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committed to a healthier mississippi

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Blue Care Outline of Benefits

Healthy You! Wellness Benefits

Healthy You! Covered Screenings (Males)						
Services are covered once per calendar year unless otherwise noted.	Birth - 24 Months	2 - 11 Years	12-17 Years	18-39 Years	40-49 Years	50+ Years
Preventive medicine evaluation or re-evaluation	8 visits	♦	♦	♦	♦	♦
Hemoglobin, hematocrit or CBC	♦	♦	♦	♦	♦	♦
Urinalysis	♦	♦	♦	♦	♦	♦
Immunizations (Coverage varies by age.)	♦	♦	♦	♦	♦	♦
Blood pressure		♦	♦	♦	♦	♦
Glucose (High-risk ages 3-39.)		♦	♦	♦	♦	♦
Lipid profile (High-risk ages 2-17.)		♦	♦	♦	♦	♦
Prostate specific antigen with digital rectal exam					♦	♦
Stool for occult blood					♦	♦
Flexible sigmoidoscopy (Every 5 Years.) Colonoscopy (Every 10 Years.)						♦

Healthy You! Covered Screenings (Females)							
Services are covered once per calendar year unless otherwise noted.	Birth - 24 Months	2 - 11 Years	12 - 17 Years	18 - 34 Years	35 - 39 Years	40 - 49 Years	50+ Years
Preventive medicine evaluation or re-evaluation	8 visits	♦	♦	♦	♦	♦	♦
Hemoglobin, hematocrit or CBC	♦	♦	♦	♦	♦	♦	♦
Urinalysis	♦	♦	♦	♦	♦	♦	♦
Immunizations (Coverage varies by age.)	♦	♦	♦	♦	♦	♦	♦
Blood pressure		♦	♦	♦	♦	♦	♦
Breast exam			♦	♦	♦	♦	♦
Pap smear and pelvic exam			♦	♦	♦	♦	♦
Glucose (High-risk ages 3-39.)		♦	♦	♦	♦	♦	♦
Lipid profile (High-risk ages 2-17.)		♦	♦	♦	♦	♦	♦
Mammogram					♦	♦	♦
Stool for occult blood						♦	♦
Flexible sigmoidoscopy (Every 5 Years.) Colonoscopy (Every 10 Years.)							♦

Healthy You! wellness benefits do not apply to services rendered by non-Network Providers. For detailed information regarding screenings, visit www.bcbsms.com.

Related Links

- [Healthy You!](#)
- [be smoke-free](#)
- [Large Provider Networks](#)



Commitment

Our commitment to helping you be healthy begins by helping you take control of your health. Blue Care and Network Blue benefits include the excellent Healthy You! wellness benefit.

Outline of Benefits		
Benefit Period	Calendar Year	
Lifetime Maximum	\$2,000,000	
Calendar Year Medical Deductible Options (The deductible does not apply when there is a copay. Copay amounts do not accrue toward the deductible.)	\$250; \$500; \$1,000; \$1,500; \$2,000; \$2,500; \$5,000; \$7,500 or \$10,000 (Unless stated otherwise, the deductible applies to all covered services. The \$250 and \$500 deductibles are not available on Blue Care Coinsurance Plan.)	
Policy Maximum Deductible Amount (Applies only to family members who are approved for coverage at the same time and have identical benefits under their Policy.)	Three times the calendar year medical deductible (Not applicable with Blue Care Coinsurance Plan)	
Carry-Over Medical Deductible	Charges applied to the medical deductible in October, November and December which did not satisfy the deductible amount may be applied to the next year's deductible amount.	
	Network Provider	Non-Network Provider
Prescription Drug Calendar Year Deductible	Varies, see Outpatient Prescription Drugs (Not applicable with Blue Care Coinsurance Plan)	No benefits
Out-of-Pocket/Calendar Year Limit (Copay amounts do not accrue toward the out-of-pocket maximum. Copay amounts are still applicable after the out-of-pocket has been met.)	\$2,500	No out-of-pocket maximum
Policy Out-of-Pocket Limit (Applies only to family members who are approved for coverage at the same time and have identical benefits under their Policy.)	\$7,500 (Not applicable with Blue Care Coinsurance Plan.)	No out-of-pocket maximum
Healthy You!		
Healthy You! Wellness Benefit (For detailed Wellness Guidelines, click on the "be healthy" link at www.bcbsms.com .)	100%	Not covered

