

Benefits at a Glance	Point of Service (POS) Managed by CareFirst BlueCross BlueShield	
	In-Network	Out-of-Network
Physician Network Area	Arlington, Alexandria, Fairfax, Prince William, Loudoun, Fauquier County and City of Falls Church, City of Manassas, City of Manassas Park, Leesburg, the entire state of Maryland and the District of Columbia. Physician Network Area may differ slightly from Service Area, contact Member Services Department for the plan.	
Plan Contact Information	CareFirst Customer Service: 800-628-8549 Website: <a href="http://www.carefirst.com">www.carefirst.com</a>	
Primary Care Physician (PCP)	Yes – required	
Referrals for Specialty Care	Yes – required	
Annual Deductible	\$0	\$250 individual/ \$500 family
Yearly Out-of-Pocket Limit	\$0	\$3000 individual/\$6000 family
Office Visits (PCP/Specialist)	Covered in full after \$10 copay for primary care physician; \$15 copay for specialist. Referrals required in-network.	Covered at 70% of allowed benefit after deductible. One routine physical exam/calendar year.
Preventive Care <ul style="list-style-type: none"><li>Children and Adults</li></ul>	Covered in full. Refer to benefits page on FairfaxNet for list of services.	Children through age 17: 70% of allowed benefit no deductible. Age 18 and above: 70% of allowed benefit; after deductible. Refer to benefits page on FairfaxNet for list of services.
Inpatient Hospital Care/Doctor's Services	Covered in full.	Covered at 70% of allowed benefit after deductible.
Laboratory & X-Ray	Covered in full at approved radiology/lab centers. \$25 copay at approved outpatient dept. of hospital (facility charge waived for therapeutic radiation and chemotherapy).	Covered at 70% of allowed benefit after deductible.
Prescription Deductible	\$0	
Prescription Out-of-Pocket Max	\$0	
Prescription Drugs	<i>Retail (up to 34-day supply):</i> \$10 copay for generic \$20 copay for brand formulary \$40 copay for brand non-formulary  <i>Mail Order (up to 90-day supply):</i> \$20 copay for generic \$40 copay for brand formulary \$80 copay for brand non-formulary	<i>Retail (up to 34-day supply):</i> Not Covered  <i>Mail Order (up to 90-day supply):</i> Not Covered
Maternity Care	Covered in full after initial \$10 copay for primary care physician or \$15 copay for specialist to confirm pregnancy.	Covered at 70% of allowed benefit after deductible.
Emergency Treatment	Covered in full after \$150 copay for bona fide accidental injury or medical emergency (waived if admitted for treatment other than observation).	Benefits provided in-network only.
Urgent Care	\$25 copay per visit copay	Initial Care: Covered in-network;  Follow up Care: Covered at 70% of allowed benefit after deductible.
Mental Health Services and Substance Abuse Treatment	<i>Inpatient</i> – Covered in full.  <i>Outpatient</i> – Covered in full after \$10 copay.	<i>Inpatient</i> – Covered at 70% of plan allowance after deductible.  <i>Outpatient</i> – Covered at 70% of plan allowance after deductible.
Infertility Coverage	Covered in full for in-vitro fertilization (IVF), up to 3 attempts per live birth. \$100,000 lifetime maximum (combined in-network and out-of-network).	Covered at 70% of allowed benefit after deductible for in-vitro fertilization (IVF), up to 3 attempts per live birth. \$100,000 lifetime maximum (combined in-network and out-of-network).

<b>Benefits at a Glance</b>	<b>Point of Service (POS)</b> Managed by CareFirst BlueCross BlueShield	
	<b>In-Network</b>	<b>Out-of-Network</b>
<b>TMJ, surgical and non-surgical</b>	Covered in full for pre-surgical x-rays and surgery.  Physician: \$15 copay  Inpatient: \$25 copay	Covered at 70% of allowed benefit after deductible for pre-surgical x-rays and surgery.
<b>Hearing Aids</b> <ul style="list-style-type: none"> <li>• <b>Maximum benefit is \$2800 every 36 months (combined in-network and out-of-network).</b></li> </ul>	Covered in full up to \$2800 maximum per 36 months (combined in-network and out-of-network).	Covered at 70% of allowed benefit after deductible.  Maximum benefit is \$2800 every 36 months (combined in-network and out-of-network).
<b>Wigs</b> <ul style="list-style-type: none"> <li>• <b>Based on medical necessity</b></li> <li>• <b>\$350 maximum per calendar year</b></li> </ul>	Covered in full.	Covered at 70% of allowed benefit after deductible.
<b>Dental Care</b>  (add'l coverage available through Delta Dental plan – separate premium required)	Discounts on services by participating dentists.	Routine care not covered.
<b>Routine Vision Care</b>	Vision benefits provided through Davis Vision.	