retiree or spouse reaches age 65 and becomes eligible for Medicare and the UnitedHealthcare Medicare Carve-Out plan.

Advantages of Using Network Providers

Network providers have agreed to charge set amounts that are typically less than the reasonable and customary cost — or “going rate” — for services in a geographical area, so you won’t have to pay any costs above the reasonable and customary level and your out-of-pocket expenses will be lower.

Charges that exceed the reasonable and customary standards set by UnitedHealthcare will not be covered by the plan and cannot be applied to the deductible or out-of-pocket maximum.

Keep in mind that when you use network providers, you will not have to file claim forms for the services you receive but you will have to file claims for services received through non-network providers. Network providers also will handle the required approval for hospital stays. When you use non-network providers, you will need to call the toll-free number on your ID card to notify your hospital stay. *See Notification of Hospital Stays, page 12-14.*

A complete list of participating providers in your location is available by calling UnitedHealthcare’s customer service number at 866-365-7164 and requesting a provider directory for the area in which you live. If you have access to a computer, you may view participating physicians in your area by contacting the UnitedHealthcare Website at www.provider.uhc.com/bl. You will be asked to type in your zip code and plan name (UHC Choice Plus Plan).

Health Maintenance Organization (HMO)

If you retired on or after January 1, 2000, you can choose medical coverage through a local health maintenance organization that is offered by the company. Eligible retirees who live in Rochester, New York, currently have a choice of two local HMOs. If you reside outside of Rochester and leave the company after January 1, 2000, you may continue coverage through your current HMO until you (or your spouse, if covered) reach age 65. Once age 65, you must transfer into the UnitedHealthcare Medicare Carve-Out Plan

Generally, the HMO covers care only when you visit network providers. You must choose a primary care physician (PCP) from the HMO provider network to coordinate all your care.

You will have to visit your PCP first whenever you need care — your PCP can provide a specialist referral when needed. Most HMOs cover care after you pay a set dollar amount or co-payment. The plan pays the rest. You do not have to meet an annual deductible.

Contact the Corporate Benefits Department for more information.

How the Choice Plus Plan Pays Benefits

Meeting a Deductible

For most covered services, you must meet an annual deductible before the plan pays benefits for covered services under the Choice Plus plan. You must meet a deductible each calendar year — January 1 to December 31. The plan begins paying a percentage of your covered expenses after you meet your deductible.

If you enroll dependents, the covered expenses of each enrolled person will go toward meeting the family deductible for the calendar year. Each person, however, cannot have more than the individual deductible amount count toward the family deductible. If one person in the family meets the individual deductible, the plan begins paying a percentage of that person's covered expenses.

Keep in mind that if you are enrolled in the Choice Plus plan and use the network, your deductible is lower than if you were to use non-network providers. Both the individual and family calendar-year deductibles are lower when you use network providers (see chart on page 13-8).

If you go to non-network providers for care, the amount you pay toward non-network covered expenses can also help you meet your network deductible. Your share of network covered expenses, however, will not count toward the non-network deductible.

Annual Out-of-Pocket Maximum

The Choice Plus plan is designed to protect you against the burden of high medical costs that could be financially devastating by limiting the amount you pay out of your pocket during a calendar year. Once the out-of-pocket maximum is reached, the plan will pay 100% of the reasonable and customary cost for most covered care for the rest of the year.

Expenses that do not count toward the out-of-pocket limit are:

- cost for care not covered as an eligible expense by the plan;
- charges above reasonable and customary cost;
- added costs you must pay for not following notification procedures, as described on page 13-8;
- your share of prescription drug costs.

Maximum Plan Benefits

The total lifetime maximum amount the UnitedHealthcare plans will pay is \$1,000,000 toward the covered expenses of each enrolled person for the length of time the person is covered by the company's plans. The lifetime maximum includes any claims paid while you were an active employee.

Some services and treatments have specific lifetime and/or calendar year limits. What you pay toward these special limits counts toward your lifetime maximum. See the covered services charts on pages 13-8 through 13-20 for details on special limits/circumstances for specific covered services.

Choice Plus Covered Services

The following chart provides an overview of how the Choice Plus plan pays benefits for specific covered services. The cost of care is covered if the care is considered medically necessary for treating or diagnosing an illness or injury.

	In Network	Out Of Network
Individual Deductible	\$250	\$500
Family Deductible	\$500	\$1,000
Coinsurance	90%	70%
Office Copay	\$20	NA
Individual Out-of-Pocket Expense	\$1,250	\$2,500
Family Out-of-Pocket Expense	\$2,500	\$5,000
Inpatient Hospitalization	\$200/Admission then 90%	70%
Outpatient Hospitalization	90%	70%
Maternity Services	\$200/Admission then 90%	70%
Pre and Post Natal Care	\$25	70%
Emergency Room Charge	\$100 (waived if admitted to the hospital)	90%
X Ray	90%	70%
Lab	90%	70%
Doctor Visits - includes illness, routine, well baby/child visits	\$20 Copay	70%
Specialist Visits	\$25	70%
Mental Health Inpatient	\$200/Admission then 90%	70%
Mental Health Outpatient	80%	50%
Mental Health Maximum	40 Visits	NA
Eye Exam	\$25 Copay	70%
Retail Prescription Drugs (30-day supply)	\$10, \$25, \$40	NA
Mail Order Prescription Drugs (90-day supply)	\$20, \$50, \$80	NA
Chiropractic Visits	90%, 20 Visits	70%, 20 visits
Customer Service Number	866-365-7164	866-365-7164

Notification of Hospital Stays

Under the Choice Plus plan, providers are responsible for the notification requirements for in-network services. Members are responsible for notification notice for out of network services. You must contact UnitedHealthcare customer service at 866-365-7164 at least 10 to 14 days before you are admitted to the hospital.

In case of an emergency, you must contact customer service within 48 hours after your admission. Based on your discussions with a customer service nurse and your doctor, it will be determined if hospitalization is necessary and the appropriate length of the stay.

If you do not call UnitedHealthcare to notify them of your stay, at a minimum, benefits will not be paid for the first \$500 of hospital charges. This \$500 penalty will not count toward your annual deductible or out-of-pocket maximum. If it is determined that hospitalization was unnecessary, you may be responsible for all costs of the hospital stay.

Individual Case Management

Individual Case Management is a special program that offers a creative approach to healthcare treatment in cases of a serious injury or terminal illness. The program provides professional healthcare consultants at UnitedHealthcare who will work closely with you, your physicians, family and the employer to arrange quality care in alternate settings, such as skilled nursing homes, residential facilities, or your home. The care may include benefits for medical expenses that are not generally covered by the plan. UnitedHealthcare determines if individual case management is required.

