MASSACHUSETTS

# BLUE 20/20
# VISION PLAN SETUP AND EMPLOYER APPLICATION

Blue 20/20 is administered by EyeMed Vision Care®, an independent company. Blue 20/20's enrollment and billing teams are supported by the Employee Benefit Plan Administration (EBPA), a Blue Cross Blue Shield of Massachusetts third-party administrator.

## PLAN REQUIREMENTS

### Participation Levels

- For groups of 2–9 eligible employees, at least 75% participation and a minimum of two employees enrolled
- For groups of 10 or more eligible employees, at least 10% participation and a minimum of three employees enrolled

### Contribution Strategy Options

- **Voluntary—**100% employee-paid, or employers contribute less than 25% of the plan premiums
- **Non-Voluntary—**Employers contribute 25% or more of the plan premiums

**Plans must take effect on the first day of the month.**

### Documentation Requirements*

- Send your completed Blue 20/20 Employer Application and Member Enrollment to your Blue Cross Account/Sales Executive.
- Once we confirm that your organization meets our participation requirements, we'll start setting up your coverage. To avoid any delays, complete all fields on this application form.

## POST-SETUP ACTIONS

- Once the plan setup is complete, a confirmation email with vision plan information and contracts will be sent to the broker of record.
- Within 10–20 business days after the plan setup, members will receive a welcome letter that will include two ID cards in the subscriber's name, which can be shared with anyone in the family (enrolled dependents).

## BILLING CRITERIA

- Billing is based on a full month of enrollment. Rates can not be prorated.
- Invoices are processed on the 15th of each month and mailed to the employer's billing address. The invoices are also available on the HR portal.
- Premium payments are due on the first day of each month.

*All Blue 20/20 materials, including plan summaries, are available on Broker Central or through your Blue Cross Account/Sales Executive.

# EMPLOYER APPLICATION

**All fields must be completed.**

Include Blue Cross Blue Shield of Massachusetts or Indigo Account/Sales Executive (AE/SE) name and account number, if applicable.

| | | | |
|---|---|---|---|
| **Number of Eligible Employees:** | **Number of Participating Employees:** | **Blue Cross AE/SE:** | **Indigo AE/SE:** |
| **Effective Date:** (MM / DD / YYYY) | **Renewal Date:** (MM / DD / YYYY) | **Blue Cross Account Number:** | **Blue 20/20 Group Number:** |

## Employer Information

| | | | |
|---|---|---|---|
| **1. Legal Name of Employer:** | | **2. Tax ID#:** | |
| **3. Physical Address:** | **City:** | **State:** | **ZIP Code:** |
| **4. Billing Address** (if different from above)**:** | **City:** | **State:** | **ZIP Code:** |

**5. Enrollment Contact:**

**Telephone Number:** **Fax Number:**

**Email Address (required):**

**HR Portal Access:**
☐ View Only ☐ Full Access (view and change capabilities)

**6. Billing Contact:**

**Telephone Number:** **Fax Number:**

**Email Address (required):**

**HR Portal Access:**
☐ View Billing Information

**7. Voluntary:** 100% employee-paid or less than 25% employer contribution. Groups with 2–9 eligible employees: at least 75% participation with a minimum of two employees required. Groups with 10+ eligible employees: at least 10% participation with a minimum of three employees required.

**Non-Voluntary:** 25% or more employer contribution. Groups with 2–9 eligible employees: at least 75% participation with a minimum of two employees required. Groups with 10+ eligible employees: at least 10% participation with a minimum of three employees required.

**(a) Contribution Strategy:**
☐ Voluntary ☐ Non-Voluntary

**(b) Enter the Employer contribution percentage for a non-voluntary offering:**
For Employee: _____% For Dependents: _____%

## Employee Eligibility

**8. (a) Eligibility Requirements (applicable to newly hired employees):**
☐ Date of Hire or Actual Effective Date ☐ 1st of the month following the Date of Hire ☐ 1st of the month following 30 days
☐ 1st of the month following 60 days ☐ 1st of the month following 90 days

