2024 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

Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy (cont.)

Not covered:

- *Massage therapy*

You Pay
All charges

Benefit Description

Hearing Services
Visits related to the covered hearing services listed below

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))

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
Hearing tests related to illness or injury

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:

- *Routine hearing tests*
- *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.

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

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

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

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Go to page 48. Go to page 50.