Medical Coverage for Eligible Retirees or Covered Spouses Age 65 or Older

Eligible retirees and spouses can continue medical coverage after age 65. However, you must enroll in both Medicare Part A and Part B in order to maximize your benefits. If you fail to enroll in Medicare Parts A and B, the coverage provided by Bausch & Lomb will “assume” that you have Medicare and will not pay the benefits that typically would be covered by Medicare. Your Medicare coverage is the primary payor of benefits under the Medicare Supplement and Carve-Out Plans. The intent of the Supplement and Carve-Out Plans is to help pay some of the expenses not paid by Medicare. Medicare HMO plans are designed to be an alternative to Medicare. However, you must be enrolled in Medicare Parts A and B in order to participate in these plans. Preferred Care Gold and Medicare Blue Choice – offered in Rochester – are examples of Medicare HMOs.

The coverage choices you have depend on the date you retired.

<i>If you retired...</i>	<i>You can choose coverage under...</i>
before March 1, 1989	<ul style="list-style-type: none"> • Medicare Supplement plan • Medicare HMO, Rochester only
on or after March 1, 1989	<ul style="list-style-type: none"> • Medicare Carve-Out plan • Medicare HMO, Rochester only

This section describes the medical benefits provided by the Medicare Supplement and the Medicare Carve-Out plans. Medicare HMOs have their own plan of benefits. Contact the

Corporate Benefits Department for information on the two Medicare HMOs available in Rochester.

About Medicare

Medicare benefits are divided into two categories – Part A and Part B – and are based on allowed charges for covered services determined by Medicare. Medicare pays part or all of the allowed charge for covered services. For some services, you pay part of the cost – called your coinsurance. Here is an overview.

Part A

- In-hospital care – Medicare covers semi-private room and board, general nursing and necessary services and supplies. It pays 100% for the first 60 days of your hospital stay after you meet a hospital deductible, which is \$952 in 2006. After the first 60 days, you pay a daily coinsurance -- \$238 a day in 2006– and Medicare pays the rest. If you need continued hospital care after 90 days, you can use up to 60 lifetime reserve days and pay a coinsurance, which is \$476 a day in 2006. Coverage for care in a psychiatric hospital is limited to 190 days per person per lifetime.
- Skilled nursing facility care – This care is covered if it follows a hospital stay of at least three days and you enter the facility within 30 days of your hospital stay. Medicare pays 100% for the first 20 days. For the next 80 days, you pay a coinsurance of \$119.00 a day of which Bausch & Lomb covers 80% or \$95.20 (under the Supplemental Plan) and Medicare pays the rest. After 100 days, care is not covered.
- Hospice care – Medicare covers inpatient, outpatient and home care for terminally ill patients. Covered care includes pain reduction, control of symptoms and counseling, but not curative treatment. Medicare pays most costs; you pay limited coinsurance for respite care in an inpatient facility and outpatient prescription drugs.

Part B

Medicare generally pays 80% of the allowed charge for Part B services after you meet a \$124 annual deductible. You pay a coinsurance of 20%. Part B services include:

- physician services;
- physical, speech and occupational therapy;
- diagnostic lab work, x-rays and other tests;
- durable medical equipment;
- preventive care – annual mammograms, pap smears, colorectal screening and bone mass measurements;
- flu shots and pneumococcal vaccines;
- ambulance services.

About the Bausch & Lomb Plans

Both the Medicare Supplement Plan and the Medicare Carve-Out Plan are designed to work with Medicare to cover some of the expenses that Medicare does not pay. Both plans pay benefits for services and supplies that:

- are approved in whole or in part by Medicare;
- are covered by Medicare, or could have been covered by Medicare if you had enrolled.

Benefits under both plans are based on the reasonable and customary (R&C) charge – or “going rate” – for services in your geographical area. Charges above the R&C limits will not be covered by either plan.

How the Medicare Supplement Plan Pays Benefits

This chart provides an overview of how the Medicare Supplement Plan pays benefits for specific services. Keep in mind that the Medicare Supplement Plan covers only those services that are also covered by Medicare.

Type of Care	What the Medicare Supplement Plan Pays
In-hospital Care	100% up to \$5,000, then 80% The plan covers: <ul style="list-style-type: none"> • Medicare Part A hospital deductible • Medicare Part A daily coinsurance for 61st through 90th day • Medicare Part A daily coinsurance for days above 90th day • first three pints of blood not covered by Medicare
Skilled Nursing Facility Care	80% of the Medicare Part A coinsurance amount for the 21st through the 100th day of your stay
Emergency Room Care	<ul style="list-style-type: none"> • for an accident or injury – 100% of the Medicare Part B deductible and coinsurance – if you go to the emergency room within 24 hours • for an illness – 80% of the Medicare Part B coinsurance after you pay the Part B deductible
Hospice Care	100% of charges not covered by Medicare Part A
Other services covered under Medicare Part B	80% of Medicare Part B coinsurance after you meet the Part B annual deductible of \$124
Lifetime maximum benefit	\$1,000,000 per person

A Medicare Supplement Plan Example

Some healthcare providers accept Medicare assignment – this means they agree to accept the Medicare allowed amount for services and not bill you for charges above that allowed amount. Providers who do not accept Medicare assignment may bill you for charges up to 15% more than the Medicare allowed amount. Here’s an example showing how the Medicare Supplement Plan pays benefits in both situations.

Assume you have minor surgery. The doctor's normal charge for this service is \$500, but the Medicare allowed amount is \$400. In this example, you have met the Medicare Part B deductible of \$124 a year.

	<i>If doctor accepts Medicare assignment</i>	<i>If doctor does not accept Medicare assignment</i>
Doctor's normal charge	\$500	\$500
Medicare allowed charge	<u>- \$400</u>	<u>- \$400</u>
Amount above allowed charge	\$100	\$100
<i>What Medicare Pays</i>		
Medicare allowed charge	\$400	\$400
times Medicare Part B benefit of 80%	<u>x 80%</u>	<u>x 80%</u>
Amount Medicare pays	\$320	\$320
	\$400 Medicare approved charge	\$500 actual charge
	<u>- \$320 Medicare payment</u>	<u>- \$320 Medicare payment</u>
Remaining charges	\$80	\$180
<i>What the Medicare Supplement plan pays</i>		
Remaining charge	\$ 80	\$ 180
times plan benefit of 80%	<u>x 80%</u>	<u>x 80%</u>
Amount plan pays	\$ 64	\$144
<i>What you pay</i>		
Remaining charge	\$80	\$180
minus plan benefit	<u>- \$64</u>	<u>- \$144</u>
Amount you pay	\$16	\$36

How the Medicare Carve-Out Plan Pays Benefits

The Medicare Carve-Out Plan is designed to pay a benefit of 80% in combination with Medicare after you meet the plan's calendar year deductible. This chart gives an overview of key features of the plan. Keep in mind that the Medicare Carve-Out plan covers only those services that are also covered by Medicare.

