



Exam-Plus Integrated Vision Plan: Insight Network

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

Vision care service	In-network member cost	Out-of-network reimbursement ¹
Comprehensive eye exam	\$20 copay	up to \$50
Contact lens fit and follow-up²		
• Standard	up to \$55	n/a
• Premium	10% off retail price	n/a
Retinal imaging	up to \$39	n/a
Frames	\$130 allowance, then additional 20% off balance	up to \$74
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
• Premium progressive lens tier 4	\$90 copay, then 80% of charge less \$120 allowance	up to \$196
Lens options²		
• 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	\$57-\$68	n/a
• Photochromic/Transitions® plastic	20% off retail price	n/a
• Polarized	20% off retail price	n/a
• Other add-ons	20% off retail price	n/a
Contact lenses³		
• Conventional	\$130 allowance, then additional 15% off balance	up to \$104
• Disposable	\$130 allowance	up to \$104
• Medically necessary	Paid in full	up to \$210
Frequency		
• Exam	once every 24 months	
• Lenses for frames or one order of contact lenses	once every 12 months	
• Frames	once every 24 months	

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 customer service:
1-855-875-6948

To locate an in-network provider near you, visit blue2020ma.com

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. Discount applies to materials only and not fittings for contact lenses.

Choose from thousands of independent and retail providers including:



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 the EyeMed Network/Patient Services 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 EyeMed Network/Servicio al Paciente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se você não fala inglês, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para a EyeMed Network/Serviços ao Paciente usando o número no seu cartão de ID (TTY: 711).





MASSACHUSETTS

Blue^{glasses}20/20

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: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Last Name:	First Name:	MI:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Mailing Address:		City:	State:	Zip Code:
Date of Hire:	Home Phone Number:	Work Phone Number:	E-Mail Address:	

B. If Making a Change from Previous Enrollment

Check All That Apply: <input type="checkbox"/> Name Change <input type="checkbox"/> Employee SSN Correction <input type="checkbox"/> Add/Remove Dependent <input type="checkbox"/> Address/Telephone Number Change <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Other: _____	Add Dependent(s): <input type="checkbox"/> Marriage _____ <input type="checkbox"/> Domestic Partner _____ <input type="checkbox"/> Newborn (up to age 1) _____ <input type="checkbox"/> Adoption _____ <input type="checkbox"/> Court Order _____ <input type="checkbox"/> Loss of Coverage _____ <input type="checkbox"/> Other _____	Reinstate Coverage: Date: _____ Reason: _____ _____ _____
	<input type="checkbox"/> Remove Dependent(s) _____ Reason: _____ _____ _____	Terminate Coverage: Date: _____ Reason: _____ _____ _____

C. Coverage Selection

Options Selected: Employee Employee plus Spouse or Domestic Partner
 Employee plus Child 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
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
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<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M

* 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 www.blue2020ma.com

