ATTACHMENT 15

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Non-Network Reimbursement Schedule - RFP entitled: "New York State Vision Plan Services"

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

	PBANYS	C82	GSEU	M/C & unrep	NYSCOPBA	PEF	PBA-S	PBA-T	PIA
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.