Key Features	
Calendar-year deductible	\$300 per person
What the plan pays for covered services	80%, in combination with Medicare
Plan maximums:	
<ul style="list-style-type: none"> • mental health and substance abuse treatment 	\$40,000 a person/lifetime
<ul style="list-style-type: none"> • lifetime maximum benefit 	\$1,000,000 per person

Here are two examples showing how the Medicare Carve-Out Plan pays benefits.

Example One – An Office Visit

Assume you go to the doctor for an office visit that costs \$60. You have already met the Medicare Part B deductible and the plan's \$300 annual deductible.

First, Medicare Carve-Out Plan benefits are calculated as if you have no other coverage.

Office visit charge	\$60
times plan benefit of 80%	<u>x 80%</u>
Amount plan would pay	\$48

Next, Medicare benefits are calculated

Medicare allowed charge	\$50
times Medicare Plan B benefit of 80%	<u>x 80%</u>
Amount Medicare pays	\$40

Since the amount the plan would pay, \$48, is higher than the Medicare benefit, the plan will pay the difference up to 80% of charges. In this example, the plan would pay \$8 (\$48 plan benefit minus \$40 Medicare payment).

Example Two – A Hospital Stay

Assume you have a hospital stay that costs \$10,000. In this example, you have not met the plan's \$300 annual deductible.

First, Medicare Carve-Out Plan benefits are calculated as if you have no other coverage.

Hospital charge	\$10,000
minus plan deductible	<u>- \$300</u>
Remaining charge	\$9,700
times plan benefit of 80%	<u>x 80%</u>
Amount plan would pay	\$7,760

Next, Medicare benefits are calculated.

Hospital charge	\$10,000
minus Medicare hospital deductible	<u>- \$952</u>
Amount Medicare pays	\$9,048

In this example, the amount Medicare pays is higher than the benefit the plan would have paid. The Medicare Carve-Out Plan does not pay a benefit, and the patient is responsible for the \$952 Medicare hospital deductible.

Services Not Covered

Plan Exclusions

The plans will not pay benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a physician.
- It is the only available treatment for your condition.

A. Alternative Treatments

- Acupressure
- Aromatherapy
- Hypnotism
- Massage Therapy
- Rolfing
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health

B. Comfort or Convenience

- Television
- Telephone
- Beauty/Barber service
- Guest service
- Supplies, equipment, and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners
 - Air purifiers and filters
 - Batteries and battery chargers
 - Dehumidifiers
 - Humidifiers
- Devices and computers to assist in communication and speech
- Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

C. Dental

- Dental care except when care is needed as a result of an accident
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - Extraction, restoration and replacement of teeth
 - Medical or surgical treatment of dental conditions
 - Services to improve dental clinical outcomes.
- Dental implants

- Dental braces
- Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
 - Transplant preparation
 - Initiation of immunosuppressives
 - The direct treatment of acute traumatic injury, cancer or cleft palate.
- Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a congenital anomaly

D. Drugs

- Self-injectable medications, excluding insulin
- Non-injectable medications given in a physician's office except as required in an emergency
- Over-the-counter drugs and treatments

E. Experimental or Investigational Services or Unproven Services

Experimental or investigational services and unproven services are excluded. The fact that an experimental or investigational service or an unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition.

F. Foot Care

- Routine foot care (including the cutting / removing of corns or calluses except when needed for severe systemic disease)
- Nail trimming, cutting, or debriding
- Hygienic and preventive maintenance foot care. Examples include the following:
 - Cleaning and soaking the feet
 - Applying skin creams in order to maintain skin tone
 - Other services that are performed when there is not a localized illness, injury or symptom involving the foot
- Treatment of flat feet
- Treatment of subluxation of the foot
- Shoe orthotics

G. Medical Supplies and Appliances

- Devices used specifically as safety items or to affect performance in sports-related activities
- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Elastic stockings
 - Ace bandages
 - Gauze and dressings
 - Syringes
 - Diabetic test strips

- Tubings, nasal cannulas, connectors and masks are not covered except when used with durable medical equipment
- Blood or blood derivatives only if not donated or replaced
- Orthotic appliances that straighten or re-shape a body part

H. Mental Health/Substance Abuse

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services for mental health and substance abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention
- Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis
- Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee
- Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
 - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
 - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
 - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
 - Not consistent with the Mental Health/Substance Abuse Designee's guidelines or best practices as modified from time to time.
 - The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.
- Pastoral counselors
- Treatment provided in connection with autism
- Treatment provided in connection with tobacco dependency
- Routine use of psychological testing without specific authorization

I. Nutrition

- Megavitamin and nutrition based therapy

- Nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs
- Nutritional (other than enteral feedings) and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism

J. Physical Appearance

- Cosmetic Procedures. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
 - Skin abrasion procedures performed as a treatment for acne
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure
Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded
- Wigs regardless of the reason for the hair loss

K. Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself
- Services performed by a provider with your same legal residence
- Naturopaths
- Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a free-standing or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received

This exclusion does not apply to mammography testing.

L. Reproduction

- Surrogate parenting
- Fees or direct payment to a donor for sperm or ovum donations

- Monthly fees for maintenance and/or storage of frozen embryos
- Contraceptive supplies and services
- Health services and associated expenses for infertility treatment

M. Services Provided under another Plan

- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected

- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you
- Health services while on active military duty

N. Transplants

- Health services for organ and tissue transplants, except those allowed. Contact UnitedHealthcare for more information
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan)
- Health services for transplants involving mechanical or animal organs
- Any solid organ transplant that is performed as a treatment for cancer
- Any multiple organ transplant not listed as a covered benefit above

O. Travel

- Health services provided in a foreign country, unless required for emergency health services
- Travel or transportation expenses, even though prescribed by a physician. Some travel expenses related to covered services may be reimbursed at our discretion

P. Vision and Hearing

- Purchase cost of eyeglasses, contact lenses, or hearing aids
- Fitting charge for hearing aids, eyeglasses or contact lenses
- Eye exercise therapy
- Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery

Q. All Other Exclusions

- Health services and supplies that do not meet the definition of a covered health service

- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
 - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption
 - Related to judicial or administrative proceedings or orders
 - Conducted for purposes of medical research
 - Required to obtain or maintain a license of any type
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country
- Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan
- In the event that a provider waives co-payments and/or the annual deductible for a particular health service, no benefits are provided for the health service for which the co-payments and/or annual deductible are waived
- Charges in excess of eligible expenses or in excess of any specified limitation
- Services and treatment of temporomandibular joint syndrome (TMJ) that are considered to be dental in nature (i.e.: initial exam by a dentist, diagnostic X-rays, oral appliances and subsequent adjustments)
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or a congenital anomaly
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer
- Non-surgical treatment of obesity, including morbid obesity
- Surgical treatment of obesity excluding severe morbid obesity (with a BMI greater than 35)
- Growth hormone therapy
- Sex transformation operations
- Custodial care
- Domiciliary care
- Private duty nursing received on an inpatient basis beyond the \$500 maximum
- Respite care
- Rest cures
- Psychosurgery
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring

- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment
- Any charge for services, supplies or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
- Any charges prohibited by federal anti-kickback or self-referral statutes
- Any additional charges submitted after payment has been made and your account balance is zero
- Any outpatient facility charge in excess of payable amounts under Medicare
- Any charges by a resident in a teaching hospital where a faculty physician did not supervise services
- Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies
- Speech therapy to treat stuttering, stammering, or other articulation disorders
- All expenses related to abortions, including elective or therapeutic abortions
- Bereavement counseling
- Naturopaths
- Sterilizations
- Preventive care (limited coverage under some plans)
- Covered health services incurred by attempting or committing a felony

Prescription Drug Coverage

If you enroll in a UnitedHealthcare medical plan, you are automatically eligible for the prescription drug program. The program is simple to use and includes a home delivery service.

If there is an HMO available in your location and you enroll in that option, the HMO has a separate prescription drug program. See your HMO medical plan information for details about your prescription drug coverage.

At Retail Pharmacies

The UnitedHealthcare retail program offers an extensive network of approximately 40,000 pharmacies in all 50 states, the District of Columbia, and Puerto Rico. The pharmacy may be a chain store — national, regional or local — or an independently-owned pharmacy. Most national chains participate in the program. Look for a sign at your pharmacy identifying it as

a UnitedHealthcare participating pharmacy or ask your pharmacist. You may also call 866-365-7164 if you have questions or to ask if your pharmacy participates in the program.

You must use a participating pharmacy. There are no out-of-network benefits for prescription drug coverage. You also have the option of using the mail order drug program which is available for obtaining a 90-day supply of your prescriptions.

If you are covered by the Medicare Supplement Plan

When you need a prescription filled, simply present your UnitedHealthcare ID card at a participating pharmacy and you'll pay 20% of the reasonable and customary cost of the prescription with no deductible. You can receive up to a 31-day supply and you don't have to file claim forms — your pharmacist handles the paperwork. Generic substitutes will be provided whenever available and legally permitted, unless your doctor specifically prescribes the brand name product. If you have any questions on generic vs. brand name drugs, you can call UnitedHealthcare at 866-365-7164 for more information.

If you are covered by the Choice Plus or the Medicare Carve-Out Plans, the following chart summarizes the prescription drug benefit:

Description of Pharmacy Type and Supply Limits	Your Co-payment Amount
<p>Prescription drugs from a retail network pharmacy for a 31-day supply, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.</p>	<p>The greater of 20% or \$10 per prescription order or refill for a generic or lower priced name brand prescription drug product*</p> <p>The greater of 20% or \$25 for higher priced generic or brand name drugs which do not have a generic drug equivalent but are ON the Preferred Drug List*</p> <p>The greater of 20% or \$40 for brand name drugs which do not have a generic drug equivalent but are NOT ON the Preferred Drug List*</p>
Description of Pharmacy Type and Supply Limits	Your Co-payment Amount
<p>For maintenance medications, as written by the provider, up to a consecutive 90-day supply of a prescription drug product (for the payment of up to three co-payments), unless adjusted based on the drug manufacturer's packaging size. In order to receive the maximum benefit, you should ask your provider to write your prescription order or refill for up to the full 90 days. This prescription can be dispensed from a retail pharmacy or through UnitedHealthcare's Pharmacy</p>	<p>The greater of 20% or \$20 per prescription order or refill for a generic or lower priced name brand prescription drug product</p> <p>The greater of 20% or \$50 per prescription order or refill for a higher priced generic or brand name prescription drug product ON the Preferred Drug List</p> <p>The greater of 20% or \$80 per prescription order</p>

Management Mail Order Drug program at Medco.	or refill for a brand-name prescription drug product which is NOT ON the Preferred Drug List
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*For all other brand names with a generic equivalent, a covered person pays:

- The co-payment amount and ancillary charge (an ancillary charge applies when a covered Brand-name Prescription Drug Product is dispensed at your request, when a Generic substitute is available for a generic prescription drug product), PLUS
- The difference in cost between the generic drug and the brand-name prescription drug product dispensed.

The minimum amount you are responsible for paying is the applicable co-payment

UnitedHealthcare has a medication formulary guide that identifies preferred brands and alternatives for excluded medications. If you do not have a guide, call UnitedHealthcare's customer service at 866-365-7164 and request the representative to mail one to you. When visiting your doctor, take a copy of the guide so your physician can prescribe preferred brands that will cost you less.

Services Not Covered by the Prescription Drug Program

- Outpatient prescription drug products obtained from a non-network pharmacy
- Coverage for prescription drug products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit
- Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a hospital, skilled nursing facility, or alternate facility
- Experimental or investigational services or unproven services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental
- Prescription drug products furnished by the local, state or federal government. Any prescription drug product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received
- Any product dispensed for the purpose of appetite suppression and other weight loss products
- A specialty medication prescription drug product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting
- Durable medical equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered
- General vitamins, except the following which require a prescription order or refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

- Unit dose packaging of prescription drug products
- Medications used for cosmetic purposes
- Prescription drug products, including new prescription drug products or new dosage forms, that are determined not to be a covered health service
- Prescription drug products as a replacement for a previously dispensed prescription drug product that was lost, stolen, broken or destroyed
- Glucose monitors
- Treatment for toenail onychomycosis (toenail fungus)
- Prescription drug products for smoking cessation
- Compounded drugs that do not contain at least one ingredient that requires a prescription order or refill
- Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug. prescription drug products that are comprised of components that are available in over-the-counter form or equivalent
- New prescription drug products and/or new dosage forms until the date they are reviewed by our Pharmacy and Therapeutics Committee and approved by UHC's Preferred Drug List Management Committee
- Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction

Medicare Part D Prescription Drug Coverage – Should you enroll?

