49

2025 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
Page 49

Benefit Description

Hearing Services (cont.)

Not covered:

- *Hearing aids, including bone-anchored hearing aids, accessories or supplies (including remote controls and warranty packages) and all associated services*
- *Hearing aid exams*

You Pay
All charges

Benefit Description

Vision Services (Testing, Treatment, and Supplies)

Eye examinations or visits related to a specific medical condition.

You Pay
Preferred: $10 copayment (no deductible) per visit up to a combined total of 10 visits per calendar year (benefits combined with visits described at the beginning of this section)

Preferred provider, visits after the 10th visit: 30% of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges

Note: You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.

Benefit Description

Diagnostic testing and treatment, such as:

- Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21
- Lab, X-ray, and other diagnostic tests performed or ordered by your provider.
- Refraction, only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described below.

Note: See Section 5(b), *Surgical Procedures*, for coverage for surgical treatment of amblyopia and strabismus.

You Pay
Preferred: 30% of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges

Benefit Description

Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed:

- To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery;
- If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition;
- For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 21

You Pay
Preferred: 30% of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges

---

Benefit Description

Not covered:

- *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described above*
- *Deluxe eyeglass frames or lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.*
- *Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom*

You Pay
All charges

Vision Services (Testing, Treatment, and Supplies) - continued on next page

---

Go to page 48. Go to page 50.