



**VISION BENEFIT SUMMARY FOR
Truman State University**
Program Year Effective January 1, 2009
Underwritten by United HealthCare Insurance Company

BENEFITS AT A SPECTERA NETWORK PROVIDER

COMPREHENSIVE VISION EXAM (\$10 Copay; Once Every 12 Months)

Receive a comprehensive eye examination from a state-licensed optometrist or ophthalmologist.

MATERIALS (\$25 Copay)

The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.

Pair of Lenses for Eyeglasses (Once Every 12 Months)

- One pair of standard single vision, lined bifocal, lined trifocal, or standard lenticular lenses is covered-in-full.
- Standard scratch-resistant coating and polycarbonate lenses are covered-in-full.
- Lens Options - Options such as progressive lenses, polycarbonate lenses, tints, UV, and anti-reflective coating may be available at a discount.

Frames (Once Every 24 Months)

Receive a \$50 wholesale frame allowance (approximate retail value of \$120 to \$150) at private practice providers, or a \$130 frame allowance at retail chain providers.

Contact Lenses in Lieu of Eyeglasses (Once Every 12 Months)

• *Covered-in-full elective contact lenses*

The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after applicable copay) for many of the most popular brands on the market. If covered disposable contact lenses are chosen, up to 4 boxes (depending on prescription) are included when obtained from a network provider. It is important to note that Spectera's covered-in-full contact lenses may vary by provider.

• *All other elective contacts*

A \$125 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of Spectera's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

• *Necessary contact lenses**

Covered-in-full (after applicable copay)

REFRACTIVE EYE SURGERY

Spectera participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at www.spectera.com, or call 1-877-28-SIGHT.

BENEFITS AT AN OUT-OF-NETWORK PROVIDER

<u>SERVICE</u>	<u>AMOUNT</u>	<u>SERVICE</u>	<u>AMOUNT</u>
Exam		Lenses	
Optometrist	up to \$40	Single Vision	up to \$40
Ophthalmologist	up to \$40	Bifocal	up to \$60
		Trifocal	up to \$80
Contact Lenses (in lieu of eyeglasses)		Lenticular	up to \$80
Elective	up to \$125		
Necessary*	up to \$210	Frames	up to \$45

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of the date of service.

* Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Spectera concerning the reimbursement that Spectera will make before you purchase such contacts.

Spectera's vision benefit is very affordable. The monthly premiums are:

Exam copay	\$10	Employee Only:	\$6.85 per month
Materials copay	\$25	Employee + Spouse:	\$13.05 per month
		Employee + Child(ren)	\$13.70 per month
		Employee + Family:	\$21.10 per month

SAMPLE ILLUSTRATION OF SAVINGS

Cost	Employee Only	Employee + Spouse	Employee + Child(ren)*	Employee + Family**
Monthly Premium	\$6.85	\$13.05	\$13.70	\$21.10
Annual Premium	\$82.20	\$156.60	\$164.40	\$253.20
Approx. Pre-tax Savings (20%)***	\$16.44	\$31.32	\$32.88	\$50.64
Annual Tax-Adjusted Premium	\$65.76	\$125.28	\$131.52	\$202.56
Plus Copays	\$35	\$70	\$105	\$140
Total Cost to Employee	\$100.76	\$195.28	\$236.52	\$342.56

Exam and Materials Covered by Spectera's Vision Plan	Estimated Cost Without a Vision Plan****	Less Employee Cost	Total Savings With Spectera
Employee Only Exam, Single Vision, & Covered-in-Full Frames	\$275	\$101	\$174
Employee + Spouse Exam, Single Vision, & Covered-in-Full Frames	\$550	\$195	\$355
Employee + Child(ren) Exam, Single Vision, & Covered-in-Full Frames	\$825	\$237	\$588
Employee + Family Exam, Single Vision, & Covered-in-Full Frames	\$1,100	\$343	\$757

*For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.

** For purposes of this sample calculation, Employee + Family is calculated with four (4) members.

***Actual tax savings will depend upon your individual tax bracket.

****Approximate retail value illustrated: Exam & Refraction (\$65), Single Vision Lenses (\$80), and Frames (\$130). Average retail costs may vary by provider.

Important to Remember:

- Benefits available every 12 or 24 months (depending on the benefit frequency), based on last date of service.
- Your \$125 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30, you will have \$95 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. To contact Spectera's Customer Service department, call toll-free 1-800-638-3120 or TDD 1-800-524-3157 for the hearing impaired. Customer service representatives are available:

Monday through Friday from 7:00 a.m. to 10:00 p.m. CT
Saturdays from 8:00 a.m. to 5:30 p.m. CT

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document.

The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.