Medicare Part D is a prescription drug program assisting Medicare-eligible members with the cost of medications. **It is a voluntary program in which you don't have to enroll if you have adequate prescription drug coverage elsewhere.** Bausch & Lomb intends to continue to offer retiree medical insurance with its prescription drug benefit to its eligible retirees and spouses. The prescription coverage offered by Bausch & Lomb has benefits equal to or better than those offered by the new Medicare Part D prescription plan.

Before making a decision to enroll in Medicare Part D:

- Compare the prescription drug provisions under the plans that Bausch & Lomb offers to Medicare Part D coverage.
- **Understand that if you decide to enroll in Medicare Part D, your Bausch & Lomb medical and prescription drug coverage will cancel.** You will then have coverage only through Medicare, or a Medicare Advantage Plan (a local HMO that replaces Medicare).
- Realize your decision is locked in for the year. In the fall of each year, you will have an open enrollment opportunity to decide whether you want prescription drug coverage under a Bausch & Lomb plan or through Medicare Part D. This will give you a chance to re-enroll in a Bausch & Lomb plan at a later date if you decide to elect a Medicare Part D plan for the year.

General Medical Provisions

How to File a Claim — Medical Services

If you are enrolled in any of the UnitedHealthcare plans (Choice Plus, Medicare Supplement or Medicare Carve-Out Plans), you don't have to file claim forms for most covered care if you use network providers.

Where to Request Claim Forms

If you use non-network providers and facilities or if you live outside the network service area, you must file a claim form. To request claim forms, contact:

- 866-365-7164 for UnitedHealthcare
- 585-338-8604 for the Corporate Benefits Department, if you live in Rochester, NY
- 866-422-3937, ext 8604 for the Corporate Benefits Department if you live outside of Rochester.

The claim form includes instruction on how it should be completed and where it should be sent. Be sure to include all information requested on the form so your claim can be processed quickly.

You will have to file a claim if you use non-participating providers, including hospitals, doctors, and pharmacies. Your provider can complete the part of the form showing his or her charges, or you can attach an itemized bill for medical services. The bill must show:

- the name of the person or firm making the charge;
- the name of the patient;
- the dates of treatment;
- the service rendered, diagnosis of condition treated, and the amount charged.

Benefits may be paid to the hospital or doctor at your authorization. All other benefits are paid directly to you. When you submit a claim, you will receive an Explanation of Benefits (EOB) showing what the plan paid, what was not paid, and reasons for denial. If you reside in a nursing home, a special claim form should be filed in order to receive the proper prescription drug reimbursement. This form can be obtained by contacting Corporate Benefits.

If You are Enrolled in the Medicare Supplement or Medicare Carve-Out Plans

When you receive covered care, your providers will send bills for services to Medicare first. Once you receive the Explanation of Benefits (EOB) from Medicare stating how much has been paid, complete a claim form and attach your Medicare EOB and a copy of your bills. Mail claims to:

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374

Medical providers are legally required to file claims directly with Medicare for eligible patients. Some providers will also send claims to the secondary carriers.

Medicare Crossover

If you are eligible for Medicare, you may choose to participate in the Medicare Crossover program, a convenient service that can reduce the time it takes to process claims. With

Medicare Crossover, your provider files your claim with Medicare and these claims are automatically sent to UnitedHealthcare for you. You won't have to file a separate claim. Payments are made directly to the participant.

You are eligible for Medicare Crossover if:

- you are covered under Medicare Part B benefits;
- your secondary medical coverage is a Bausch & Lomb medical plan administered by UnitedHealthcare.

Medicare Crossover is available in all states. Contact UnitedHealthcare at 866-365-7164 and speak with a customer service representative to enroll in this valuable service.

When to Submit Claims

To ensure that claims are paid promptly and correctly, you should file your claims within 90 days of the date you receive services. You must file a claim within one year from the date you received service. No legal action can be brought to recover expenses under any benefit after three years from the deadline for filing claims.

If You Have Questions about Claims

If you have a question about UnitedHealthcare's decision regarding your claim, write or call UnitedHealthcare's claim office at 866-365-7164 . Make sure to have all of your background documents, Social Security number, and the UnitedHealthcare Explanation of Benefits form available when calling.

To Resolve a Question or Appeal:

If your question or concern is about a benefit determination, you may informally contact Customer Service at 866-365-7164 before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in *How to File a Claim* you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

If you are appealing an Urgent Care Claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call 8:00 am through 5:00 pm (eastern time), Monday through Friday.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your request should include:

1. The patient's name and the identification number from the ID card;
2. The date(s) of medical service(s);
3. The provider's name;
4. The reason you believe the claim should be paid;
5. Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations: Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.
- For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator in writing within 60 days from receipt of the first level appeal decision.

For pre-service and post-service claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing.
- You or your physician should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding.

Voluntary External Review Program

If a final determination to deny benefits is made, you may choose to participate in our voluntary external review program. This program only applies if the decision is based on either of the following:

- Clinical reasons.
- The exclusion for experimental, investigational or unproven services.
- The external review program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits.

Contact the Claims Administrator at the telephone number shown on your ID card for more information on the voluntary external review program.

Coordinating Benefits with Other Coverage

If you, your spouse, or dependents have Bausch & Lomb retiree medical coverage as well as any other group health plan or any local, state or government program other than Medicaid, benefits from the company's plan will coordinate with any other benefits you receive.

Here are guidelines for determining which plan pays first when Bausch & Lomb retiree medical coverage coordinates benefits.

For All Covered Individuals

- benefits from automobile insurance will be paid before any other benefits
- the plan covering the person as an employee pays before the plan covering the person as a dependent
- the plan covering the person as an active employee, or that employee's dependent, pays before the plan covering the person as a laid-off or retired employee or COBRA participant, or that employee's or COBRA participant's dependent.
- Medicare pays before the plan covering the person as a retired employee or that employee's dependent

For Eligible Dependent Children

- the plan of the parent whose birthday comes first in the calendar year pays first for covered dependent children, unless the parents are divorced or separated
- in a divorce or separation, the plan of the parent with legal custody pays first, except where a court decrees otherwise
- if the parent with legal custody has remarried
 - the plan of the parent with legal custody pays first
 - the plan of the stepparent with custody pays next
 - the plan of the parent without custody pays last.

If none of these rules apply, the plan that has covered the person for the longest time pays first.

