

**2023 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****Vision Services (Testing, Treatment, and Supplies)**

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**Note:** We state whether or not the calendar year deductible applies for each benefit listed in this section.

**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 in Section 5(a) page [39](#))

Preferred provider, visits after the 10<sup>th</sup> 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. (See page [128](#) for more information about “agents.”)

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**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

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### 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

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### 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*
- *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above*
- *LASIK, INTACS, radial keratotomy, and other refractive surgical services*
- *Refractions, including those performed during an eye examination related to a specific medical condition, except as described above*

**You Pay**

*All charges*