

Exam-Plus Integrated Vision Plan: Access 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 • Premium	up to \$55 10% off retail price	n/a n/a
Retinal imaging	up to \$39	n/a
Enhanced Diabetes Eye Care Benefit³ 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	\$130 allowance, then additional 20% off balance	up to \$74
Standard plastic lenses • Single vision • Bifocal • Trifocal • Lenticular • Standard progressive lens • Premium progressive lens	\$25 copay \$25 copay \$25 copay \$25 copay \$90 copay \$90 copay, then 80% of charge less \$120 allowance	up to \$42 up to \$78 up to \$130 up to \$130 up to \$140 up to \$196
Lens options² • UV treatment • Tint (solid and gradient) • Standard plastic scratch coating • Standard polycarbonate • Standard polycarbonate for covered dependents under age 19 • Standard anti-reflective coating • Photochromic/Transitions® plastic • Polarized • Other add-ons	\$15 \$15 \$15 \$40 Paid in full \$45 20% off retail price 20% off retail price 20% off retail price	n/a n/a n/a n/a up to \$26 n/a n/a n/a n/a
Contact lenses⁴ • Conventional • Disposable • Medically necessary	\$130 allowance, then additional 15% off balance \$130 allowance Paid in full	up to \$104 up to \$104 up to \$210
Frequency • Exam • Lenses for frames or one order of contact lenses • Frames	once every 24 months once every 12 months 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

Customer service:
1-855-875-6948
To locate an in-network provider, visit blue2020ma.com.
*Registration not required to search for providers.

Save on hearing exams and hearing aids

Offered by Amplifon Hearing, an independent company.

To learn more about the savings available, visit amplifonusa.com/blue2020.

Call **1-866-921-5367** to get started.

Choose from thousands of independent and retail providers including:



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.

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^{20/20}

Application / Change Form

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

Blue 20/20 Group No. _____

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: _____

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:	Email 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"/> 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) _____ Date: _____ Reason: _____	Terminate Coverage: Date: _____ Reason: _____	

C. Coverage Selection

Options Selected: Employee Employee plus Spouse
 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
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> 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](http://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).