

**2026 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.)**

**Basic Option**

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.

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**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 35% 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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**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 may be required, see Section 3)

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 35% 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.