CareFirst
Family of health care plans

Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

BlueChoice Advantage 2022 Summary of Benefits

Fairfax County Public Schools

Services	In-Network You Pay[1]	Out-of-Network You Pay[1,2]
	Visit carefirst.com/fcps to locate providers and facilities	
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
ANNUAL DEDUCTIBLE (Benefit period)		
Individual	$250	$500
Family	$500	$1,000
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)		
Medical	$2,000 Individual/$4,000 Family (combined in-and out-of-network)	
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	Deductible, then 40% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	Deductible, then 40% of Allowed Benefit
Cancer Screening (prostate, mammogram, pap test, colorectal)	No charge*	Deductible, then 40% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then $20 PCP/$40 Specialist per visit	Deductible, then 40% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)	Deductible, then $75 per visit (when received at freestanding radiology facility) Deductible, then $100 per visit (when received at outpatient hospital)	Deductible, then 40% of Allowed Benefit
Lab[3]	No charge* after deductible	Deductible, then 40% of Allowed Benefit
X-ray	No charge* after deductible	Deductible, then 40% of Allowed Benefit
Allergy Testing	Deductible, then $20 PCP/$40 Specialist per visit	Deductible, then 40% of Allowed Benefit
Allergy Shots****	Deductible, then $20 PCP/$40 Specialist per visit	Deductible, then 40% of Allowed Benefit
Physical, Speech and Occupational Therapy[4] (limited to 90 days combined/illness/benefit period and combined between in- and out-of-network)	Deductible, then $40 per visit	Deductible, then 40% of Allowed Benefit
Chiropractic	Deductible, then $40 per visit	Deductible, then 40% of Allowed Benefit
Acupuncture	Not covered (except when approved or authorized by Plan when used for anesthesia)	Not covered (except when approved or authorized by Plan when used for anesthesia)
EMERGENCY AND URGENT CARE SERVICES		
Urgent Care Center	$40 per visit	$40 per visit^
Emergency Room—Facility Services^^	Deductible, then $250 copay per visit, then 10% of Allowed Benefit (copay waived if admitted)	In-network deductible, then $250 copay per visit, then 10% of Allowed Benefit (copay waived if admitted)
Emergency Room—Physician Services^^	Deductible, then 10% of Allowed Benefit	In-network deductible, then 10% of Allowed Benefit
Ambulance Service to a Hospital—for Emergency Services	Deductible, then 10% of Allowed Benefit	In-network deductible, then 10% of Allowed Benefit

BlueChoice Advantage 2022 Summary of Benefits

Services	In-Network You Pay[1]	Out-of-Network You Pay[1,2]
Provider	Care received by a BlueChoice, BluePreferred, or BlueCard PPO provider	Care received by a non-participating provider
HOSPITALIZATION (Members are responsible for applicable physician and facility fees)		
Outpatient Facility Services	Deductible, then $100 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then $20 PCP/$40 Specialist per visit	Deductible, then 40% of Allowed Benefit
Inpatient Facility Services	Deductible, then $150 per admission, then $100 per day (5 day maximum payment)	Deductible, then $150 per admission, then 40% of Allowed Benefit
Inpatient Physician Services	Deductible, then $20 PCP/$40 Specialist per visit	Deductible, then 40% of Allowed Benefit
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then $40 per visit	Deductible, then 40% of Allowed Benefit
Hospice*** (Facility Services)	Deductible, then $150 per admission, then $100 per day (5 day maximum payment)	Deductible, then 40% of Allowed Benefit
Hospice (Alternative Setting)	Deductible, then $40 per visit	Deductible, then 40% of Allowed Benefit
Skilled Nursing Facility*** (limited to 120 days/benefit period)	Deductible, then $150 per admission copay, then $100 per day (5 day maximum payment)	Deductible, then 40% of Allowed Benefit
MATERNITY AND FAMILY PLANNING		
Preventive Prenatal and Postnatal Office Visits	No charge*	Deductible, then 40% of Allowed Benefit
Delivery and Facility Services	Deductible, then $150 per admission, then $100 per day (5 day maximum payment)	Deductible, then $150 per admission, then 40% of Allowed Benefit
AI/IVF** (Facility charge)[5]	Deductible, then $100 per/visit	Deductible, then 40% of Allowed Benefit
AI/IVF** (Professional charge)[5]	Deductible, then $40 per/visit	Deductible, then 40% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then $150 per admission, then $100 per day (5 day maximum payment)	Deductible, then $150 per admission, then 40% of Allowed Benefit
Outpatient Facility Services	Deductible, then $100 per visit	Deductible, then 40% of Allowed Benefit
Outpatient Physician Services	Deductible, then $40 per visit	Deductible, then 40% of Allowed Benefit
Office Visits	Deductible, then $20 per visit	Deductible, then 40% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then $40 copay	Deductible, then 40% of Allowed Benefit

Note: Allowed Benefit is the fee that participating providers in the network have agreed to accept for a particular service. The participating provider cannot charge the member more than this amount for any covered service. Example: Dr. Carson charges $100 to see a sick patient. To be part of CareFirst's network, he has agreed to accept $50 for the visit. The member will pay their copay/coinsurance and deductible (if applicable) and CareFirst will pay the remaining amount up to $50.

* No copayment or coinsurance.
** Benefits subject to medical policy; limited to $100,000 lifetime maximum across all self-insured plans.
*** Copay waived if transferred directly from inpatient hospital setting.
**** Deductible, then $0 copay if no office visit.
^ Services must be of an urgent nature to use out of network urgent care centers. You may be required to pay up front and file for reimbursement.
^^ Bona fide emergency must exist for emergency room services to be covered.
1 When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.
2 Out-of-Network: When covered services are rendered by a non-participating provider, the care is reimbursed as out-of-network. Out-of-network benefits are based on the Allowed Benefit. The Allowed Benefit is generally the contracted rates or fee schedules that are established by CareFirst BlueChoice, or the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.
3 Participating BlueChoice providers and outpatient facilities must use LabCorp® facilities for laboratory services to be covered in-network. For BlueChoice providers who refer you to a lab, you must use a LabCorp® facility for laboratory services to be covered under your in-network coverage. You may also use a participating BlueCard PPO laboratory and receive in-network benefits if the ordering physician and/or outpatient facility is not a BlueChoice participating provider.
4 Visit Limitation does not apply when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.
5 Members who are unable to conceive have coverage for the evaluation of infertility services performed to confirm an infertility diagnosis, and some treatment options for infertility. Preauthorization required.

Not all services and procedures are covered by your benefits contract. This summary is for comparison purposes only and does not create rights not given through the benefit plan.

CST2977-1P (9/21)