Physician		
	Network Provider	Non-Network Provider
Office Visit Primary Care Physician (PCP) / Specialist (Primary Care Physician specialties are Family Practice, General Practice, Internal Medicine, Pediatrics and Obstetrics / Gynecology.)	Copay Plan 100% after \$15 copay for PCP \$25 copay for Specialist Coinsurance Plan 80%	50%
Other Office Services (Injections, x-rays, lab, surgery, etc.)	Copay Plan 80% Deductible Waived Coinsurance Plan 80% Deductible Applies	50%
Inpatient Newborn Well Baby (Exams and circumcision) You must add your newborn to your policy within 31 days of birth for these benefits to apply.	80%	50%
Outpatient Prescription Drugs		
	Community PLUS Pharmacy	Non-Community PLUS Pharmacy
Calendar Year Deductible (In addition to the copay/ coinsurance amount, all outpatient prescription drugs are subject to a pharmacy deductible.)	Copay Plan Standard: \$50 Other Deductible Options: \$250; \$500; \$1,000; \$1,500; \$2,000 Coinsurance Plan 30% of Medical Deductible	No benefits
Category 1 - Most Generic Drugs	100% after \$10 copay	No benefits
Category 2 - Some Generic Drugs - Many Brand Name Drugs	100% after \$25 copay	No benefits
Category 3 - Some Generic Drugs - and Brand Name Drugs	100% after \$50 copay	No benefits
Category 4 - Some Generic and - Brand Name Drugs High Cost Drugs	100% after \$100 copay	No benefits

Disease Specific Drugs		
	Network Provider	Non-Network Provider
Network Physician must receive Prior Authorization and drugs must be supplied by a Network Disease Specific Pharmacy or a Non-Pharmacy Network Provider	\$100 or 20% Copay, whichever is greater \$10,000 Out-of-pocket limit, then a \$100 Copay	No benefits
Inpatient Hospital Services		
	Network Provider	Non-Network Provider
Hospital Per Admission Deductible	(Calendar Year Deductible Applies)	\$100 (In addition to Calendar Year Deductible)
Hospital Inpatient Services	80%	50% after Per Admission Deductible
Well Baby Care-Nursery	80%	50% after Per Admission Deductible
Inpatient Rehabilitation Services (Limited to 30 inpatient days per calendar year. Covered Services must be rendered by a Network Provider.)	80%	Not Covered
Outpatient Hospital Services		
	Network Provider	Non-Network Provider
Hospital Emergency Room Deductible	(Calendar Year Deductible Applies)	\$50 (In addition to Calendar Year Deductible)
Emergency Room Services (Will pay Non-Network at 80% if accident or emergency.)	80%	50% after \$50 Emergency Room Deductible
Surgery	80%	50%
X-ray and Laboratory	80%	50%
Ambulatory Surgical Facility		
	Network Provider	Non-Network Provider
Elective Surgical Procedures	80%	50%

Allied Primary Care Health Professional		
	Network Provider	Non-Network Provider
Nurse Practitioner Office Visits (The copay does not apply to any other service rendered in the office.)	Copay Plan 100% after \$15 copay Coinsurance Plan 80%	50%
Other Office Services (Deductible does not apply to office services rendered by a Network Provider.)	80%	50%
Allied Specialist		
	Network Provider	Non-Network Provider
Optometrists, Chiropractors, Podiatrists		
Office Visits (The copay does not apply to any other services rendered in the office.)	Copay Plan 100% after \$25 copay Coinsurance Plan 80%	50%
Other Office Services (Deductible does not apply to office services rendered by a Network Provider.)	80%	50%
Diabetes Treatment		
	Network Provider	Non-Network Provider
Equipment, Supplies for Monitoring Blood Glucose	80%	50%
Training / Education and Medical Nutrition Therapy (Limited to \$250 per calendar year maximum.)	80%	50%
Transplant		
	Network Provider	Non-Network Provider
Prior Approval and Case Management Required	80%	No benefits

Nervous / Mental		
	Network Provider	Non-Network Provider
Inpatient (Limited to 30 days per calendar year.)	80% (Calendar Year Deductible Applies)	50% after Per Admission Deductible
Partial Hospitalization (Limited to 60 days per calendar year.)	80%	50%
Outpatient Hospital (Limited to 52 visits per calendar year, including Physician office visits.)	80%	50%
Other Outpatient Physician Services	50%	50%
Alcohol Abuse		
	Network Provider	Non-Network Provider
\$1,500 calendar year maximum (Physician office visit copay applies with Blue Care Copay Plan.)	80%	50%
Drug Abuse		
	Network Provider	Non-Network Provider
\$1,500 calendar year maximum (Physician office visit copay applies with Blue Care Copay Plan.)	80%	50%
Speech Therapy		
	Network Provider	Non-Network Provider
Speech Therapy (Limited to 20 visits per calendar year.)	80%	50%

TMJ		
	Network Provider	Non-Network Provider
Treatment plan is required. (Surgery / diagnostic services limited to \$5,000 lifetime maximum.)	80%	50%
Hospice Care		
	Network Provider	Non-Network Provider
Limited to 6 months per the lifetime of the member. Subject to Case Management.	80%	No benefits
Optional Maternity Benefits		
	Network Provider	Non-Network Provider
If this benefit is selected, a 12 month waiting period applies before maternity benefits will be provided. (Physician office visit copay applies with Blue Care Copay Plan.)	80% (If Selected)	50% (If Selected)

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