New York | 2026

Blue View Vision plans

(2-100 employees) - standalone, off-exchange

Plan	Copay[1] eye exam / eyeglass lenses	Allowance[1,2] frames / contact lenses	Eye exam (frequency)	Eyeglass lenses (frequency)	Frames (frequency)	Contact lenses (frequency)
Full service plans						
FS.A.10.0.130.130	$10 / $0	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.0.150.150	$10 / $0	$150 / $150	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.0.180.180	$10 / $0	$180 / $180	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.10.130.130	$10 / $10	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.10.150.150	$10 / $10	$150 / $150	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.20.130.130	$10 / $20	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.25.130.130	$10 / $25	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.25.150.150	$10 / $25	$150 / $150	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.10.25.200.200	$10 / $25	$200 / $200	Once every CY	Once every CY	Once every CY	Once every CY
FS.A.20.20.130.130	$20 / $20	$130 / $130	Once every CY	Once every CY	Once every CY	Once every CY
FS.B.10.0.180.180	$10 / $0	$180 / $180	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.10.130.130	$10 / $10	$130 / $130	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.10.150.150	$10 / $10	$150 / $150	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.20.130.130	$10 / $20	$130 / $130	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.25.130.130	$10 / $25	$130 / $130	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.25.150.150	$10 / $25	$150 / $150	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.10.25.200.200	$10 / $25	$200 / $200	Once every CY	Once every CY	Once every other CY	Once every CY
FS.B.20.20.130.130	$20 / $20	$130 / $130	Once every CY	Once every CY	Once every other CY	Once every CY
FS.C.10.20.100.100	$10 / $20	$100 / $100	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.10.20.130.130	$10 / $20	$130 / $130	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.20.20.130.80	$20 / $20	$130 / $80	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.20.20.130.130	$20 / $20	$130 / $130	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.20.20.150.150	$20 / $20	$150 / $150	Once every CY	Once every other CY	Once every other CY	Once every other CY
FS.C.25.0.120.115	$25 / $0	$120 / $115	Once every CY	Once every other CY	Once every other CY	Once every other CY
Material only plans						
MO.A.10.130.130	Not covered / $10	$130 / $130	Not covered	Once every CY	Once every CY	Once every CY
MO.B.10.130.130	Not covered / $10	$130 / $130	Not covered	Once every CY	Once every other CY	Once every CY
MO.A.10.150.150	Not covered / $10	$150 / $150	Not covered	Once every CY	Once every CY	Once every CY
MO.B.10.150.150	Not covered / $10	$150 / $150	Not covered	Once every CY	Once every other CY	Once every CY
MO.A.20.130.130	Not covered / $20	$130 / $130	Not covered	Once every CY	Once every CY	Once every CY
MO.B.20.130.130	Not covered / $20	$130 / $130	Not covered	Once every CY	Once every other CY	Once every CY

Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both.

1 Above amounts reflect in-network copays and allowances.
2 Non-elective contacts covered in full.

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