2024 Benefits At-A-Glance[1]
Cigna Open Access Plus (OAP) Plan
Fairfax County Public Schools

Benefit	In-Network You Pay	Out-of-Network You Pay
Medical Lifetime Maximum [2]	Unlimited	Unlimited
Individual Annual Deductible	$300 (Combined in- and out-of-network)	
Family Annual Deductible	$600 (Combined in- and out-of-network)	
Medical Plan Out-of-Pocket Maximum	$2,500 Individual / $5,000 Family (Combined in- and out-of-network)	
Benefit	**In-Network You Pay**	**Out-of-Network You Pay**
MDLive Virtual Care Services		
MDLive Primary Care Services	$20 copay, no deductible	Not covered
MDLIVE Specialty Care Services	$40 copay, no deductible	Not covered
MDLive Urgent Virtual Care Services	$20 copay, no deductible	Not covered
MDLive Behavioral Health Services	$20 copay, no deductible	Not covered
Urgent Care and Emergency Services		
Convenience Care Clinic (in-person only)	$20 copay, no deductible	10% coinsurance, no deductible
Urgent Care Facility	10% coinsurance, no deductible	10% coinsurance, no deductible
Emergency Room (per visit copay waived if admitted)	Deductible, then $250 copay, then 10% coinsurance	Deductible, then $250 copay, then 10% coinsurance
Preventive Services		
Preventive Care	Plan pays 100%	Plan pays 100%
Preventive Care - Immunizations	Plan pays 100%	Plan pays 100%
Preventive Care - Mammogram, PAP and PSA Tests	Plan pays 100%	Plan pays 100%
Office Visits		
Primary Care Physician Office Visit	Deductible, then $20 copay	Deductible, then 10% coinsurance
Specialty Care Physician Office Visit	Deductible, then $40 copay	Deductible, then 10% coinsurance
Allergy Treatment/Injections and Allergy Serum – Allergy Serum dispensed by the physician in the office. *Note: Office copay does not apply if only the allergy serum is provided.*	Deductible, then included with office visit copay	Deductible, then 10% coinsurance
Laboratory and Radiology Services		
X-rays and laboratory services performed at a provider's office or outpatient setting	Deductible, then included with office visit copay	Deductible, then included with office visit copay'
Advanced Radiology (Includes MRI, MRA, CAT Scan, etc.) – performed at a freestanding radiology center or outpatient setting	Deductible, then $75 copay per type of scan per day	Deductible, then $75 copay per type of scan per day

[1] This is a summary of benefits and copayments under the plan. Once available, please refer to the Summary Plan Description (SPD) for more details. If there is a discrepancy between this summary and the SPD, the SPD governs.

[2] Separate lifetime maximum applies for infertility benefits.

Updated: 10/20/23

Benefit	In-Network You Pay	Out-of-Network You Pay
Maternity & Family Planning		
Prenatal and Postnatal Office Visits	Plan pays 100%	Plan pays 100%
Labor and Delivery (Hospital and Facility Services)	Deductible, then $150 per admission copay, then 10% coinsurance	Deductible, then $150 per admission copay, then 10% coinsurance
Infertility Treatment (medical treatment must be pre-approved through WINFertility)	Deductible, then copay/coinsurance based on place of service	Deductible, then copay/coinsurance based on place of service
Infertility Lifetime Maximum: subject to a $100,000 lifetime maximum. The lifetime maximum is separated into two parts: $50,000 is allocated to benefits under the medical plan, and $50,000 is allocated to pharmacy benefits.		
Therapeutic Services		
Outpatient Physical/Speech/Occupational Therapy (90 days/therapy/year)	Deductible, then $40 copay/visit	Deductible, then 10% coinsurance
Chiropractic	Deductible, then $40 copay/visit	Deductible, then 10% coinsurance
Cardiac Rehab (36 days/therapy/year)	Deductible, then $40 copay/visit	Deductible, then 10% coinsurance
Inpatient and Outpatient Hospital Services		
Outpatient Hospital - Facility	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient Hospital - Physician and Professional Services	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient Hospital – Professional Services (Radiologist and Pathologists)	Deductible, then Plan pays 100%	Deductible, then no charge
Inpatient Hospital - Facility	Deductible, then $150 per admission copay, then 10% coinsurance	Deductible, then $150 per admission copay, then 10% coinsurance
Inpatient Physician and Professional Services	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Inpatient Hospice	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Ambulance Services (ambulance services used as non-emergency transportation generally are not covered)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Hospital Alternatives		
Home Health Care: annual limit 90 days/16 hours max per day	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient Hospice	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility (120 day annual limit)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Mental Health and Substance Use		
Inpatient Mental Health or Substance Abuse Disorder Treatment – Facility	Deductible, then $150 per admission copay, then 10% coinsurance	Deductible, then $150 per admission copay, then 10% coinsurance
Inpatient Mental Health or Substance Abuse Disorder Treatment – Physician and professional services	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient Facility Mental Health or Substance Abuse Disorder – Physician and Professional Services	Deductible, then Plan pays 100%	Deductible, then 10% coinsurance
Outpatient Facility Mental Health or Substance Abuse Disorder – all other professional services (including ABA therapy)	Deductible, then Plan pays 100%	Deductible, then 10% coinsurance
Office Visit – Mental Health/Substance Abuse professional services	Deductible, then $40 copay	Deductible, then 10% coinsurance

