



Out-of-Network Reimbursements

Service Types	Reimbursement Amount	Percentage of Paid Amount
EXAM	\$60.00	
SINGLE VISION	\$40.00	
BIFOCAL	\$60.00	
TRIFOCAL	\$80.00	
LENTICULAR/CATARACT	\$80.00	
FRAME	\$45.00	
CONTACTS	\$200.00	
DISPOSABLE CONTACTS	\$200.00	
CONTACTS-MEDICAL	\$210.00	

To receive reimbursement from a non-network provider, you will need to mail your itemized receipts, with member's unique identification number and the patient's date of birth to:

Spectera Claims Department
P.O. Box 26618
Baltimore, Maryland 21207-6618

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

Spectera will reimburse you for covered expenses according to the schedule shown above.