2023 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 5. Benefits
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals
Lab, X-ray and Other Diagnostic Tests

Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.

Benefit Description

Lab, X-ray and Other Diagnostic Tests
Diagnostic tests limited to:

- Laboratory tests (such as blood tests and urinalysis)
- Pathology services
- EKGs

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: 15% of the Plan allowance

Note: You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 152 for more information about “agents.”)

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 on the previous page.

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. (See page 152 for more information about “agents.”)

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

Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's existing medical condition. Benefits are not provided for genetic panels when some or all of the tests included in the panel are not covered, are experimental or investigational, or are not medically necessary.

Note: You must obtain prior approval for BRCA testing (see page 22). Diagnostic BRCA testing, including testing for large genomic rearrangements in the BRCA1 and BRCA2 genes: Benefits are available for members with a cancer diagnosis when the requirements in the note above are met, and the member does not meet criteria for Preventive BRCA testing. Benefits are limited to one test of each type per lifetime whether covered as a diagnostic test or paid under *Preventive Care* benefits (see page 44).

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. (See page 152 for more information about “agents.”)

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.