



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.

This document is intended to be a brief summary of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Evidence of Coverage; the Evidence of Coverage has exclusions, limitations and terms under which the Evidence of Coverage may be continued in force or discontinued.

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