If you and/or your spouse are over age 65 and covered by an HMO Medicare Alternative plan as well as a UnitedHealthcare (UHC) plan, it may be necessary for your medical and prescription co-payments to be specially handled by UHC. Contact the Corporate Benefits Department at -1-800-344-8815 for details.

Plan's Right to Recover and Sue for Losses

If you or your dependent has healthcare expenses as the result of a loss or an injury caused by another person, you or your dependent may have a claim against that person for payment of your healthcare bills. The plan will be subrogated to the right of recovery you or your dependent has against the other person.

The plan reserves the right to be reimbursed for benefits under this plan if the person for whom benefits are paid has a right to recover those benefits from a third party. In this case, the plan will pay any covered expenses for the loss or injury only if the covered person, or his or her legally authorized representative, agrees in writing to:

- reimburse the Claim Administrator up to the amount of the benefits paid out of any money received from the third party or his or her insurance company from a judgment settlement or otherwise
- provide the Claim Administrator a lien in the amount of the benefit paid. This lien may be filed with the third party, his or her agent, or the court.

Any payment or lien will be made or provided to the Claim Administrator in its capacity as the provider of administrative services to this plan.

Recovery of Overpayment

If the Claim Administrator makes a benefit payment to or on behalf of any person, and the payment is more than the benefit amount the person is entitled to receive, the plan has the right to:

- require the return of the overpayment;
- reduce any future benefit payment made for that person or another person in his or her family by the amount of the overpayment.

This right does not affect any other right the plan has to recover overpayments.

Legal Action

No legal action can be brought to recover any benefit more than three years from the date services are received.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act is referred to as COBRA. Under COBRA, you can continue medical coverage that would end because of a qualifying event, such as voluntary or involuntary termination for reasons other than gross misconduct. If you continue medical coverage, your prescription drug coverage will also be continued. Upon one of these events, you will receive notice of your right to continue coverage. This continuation coverage may be kept for up to 18 months. You must pay the required cost of the continued coverage.

If you or your dependent is disabled under the Social Security Act at any time during the first 60 days of COBRA continuation coverage as a result of termination of employment or change in employment status, an additional 11 months of coverage may be available. To be eligible for this disability extension, the disabled person must receive a Social Security disability determination and notify the Corporate Benefits Department within 60 days of the determination. Both the Social Security disability determination and the notice to the Corporate Benefits Department must happen before the end of the initial 18 months of COBRA coverage. Non-disabled family members who receive COBRA coverage because of the same termination of employment or change in employment status as the disabled person are also eligible for the disability extension. For the additional 11 months of coverage, you must pay 150% of the cost of coverage.

Spouses of retirees and or their dependent children may choose continuation coverage and keep it for up to 36 months as long as they pay the required costs — if their medical coverage ends because of:

- death of the covered person;
- divorce or legal separation from the covered person;
- covered person becomes entitled to Medicare;

- dependent child no longer meets the definition of “eligible dependent” under the plan.

If you have a newborn child or adopt a child during the time you are covered by COBRA continuation coverage, that child can be enrolled under the continuation coverage. Like your other dependents, that child can keep continuation coverage for up to 36 months from the date your COBRA coverage began if the coverage would otherwise end because of one of the four events described above.

Dependent children covered by the company’s plan may also choose continuation coverage and keep it for up to 36 months if their group coverage ends because they no longer qualify as an eligible dependent under the plan.

Under COBRA, the retiree or spouse is responsible for notifying Corporate Benefits Department of a divorce, legal separation, death or of a child losing dependent status under the plan. Notice must be given within 60 days of the event and Corporate Benefits also must receive a current and complete mailing address. If notice is not received within the 60-day period, the dependent will not be entitled to choose continuation coverage.

When the Corporate Benefits Department is notified that one of these events has occurred, the COBRA administrator, ADP, will mail an enrollment form for continuation coverage to the eligible individual along with notification of cost. The eligible individual must complete the enrollment form and return to COBRA administrator within 60 days of

- the date coverage is lost because of one of the events described here, or
- the date the form is received from the company, whichever is later.

If an individual does not complete the election form and return it to the COBRA administrator within the 60-day period, coverage will end as of the date of the event that caused you to lose coverage.

If an eligible individual chooses continuation coverage, the company must provide coverage identical to that provided to comparably situated employees/retirees or family members. An eligible individual’s continuation coverage will end when

- the company stops providing group health coverage for employees;
- payment for continuation coverage is not paid by the deadline, or your check is returned for insufficient funds;
- the individual later becomes covered by another group health plan. If the new group plan excludes benefits because of a pre-existing condition, however, you may continue coverage through the company’s plan through the end of the COBRA eligibility period or until the other plan’s pre-existing condition limits no longer apply, whichever is earlier;
- the individual later becomes entitled to Medicare. If the employee became entitled to Medicare before the reduction in hours or employment termination, coverage for other covered family members may be continued for 18 months or for up to 36 months from the date the employee became entitled to Medicare, whichever is longer;
- the 18-, 29- or 36-month COBRA period ends.

If you reach retirement age and leave the company but do not qualify for medical benefits because you have not fulfilled the service requirement for retiree medical coverage, you may continue coverage under any of the Bausch & Lomb medical plans for up to 18 months.

Dependents who lose coverage as a result of divorce or legal separation or your death or because they no longer qualify for coverage, and who are not covered under any other group health plan, may continue their coverage under any of the medical plans for up to three years.

If you are married, it is important that your spouse also reads the COBRA provisions. The intent of these rules is that no one should suddenly be denied access to group health coverage.

Any employees and/or dependents who elect to continue coverage under COBRA must pay the full premium for that coverage, including both the share you now pay and the share that Bausch & Lomb pays, plus any administrative fee permitted under law. At the end of the coverage continuation period, a personal health care policy (conversion policy) may be obtained without evidence of insurability.

If you or your dependents lose coverage and wish continuation under COBRA, the Corporate Benefits Department should be contacted at 585-338-8604 or 866-422-3937 (ext. 8604).

Medical Coverage Definitions

Claims Administrator

The company designated by the plan sponsor to process benefits for medical coverage. UnitedHealthcare is currently the claims administrator for that purpose.

Doctor

A physician licensed to practice medicine. A doctor must be licensed or certified by the state where he or she provides services and must act within the scope of that license or certificate.

