

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
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 • Photochromic/Transitions Plastic • Polarized • Other add-ons	\$15 \$15 \$15 \$40 Paid in full \$45 \$57-\$68 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 n/a
Contact lenses³ • 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
Laser vision correction² • LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	n/a
Frequency • Exam • Lenses or contact lenses • Frames	once every 24 months once every 12 months once every 24 months	

For costs and further details of the coverage, including exclusions and reductions or limitations and terms under which the policy may be continued in force, see your benefit administrator. This brochure contains a summary of benefits only. It is not your vision plan policy.

1. Your actual expenses for covered services may exceed the stated out of network amount because actual provider charges may not be used to determine the vision benefit plan's and member's payment obligations.
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 locations in the Blue 20/20 network, including:

- LensCrafters[®]
- Pearle Vision[®]
- Target Optical[®]
- JCPenney Optical[®]
- Sears Optical[®]

Find an Eye Doctor

www.blue2020ma.com

1-855-875-6948

Limitations & Exclusions

This is a partial list of services that are not covered by Blue 20/20. Refer to your member booklet for a full list of exclusions.

- Lost or broken lenses, frames, glasses or contact lenses
- Non-prescription lenses, contact lenses or sunglasses
- Two pairs of glasses in place of bifocals
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Vision training, orthoptic services, aniseikonic lenses, subnormal vision aids or any associated supplemental testing
- Services required by any governmental agency or program, or as a result of any workers' compensation law or similar legislation
- Any eye or vision examination or corrective eyewear ordered by a member's employer, including safety eyewear
- Services rendered after the last date of coverage, unless materials are ordered before the end of coverage and services are rendered within 31 days of the order
- Benefit allowances provide no remaining balance for future use within the same benefit frequency