**(b) Waive waiting period for initial enrollment?** ☐ Yes ☐ No

**9. Coverage will terminate:** ☐ End of Month ☐ Date of Term

## Benefit Design Options

**10. Plan Options** (select a product, network, and plan below):

| | |
|---|---|
| **Product Selection** | ☐ Blue 20/20 ☐ Blue 20/20 PLUS |
| **Network Selection** | ☐ Insight ☐ Access |
| **Plan Selection** | **Exam Plus** Plan:<br>☐ $20 exam/$25 lens/$130 allowance - 24/12/24<br>☐ $10 exam/$25 lens/$130 allowance - 12/12/24<br>☐ $10 exam/$25 lens/$150 allowance - 12/12/24<br>☐ $10 exam/$25 lens/$180 allowance - 12/12/24<br>☐ $10 exam/$25 lens/$150 frame and $130 contact allowance - 12/12/24<br>☐ $0 exam/$10 lens/$150 frame allowance - 12/12/12 |
| | **Materials Only** Plan:<br>☐ Basic ☐ Standard ☐ Premium |

**Rates**
Refer to your Blue 20/20 rate sheet or proposal for rates applicable to your plan selection.

| | | | |
|---|---|---|---|
| **For Internal Use Only** | **Plan ID:** _____ | **Benefit Level:** _____ | **Division Code:** _____ |

**11. Payment Method** (select one below)**:**

☐ **ACH Debit** (Please include a voided check or bank letter.) ☐ **ACH Push** ☐ **Check**

**Note:** ACH Debit Accounts must complete **Authorization for Bank Draft** section below.

| | |
|---|---|
| **For Internal Use Only Comments:** | |

**Authorization for Bank Draft**
By signing below, I certify that I am an authorized user of the bank account designated below. I hereby request and authorize EBPA on behalf of Blue Cross Blue Shield of Massachusetts to charge subsequent premium(s) for Group Insurance described in this document to the bank account payable to the order of Employee Benefi Plan Administration. I agree that EBPA's rights in respect to the bank draft shall be the same as if it were a check drawn on the bank account, and signed by me or another authorized user. I also authorize the financia institution to reduce the balance of the bank account by the amount of the bank draft. This authorization will remain in effect until it is revoked by an authorized user in writing at least 10 days prior to the date the bank account is scheduled to be charged. I further agree that if such charges were dishonored, whether with or without cause and whether intentionally or inadvertently, EBPA shall have no liability whatsoever even though dishonor results in forfeiture of insurance.

Type of Account: ☐ Checking ☐ Savings

Name of Bank Account Holder: _____

Name of Bank: _____

Bank Routing Transit Number: _____
(This number appears in the lower left-hand corner of your check.)

Bank Account Number: _____
(This number appears to the right of the transit number and is separated from the transit number by symbols/spaces.)

Signature of Account Holder: **X**_____
**Please attach a VOIDED check**

Date: _____
(MM / DD / YYYY)

**12.** Subject to the acceptance of this application by Blue Cross Blue Shield of Massachusetts, the effective date of coverage pursuant to this application shall be 12:01 a.m. ET on the fir t day of _____(month), _____(year), provided that the initial monthly fees are paid; and coverage under the Group Contract will be for a period of 48 months, and that, unless terminated in accordance with the Group Contract, the Group Contract will be renewable for subsequent 48-month periods.

## Certifications

**STATEMENT OF UNDERSTANDING**

**Insured Groups Only (all sizes):**

(1) Coverage is not effective until approved by Blue Cross and Blue Shield of Massachusetts. (2) Final premium rates are subject to current Blue Cross and Blue Shield underwriting guidelines and FINAL ENROLLMENT. (3) Requested effective date of coverage may be declined or deferred if the information submitted is incomplete. (4) Existing coverage should not be canceled until this request is approved. (5) No broker or consultant may make or modify a contract for Blue Cross and Blue Shield. (6) All enrolled groups are subject to enrollment eligibility reviews at any time. (7) All groups must verify their enrollment on an annual basis at renewal. (8) Groups found to have misrepresented eligibility of subscriber(s) are subject to immediate cancellation, with no conversion privileges, and are liable for all benefits paid for inappropriately enrolled subscribers.

I certify that the information in this application is true and complete.

Authorized Signature (for the Group): **X**_____ Date: _____
(MM / DD / YYYY)

Print Name: _____ Title: _____

## Agent's Report—Complete these fields, if applicable

| | | | |
|---|---|---|---|
| **Agent/Broker Name (please print):** | | **Agent's Email Address:** | |
| **Agency Name:** | | **Telephone Number:** | |
| **Agency Mailing Address:** | | | |
| **City:** | **State:** | **ZIP Code:** | **Country:** |
| **Is Agent or Broker licensed and appointed by Blue Cross for the types of insurance solicited where this group is located?** | | ☐ Yes | ☐ No |
| **Signature of Agent/Broker:** | | **Date:** | |





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