**2026 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**
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**Benefit Description**

**Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Rehabilitation Therapy**
Outpatient treatment therapies, subject to visit limits:

- Physical therapy, occupational therapy, and speech therapy:
    - Benefits are limited to 25 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three; regardless of the provider or facility billing for the services
- Cognitive rehabilitation therapy, limited to 25 visits per calendar year, regardless of the provider billing the service

**You Pay**
Preferred: $25 copayment per visit (no deductible)

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

Notes:

- You pay 30% of the Plan allowance (deductible applies) for agents, drugs, and/or supplies administered or obtained in connection with your care.
- See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.

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**Benefit Description**

*Not covered:*

- *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay*

- *Maintenance or palliative rehabilitative therapy*
- *Exercise programs*
- *Hippotherapy/Equine therapy*
- *Massage therapy*

**You Pay**
*All charges*

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**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.

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**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*