

NYS Vision Plan Indemnity Reimbursement Schedule

Exhibit III.E

The following is the Schedule of Indemnity Fees for Enrollees who choose to receive care from a Non-Panel Provider, or receive Non-Plan benefits.

	<u>ALESU</u>	<u>C82</u>	<u>GSEU</u>	<u>M/C & unrep</u>	<u>NYSCOPBA</u>	<u>PEF</u>	<u>PBA-S</u>	<u>PBA-T</u>	<u>PIA</u>
Examination	\$16	\$16	N/A	\$20	\$16	\$20	\$20	\$20	\$20
Frame	14	14	N/A	22	14	22	22	22	22
Single Vision Lenses	14	14	N/A	22	14	22	22	22	22
Bifocal Lenses	23	23	N/A	30	23	30	30	30	30
Trifocal Lenses	32	32	N/A	40	32	40	40	40	40
Cataract Lenses	35	35	N/A	35	35	35	35	35	35
Cataract Bifocals	35	35	N/A	35	35	35	35	35	35
Contact Lenses	184	184	N/A	40	184	40	184	184	184
Cataract Contact Lenses	184	184	N/A	40	184	40	184	184	184
Eye Exam & Contact Lenses	200	200	N/A	60	200	60	200	200	200

Note: An enrollee may receive a combination of reimbursements from one visit. For example, examination, lens and frame.