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Virtually based mental health providers (i.e., Talk Space, Ginger, etc.)	$20 copay, then Plan pays 100%	Not covered
Medical Device Services		
Durable Medical Equipment	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Hearing Aids	Deductible, then 10% coinsurance. $3,000 maximum per 36 months accumulates across in-network and out-of-network	

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MDLive Behavioral Health Services	$40 copay, no deductible	Not covered
Urgent Care and Emergency Services		
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Urgent Care Facility	10% coinsurance, no deductible	10% coinsurance, no deductible
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Preventive Care	Plan pays 100%	Plan pays 100%
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Office Visits		
Primary Care Physician Office Visit	Deductible, then $20 copay	Deductible, then 10% coinsurance
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Laboratory and Radiology Services		
X-rays and laboratory services performed at a provider's office or outpatient setting	Deductible, then covered in full	Deductible, then covered in full
Advanced Radiology (Includes MRI, MRA, CAT Scan, etc.) – performed at a freestanding radiology center or outpatient setting	Deductible, then $75 copay per type of scan per day	Deductible, then $75 copay per type of scan per day

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Updated: 3/15/23

Benefit	In-Network You Pay	Out-of-Network You Pay
Maternity & Family Planning		
Prenatal and Postnatal Office Visits	Plan pays 100%	Plan pays 100%
Labor and Delivery (Hospital and Facility Services)	Deductible, then $150 per admission copay, then 10% coinsurance	Deductible, then $150 per admission copay, then 10% coinsurance
Infertility Treatment	Deductible, then copay/coinsurance based on place of service	Deductible, then copay/coinsurance based on place of service
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Therapeutic Services		
Outpatient Physical/Speech/Occupational Therapy (90 days/therapy/year)	Deductible, then $40 copay	Deductible, then 10% coinsurance
Chiropractic	Deductible, then $40 copay	Deductible, then 10% coinsurance
Inpatient and Outpatient Hospital Services		
Outpatient Hospital - Facility	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient Hospital - Physician and Professional Services	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Inpatient Hospital - Facility	Deductible, then $150 per admission copay, then 10% coinsurance	Deductible, then $150 per admission copay, then 10% coinsurance
Inpatient Physician and Professional Services	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Inpatient Hospice	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Ambulance Services (ambulance services used as non-emergency transportation generally are not covered)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Hospital Alternatives		
Home Health Care: annual limit 90 days/16 hours max per day	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
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Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility (120 day annual limit)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Mental Health and Substance Use		
Inpatient Mental Health or Substance Abuse Disorder Treatment – Facility	Deductible, then $150 per admission copay, then 10% coinsurance	Deductible, then $150 per admission copay, then 10% coinsurance
Inpatient Mental Health or Substance Abuse Disorder Treatment – Physician and professional services	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient Mental Health – Physician and Professional Services	Deductible, then $40 copay	Deductible, then 10% coinsurance
Outpatient Mental Health – all other professional services (including ABA therapy)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Medical Device Services		
Durable Medical Equipment	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Hearing Aids	Deductible, then 10% coinsurance. $3,000 maximum per 36 months accumulates across in-network and out-of-network	

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