



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 • Premium	up to \$40 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 tier 1–tier 3 tier 4	\$25 copay \$25 copay \$25 copay \$25 copay \$90 copay \$110–\$135 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 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 • Premium anti-reflective coating tier 1–tier 2 • Photochromic/Transitions® plastic • Polarized • Other add-ons	\$15 \$15 \$15 \$40 Paid in full \$45 \$57 – \$68 \$75 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 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

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



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.

BENEFITS YOU CAN SEE—FROM A COMPANY YOU TRUST



ACCESS TO ONE OF
NATIONS LARGEST
VISION NETWORKS



THOUSANDS OF
INDEPENDENT PROVIDERS



AWARD WINNING
CUSTOMER SERVICE

FAVORITE NATIONAL RETAILERS

LENSCRAFTERS®

PEARLE VISION™

OPTICAL®

and many regional retailers.

ON-LINE SHOPPING OPTIONS

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



SPECIAL OFFERS FOR ADDITIONAL SAVINGS

Find them on the 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. Call 1-866-921-5367 to get started.

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).

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