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2024 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
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Benefit Description

Lab, X-ray and Other Diagnostic Tests (cont.)

Standard Option - You Pay
Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.

Basic Option - You Pay
Participating/Non-participating: You pay all charges (except as noted below)

Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount, in addition to the Preferred coinsurance listed under this benefit.

Benefit Description

Diagnostic tests including but not limited to:

- Cardiovascular monitoring
- EEGs
- Home-based/unattended sleep studies
- Neurological testing
- Ultrasounds
- X-rays (including set-up of portable X-ray equipment)

Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.

Standard Option - You Pay
Preferred: 15% of the Plan allowance (deductible applies)

Participating: 35% of the Plan allowance (deductible applies)

Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount

Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.

Basic Option - You Pay
Preferred: $40 copayment

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

Participating/Non-participating: You pay all charges (except as noted below)

Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.

Benefit Description

Diagnostic tests limited to:

- Bone density tests
- CT scans/MRIs/PET scans
- Angiographies
- Nuclear medicine
- Facility-based sleep studies (prior approval required)

- Genetic testing (prior approval required)

Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.

Standard Option - You Pay
Preferred: 15% of the Plan allowance (deductible applies)

Participating: 35% of the Plan allowance (deductible applies)

Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount

Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.

Basic Option - You Pay
Preferred: $100 copayment

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

Participating/Non-participating: You pay all charges (except as noted below)

Note: For services billed by Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.

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