SPECTERA

VISION BENEFIT COMMUNICATION

Grambling State University

Program Year Effective April 1, 2006
Underwritten by United HealthCare Insurance Company

BENEFITS AT A SPECTERA NETWORK PROVIDER	
COMPREHENSIVE VISION EXAM ($10 copay; Once Every 12 Months)	A vision examination is provided by a network optometrist or ophthalmologist, after applicable copay.
MATERIALS ($10 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) · Standard single vision · Standard lined bifocal · Standard lined trifocal · Standard lenticular	Standard scratch-resistant coating is 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 12 Months)	Spectera's frame benefit applies to virtually all of the frames on the market today, and most of those are covered-in-full, without any additional cost to the member, other than applicable copay. Receive a $50 wholesale frame allowance (approximate retail value of $120 to $150) at private practice providers, or a minimum $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 tthe 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 $105 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.

BENEFITS AT AN OUT-OF-NETWORK PROVIDER			
SERVICE	AMOUNT		
Exam			If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to:
Optometrist	up to	$40	
Opthalmologist	up to	$40	
Lenses			
Single Vision	up to	$40	
Bifocal	up to	$60	Spectera Claims Department
Trifocal	up to	$80	P. O. Box 26618
Lenticular	up to	$80	Baltimore, MD 21207-6618
Frames	up to	$45	
Contact Lenses (in lieu of eyeglasses)			Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.
Elective	up to	$105	
Necessary*	up to	$210	

* 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:

	Employee Only:	$10.58 per month
Exam copay $10	Employee + 1 Dependent:	$20.23 per month
Materials copay $10	Employee + Family:	$27.97 per month

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Sample Illustration of Savings

COST	EMPLOYEE ONLY	EMPLOYEE + 1 DEPENDENT	EMPLOYEE + FAMILY*
Monthly Premium	$10.58	$20.23	$27.97
Annual Premium	$126.96	$242.76	$335.64
Approx. Pre-tax Savings (20%)	$25.39	$48.55	$67.13
Annual Tax-Adjusted Premium	$101.57	$194.21	$268.51
Plus Copays	$20	$40	$80
Total Cost to Employee	**$121.57**	**$234.21**	**$348.51**

	Estimated Cost Without a Vision Plan**	Less Employee Cost	TOTAL SAVINGS WITH SPECTERA
Employee Only Exam, Single Vision, & Covered-in-Full Frames	$275	$122	$153
Employee + 1 Dependent Exam, Single Vision, & Covered-in-Full Frames	$550	$234	$316
Employee + Family * Exam, Single Vision, & Covered-in-Full Frames	$1,100	$349	$751

* For purposes of this sample calculation, Employee + Family is calculated with 4 members.
** Approximate retail value illustrated: Exam & Refraction ($65), Single Vision Lenses ($80), and Frames ($130). Average retail costs may vary by location.
Actual tax savings will depend upon your individual tax bracket.
Upgrades and add-ons discounted between 20-40% off of retail costs.
Covered-in-full frames credit equivalent to approximately $120 to $150 U&C value.

Important to Remember:
· Always identify yourself as a Spectera participant when making your appointment. This will assist your provider in obtaining a claim authorization number prior to your visit.
· Benefits available every 12 or 24 months (depending on the benefit frequency), based on last date of service.

· Your $105 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 $75 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.

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

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

Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Customer Service is available toll-free at 1-800-638-3120 from 7:30 a.m. to 10:00 p.m.CST, Monday thru Friday, and from 8:00 a.m. to 4:30 p.m.CST on Saturdays.