



MASSACHUSETTS

Blue^{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.

MIIA Client

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 _____ <input type="checkbox"/> Remove Dependent(s) _____ Date: _____ Reason: _____	Reinstate Coverage: Date: _____ Reason: _____ Terminate Coverage: Date: _____ Reason: _____



MASSACHUSETTS

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

\$130 – 24/12/24 Frequency

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 \$40	n/a
• Premium	10% off retail price	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 the 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
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		
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 lenses⁴		
• Conventional	\$130 allowance, then additional 15% off the 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

OFF A COMPLETE SECOND PAIR OF GLASSES

OFF NON-PRESCRIPTION SUNGLASSES

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.



For costs and further details about the coverage, including exclusions, 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 to fittings for contact lenses.

BENEFITS YOU CAN SEE—FROM A COMPANY YOU TRUST



ACCESS TO ONE OF
THE NATION'S LARGEST
VISION NETWORKS



THOUSANDS OF
INDEPENDENT PROVIDERS



AWARD-WINNING
CUSTOMER SERVICE

FAVORITE NATIONAL RETAILERS

LENSCRAFTERS*

PEARLECOOVISION™

 OPTICAL*

and many regional retailers.

ONLINE SHOPPING OPTIONS

- Glasses.com
- Contactsdirect.com
- Ray-Ban.com
- Targetoptical.com
- Lenscrafters.com



SPECIAL OFFERS FOR ADDITIONAL SAVINGS

Find them at blue2020ma.com.

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. To get started, call 1-866-921-5367.

Questions?

Call customer service at 1-855-875-6948.
To locate an in-network provider, visit blue2020ma.com.*

*Registration not required to search for providers.

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 Service 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).