MASSACHUSETTS

BLUE 20/20 EXAM-PLUS VISION PLAN: INSIGHT NETWORK

$180 - 12/12/24 Frequency

Vision care service	In-network member cost	Out-of-network reimbursement[1]
Comprehensive eye exam	$10 copay	up to $50
Contact lens fit and follow-up[2]		
• Standard	up to $40	n/a
• Premium	10% off retail price	n/a
Retinal imaging	up to $39	n/a
Enhanced Diabetes Eye Care Benefit[3] For members diagnosed with type 1 or type 2 diabetes	Paid in full: up to two diabetic eye exams and diagnostic testing every 12 months	n/a
Frames	$180 allowance, then additional 20% off balance	up to $114
Standard plastic lenses		
• Single vision	$25 copay	up to $42
• Bifocal	$25 copay	up to $78
• Trifocal	$25 copay	up to $130
• Lenticular	$25 copay	up to $130
• Standard progressive lens	$90 copay	up to $140
• Premium progressive lens		
tier 1–tier 3	$110–$135 copay	up to $196
tier 4	$90 copay, then 80% of charge less $120 allowance	up to $196
Lens options[2]		
• UV treatment	$15	n/a
• Tint (solid and gradient)	$15	n/a
• Standard plastic scratch coating	$15	n/a
• Standard polycarbonate	$40	n/a
• Standard polycarbonate for covered dependents under age 19	Paid in full	up to $26
• Standard anti-reflective coating	$45	n/a
• Premium anti-reflective coating		
tier 1–tier 2	$57 - $68	n/a
• Photochromic/Transitions®✓ plastic	$75	n/a
• Polarized	20% off retail price	n/a
• Other add-ons	20% off retail price	n/a
Contact lenses[4]		
• Conventional	$180 allowance, then additional 15% off balance	up to $144
• Disposable	$180 allowance	up to $144
• Medically necessary	Paid in full	up to $210
Frequency		
• Exam	once every 12 months	
• Lenses for frames or one order of contact lenses	once every 12 months	
• Frames	once every 24 months	

For costs and further details of the coverage, including exclusions, please refer to your member booklet.

1. Your actual expenses for covered services may exceed the stated out-of-network amount.
2. Indicates a service that is a discounted arrangement as part of your vision plan.
3. Consult with your eye care provider.
4. Discount applies to materials only and not fittings for contact lenses.

ADDITIONAL IN-NETWORK SAVINGS AND DISCOUNTS

40%

OFF A COMPLETE SECOND PAIR OF GLASSES

20%

OFF NON-PRESCRIPTION SUNGLASSES

15%

OFF RETAIL PRICE OR 5% OFF PROMOTIONAL PRICE FOR LASER VISION CORRECTION THROUGH U.S. LASER NETWORK

Blue 20/20 is administered by EyeMed Vision Care®✓, an independent company.

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Blue20/20

Application / Change Form

☐ **New Enrollee**
(Please complete A, C, D, and E)

☐ **Change Request**
(For changes, complete Sections A, B, and all other applicable sections. Plan changes can only be made at Open Enrollment or due to a qualifying event.)

☐ **Termination Date:** _____

Please print clearly.
Please use a black or blue pen.

Blue 20/20 Group No.

A. Employee Information

Name of Employer:	Effective Date:		Dept./Division:
Social Security Number:	Date of Birth:	Sex: ☐ Male ☐ Female	
Last Name:	First Name:	MI:	Marital Status: ☐ Single ☐ Married
Mailing Address:	City:	State:	Zip Code:
Date of Hire:	Home Phone Number:	Work Phone Number:	Email Address:

B. If Making a Change from Previous Enrollment

Check All That Apply:

☐ Name Change
☐ Employee SSN Correction
☐ Add/Remove Dependent
☐ Address/Telephone Number Change
☐ Date of Birth Correction
☐ Late Enrollee
☐ Other:

Add Dependent(s):

	Date of Occurrence
☐ Marriage	_____
☐ Domestic Partner	_____
☐ Newborn (up to age 1)	_____
☐ Adoption	_____
☐ Court Order	_____
☐ Loss of Coverage	_____
☐ Other	_____

☐ **Remove Dependent(s)** _____
Date: _____
Reason:

Reinstate Coverage:
Date: _____
Reason:

Terminate Coverage:
Date: _____
Reason:

Blue20/20

C. Coverage Selection

Options Selected: ☐ Employee ☐ Employee plus Spouse or Domestic Partner
☐ Employee plus One or More Children ☐ Family

D. Family Information–Complete for anyone taking or dropping Blue 20/20 Coverage*

	Name (First, MI, Last Name)	Social Security Number	Date of Birth mm/dd/yyyy	Relationship	Sex
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F

*Application does not guarantee enrollment.

Eligibility Notes:

1. Employees are eligible for coverage if they meet the definition of an eligible employee as defined by their employer and Blue Cross Blue Shield of Massachusetts.
2. Domestic Partners are eligible for coverage if they meet the definition of a Domestic Partner and if allowed by the employer.
3. Dependent Children are eligible for coverage up to age 26.

E. Statement of Understanding

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my vision plan.

Signature of Employee _____ Date _____

Visit us at blue2020ma.com

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Services at the number on your ID Card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).