Experimental or Investigational

A drug, device, procedure or treatment will be determined to be experimental or investigational if:

- insufficient data are available from controlled clinical trials published in the peer review literature to determine safety and effectiveness for the disease or injury;
- approval required by the Federal Drug Administration for marketing has not been granted;
- a recognized national medical or dental society or regulatory agency has determined in writing that it is experimental, under investigation or for research;
- the written protocol(s) used by the treating facility, or the protocol(s) of any other facility studying the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

Home Health Agency

An organization that meets all these requirements:

- its primary purpose is providing skilled nursing and other therapy in the private homes of persons recovering from an injury or illness;
- it is licensed or approved under any state or local standards that apply;
- it is run under policies established by a professional staff that includes doctors and registered nurses;
- its services are supervised by a doctor or registered nurse;
- it keeps clinical records on all patients;
- it does not, except incidentally, provide care or treatment of the mentally ill or care of a custodial nature.

Hospice

A public or private agency or facility that meets all these requirements:

- administers medically supervised written plans of physical, psychological, social and spiritual care for terminally ill individuals and their immediate family;
- has its own staff doctors, nurses and medical and social counseling services on call 24 hours a day, 7 days a week, or contracts and monitors this staff if not furnished by the hospice itself;
- is supervised on a full-time basis by a doctor or registered nurse (RN);
- keeps a written record of all hospice services furnished to its patients and families;
- makes use of trained volunteers and keeps written records of their use and cost savings;
- is licensed or certified according to the laws of the state where it is located;
- provides bereavement and medical social services.

Hospital

A facility that meets all of these requirements:

- its primary purpose is providing facilities supervised by one or more doctors to diagnose and treat injury and illness;
- it provides day and night lodging that includes nursing service supervised by registered graduate nurses;
- it complies with the laws pertaining to hospitals in its locality.

Hospital Stay

A hospital admission is considered an inpatient hospital stay if it lasts more than 18 hours.

Injury

An accidental bodily harm that requires treatment by a doctor.

Illness

Sickness or diseases, including mental diseases, that require treatment by a doctor. Illness includes pregnancy of a female employee or a dependent wife and complications of pregnancy for a female employee and all dependents. Illness also includes a covered child's functional defect caused by premature birth or congenital malformation.

Medical Emergency

A sudden medical condition severe enough to require immediate medical care — such as severe chest pain, severe shortness of breath, prolonged bleeding, seizures or convulsions, and allergic reactions accompanied by swelling of face or lips, wheezing or blue discoloration of the skin. For a condition to be considered a medical emergency, it must be expected that failure to get immediate care could place the person's life in danger or cause serious physical impairment.

Medically Necessary

A service or supply that:

- is prescribed by a doctor;
- is appropriate and consistent with the diagnosis;
- is in accord with generally accepted medical practice;
- could not have been left out without adversely affecting the covered person's condition or quality of medical or dental care.

The Claim Administrator may rely upon the advice of medical peer review groups and other medical experts to determine which services or supplies are medically necessary.

Reasonable and Customary Charge

For Network Benefits, Reasonable and Customary Charge is based on either of the following:

- When covered services are received from network providers, reasonable and customary charge is the contracted fee(s) with that provider.
- When covered services are received from non-network providers as a result of an emergency or as otherwise arranged by the Claims Administrator, reasonable and customary charge is the fee(s) negotiated with the non-network provider.

For Non-Network Benefits, Reasonable and Customary Charge is determined by either:

- Calculating reasonable and customary charge based on available data resources of competitive fees in that geographic area, or
- Applying the negotiated rates agreed to by the non-network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

Reasonable and Customary Charges are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, at the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications;
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Skilled Nursing Facility

A lawfully operated institution that meets **all** these requirements:

- its primary purpose is providing lodging and skilled nursing care, day and night, for persons recovering from an injury or illness;

- it is supervised on a full-time basis by a doctor or registered nurse;
- it admits patients only upon the advice of a doctor, keeps clinical records on all patients and has the services of a doctor available at all times under an established agreement;
- it has established methods and procedures to dispense and administer drugs and biologicals;
- it has a written transfer agreement with one or more hospitals;
- it is not, except incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a place for the mentally ill.

Terminally Ill Individual

A covered person who has a life expectancy of six months or less.

Unproven Services – health services that, according to prevailing medical research, do not have a beneficial effect on health outcomes, and are not based on:

- well-conducted randomized controlled trials; or
- well-conducted cohort studies.

In a randomized controlled trial, two or more treatments are compared to each other, and the patients are not allowed to choose which treatments they receive. In a cohort study, patients who receive study treatment are compared to a group of patients who receive standard therapy. In both cases, the comparison group must be nearly identical to the study treatment group.

If you have a Sickness or Injury that is likely to cause death within one year of the request for treatment, UnitedHealthcare and Bausch & Lomb may, at their discretion, determine that an Unproven Service is a Covered Health Service for that Sickness or Injury. For this to take place, UnitedHealthcare and Bausch & Lomb must determine that the procedure or treatment is:

- proved to be safe and promising;
- provided in a clinically controlled research setting; and
- using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Life Insurance Coverage

The company provides life insurance coverage to eligible retirees. Your coverage amount depends on your retirement date.

Effective January 1, 2005, there were new eligibility rules for retiree life insurance coverage. Employees will be eligible to receive life insurance if they have at least 55 points as of 1/1/05, a minimum of five years of service as of 12/31/05, and are age 55 or older at time of termination. This group of grandfathered employees will be entitled to the same retiree life insurance benefit as those who retired after 1/1/2000 as outlined below. Employees not meeting this grandfathering criteria will not be eligible for life insurance when they retire.

If You Retire On or After January 1, 2000

Your level of coverage is based on your age. If you are:

- 65 or less, the benefit is \$15,000;
- 66 to 69, your benefit decreases each year by \$1,500;
- 70 or more, the benefit is \$7,500.

There is no cost to you for retiree life insurance if you retired on or after 1/1/2000.

If You Retired On or After March 1, 1989 and Before January 1, 2000

You have one-fourth of your basic life insurance amount at retirement — up to a maximum of \$15,000 in life insurance coverage. At age 65, the amount decreases each year by 10% — to \$5,000 at age 70. The cost for the insurance is \$0.30 per \$1,000 of coverage for those with less than 20 years of service.

If You Retired Before March 1, 1989

You have one-fourth of your basic life insurance amount at retirement — up to \$20,000 in life insurance coverage. There is a cost for those who had between 10 and 20 years of service, and no cost for those with 20 or more years of service. The cost for the insurance is \$0.30 per \$1,000 of coverage for those with between 10 and 20 years of service.

Important Information about Your Life Insurance Coverage

Life insurance can help pay for such immediate short-term needs such as funeral expenses. The coverage is term insurance and is paid upon a retiree's death. There is no cash value to the retiree. If you waived life insurance coverage while employed, coverage is not available at retirement.

When you retire, you receive a life insurance certificate that shows the amount of your coverage, the effective date of your coverage, and your named beneficiaries. Make sure to keep it in a safe place for future reference.

Naming a Beneficiary

A beneficiary is a person designated to receive your life insurance benefits at the time of your death. It is very important for you to keep beneficiary information current. Beneficiary change forms can be requested from the Bausch & Lomb Corporate Benefits Department, by calling 866-422-3937 ext.8604. If you live in the Rochester area, call 585-338-8604.

You can name more than one beneficiary. In this case, you must indicate how much of your total benefit each beneficiary will receive. You can also name a primary and a contingent beneficiary. The contingent beneficiary receives your benefit if your primary beneficiary dies before you. The beneficiary form provides details on different ways you can designate beneficiaries.

A change in beneficiary will take effect on the date you sign the request. A change of beneficiary, however, will not apply to any payment made by the insurance company before the date Bausch & Lomb receives the request.

If you don't name a beneficiary or if the beneficiary you have named dies before you and you have no contingent beneficiary named, the plan will pay benefits in this order:

- your husband or wife, if living at your death;
- surviving children, equally;
- your parents, equally;
- brothers and sisters, equally;
- your estate.

Filing a Claim

When you die, your family should call the Corporate Benefits Department at Bausch & Lomb at 585-338-8392 or 866-422-3937, ext. 8392.

A benefits administrator will explain the benefits in writing and will give instructions for filing a claim. A certified death certificate will be required. Any policy or certificate related to the coverage should be sent to the company along with a certified copy of the death certificate, coroner's report and any other legal items required. A life insurance policy or certificate is not required in order for a claim to be paid.

The insurance company has the right to request additional information before paying a claim. Failure to provide requested forms or information can delay payment. Claims under this plan can only be made by your beneficiary or a person acting on behalf of the beneficiary.

Life insurance claims should be sent to:

Bausch & Lomb
Corporate Benefits Administration
One Bausch & Lomb Place
Rochester, NY 14604-2701

The life insurance benefits will be paid to the named beneficiary or to the estate as soon as possible after receipt of the death certificate and other required documents and information.

How Benefits Are Paid

When the Benefit is \$5,000 or More

The insurance company will send your beneficiary an account in the amount of your benefit. The amount of the benefit is deposited in an interest-bearing checking account and your beneficiary receives a checkbook, along with complete details on using the account. Your beneficiary may choose to leave the money in the account and write checks as needed — with \$250 minimum check amount. At any time, your beneficiary may also choose to close the account by writing a check for the account balance.

When the Benefit Is Less Than \$5,000

If the benefit is less than \$5,000, a check for the designated amount will be sent to the beneficiary or to the estate.

When Benefits May Not Be Paid

There are some circumstances when benefits may be delayed or forfeited. For example, if you do not keep your most recent address on file and the company can't locate you, benefit payments may be delayed or forfeited. To change your address after termination of employment, call the Corporate Benefits Department at 585-338-8604 or 866-422-3937, ext. 8604.

Important Information about the Plan

Appealing a Claim

If payment of your claim is denied, either in full or in part, you will receive a written notice explaining the reasons for the denial, including references to the specific plan provisions on which the denial was based, within 90 days of the date the plan administrator receives your claim. If payment is denied because you did not furnish complete information or documentation, the notice will state the additional materials needed to support your claim. The notice will also tell you how to request a review of the denied claim based on established plan rules.

Within 60 days after receiving a denial, you or your representative may appeal the decision by requesting a review, citing pertinent plan documents and summarizing issues and comments in writing to the plan administrator.

You will normally receive a written notice of the decision on your appeal within 60 days of the receipt of your request. If special circumstances require an extension, you will be notified, and the decision will be made no later than 120 days after receipt of your appeal. The notice will give reasons for the decision and will be written in clear, understandable language.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Plan Sponsor and Employer Identification Number (EIN)

Bausch & Lomb Incorporated
One Bausch & Lomb Place
Rochester, New York 14604-2701
EIN—16-0345235

A complete list of employers sponsoring the plan may be obtained upon written request to the plan administrator. Written request may also be made of the plan administrator as to whether a particular employer is a sponsor of the plan.

Plan Administrator

Bausch & Lomb has designated the Employee Benefits Administrative Committee to act as the plan administrator.

Bausch & Lomb Incorporated
One Bausch & Lomb Place
Rochester, New York 14604-2701
585-338-6000

Plan Name, Type of Plan and Plan Number

The complete name of the plan is the Bausch & Lomb Post-Retirement Plan. This plan is a retiree medical and life insurance plan. The plan number is 524.

The Aetna Life Insurance Company is the Claim Administrator for life insurance and determines benefits, according to plan provisions. The group number for Aetna is 655589. Medical benefits administered through UnitedHealthcare are self-funded by Bausch & Lomb under group contract number 702553.

Financial records are kept on a calendar-year basis, with each plan year ending on December 31. The employer may allocate part of the cost of the plan to the retiree. The employer determines the portion of the cost to be paid by the employee.

Plan Year

The plan year is the calendar year—January 1 through December 31.

Agent for Service of Legal Process

Legal process may be served on the Secretary, Employee Benefits Administrative Committee at:

Bausch & Lomb Incorporated
One Bausch & Lomb Place
Rochester, New York 14604-2701

or the trustees at their respective business addresses shown at the beginning of this booklet. For routine questions about the plans check with the Customer Service Representative whose phone number appears with the respective plan addresses.

Plan Document

The description contained in this booklet is intended to provide a summary explanation of your benefits. Easy-to-read language has been used as much as possible to help you understand the plan provisions. Official plan documents govern the operation of and are the legally governing instruments in determining all rights and obligations under the plan.

The information contained in this summary booklet does not give any person either the right to continued employment with the company or the right to interfere with the company's rights to discharge any person at any time, with or without cause, without regard to the effect such discharge shall have upon rights, if any, under the plan.

Your rights to inspect or obtain copies of these documents are described in "Your Rights under ERISA" at the end of this booklet. In case of any discrepancies between this booklet and the official plan documents, the plan documents will prevail.

Right to Amend or Terminate Plan

The company has arranged to sponsor this plan indefinitely, but reserves the right to amend, suspend or terminate the plan for any reason. In addition, any participating employer reserves the right to terminate its participation in the plan even if the plan continues to operate for other participating employers. The company and all participating employers also reserve the right to discontinue all contributions to the plan at any time. You will be given notice of any changes to the plan.

Your Rights under ERISA

Your ERISA rights are described in the last section of this book.