Fairfax County Public Schools
BlueChoice Advantage

Coverage Period: 01/01/2026 – 12/31/2026
Coverage for: Individual | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can see the Glossary at www.carefirst.com/sbcg or call 1-855-258-6518 to request a copy. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.carefirst.com.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $300 individual/$600 family; Out-of-Network: $300 individual/$600 family	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family member(s) on the plan, all family members may combine to meet the overall family deductible before the plan begins to pay, depending upon plan coverage. Please refer to your contract for further details.
Are there services covered before you meet your deductible?	Yes, all In-Network preventive care services, as well as the following (non-hospital facilities only, when applicable): Retail health and Urgent care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: In-Network: $2,500 individual/$5,000 family; Out-of-Network: $2,500 individual/$5,000 family	The out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family member(s) on the plan, all family members may combine to meet the overall family out-of-pocket limit, depending upon plan coverage. Please refer to your contract for further details.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, copayments for certain services, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.carefirst.com or call 855-258-6518 for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Provider: Deductible, then $10 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Specialist visit	Provider: Deductible, then $20 copay per visit Hospital Facility: Deductible, then 10% of Allowed Benefit	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Retail health clinic	$10 copay per visit	30% of Allowed Benefit	None
	Preventive care/screening/ immunization	No Charge	30% of Allowed Benefit	Some services may have limitations or exclusions based on your contract

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Lab Tests: Non-Hospital: Deductible, then $10 PCP/$20 Specialist copay per visit Hospital: Deductible, then No Charge X-Ray: Non-Hospital: Deductible, then $10 PCP/$20 Specialist copay per visit Hospital: Deductible, then No Charge	Lab Tests: Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit X-Ray: Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	In-Network Lab Test benefits apply only to tests performed at LabCorp.
	Imaging (CT/PET scans, MRIs)	Non-Hospital: Deductible, then $10 PCP/$20 Specialist copay per visit Hospital: Deductible, then $75 copay per visit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available	Generic drugs (Tier 1)	Retail: $7 / $14 / $21 (30 / 60 / 90-day supply) Mail Order: $14 per prescription (up to 90-day supply)	Pay in full, then file claim for reimbursement at https://info.caremark.com/fcps. Reimbursement limited to amount plan would have paid if network pharmacy was used.	Maximum $50 copay per 30-day supply of insulin. Participants using a CVS retail pharmacy for maintenance medications may receive a 90-day supply for two retail copays. Active Employees and Non-Medicare Retirees: Your plan uses a network of participating pharmacies and a formulary (a list of preferred covered medications). Some drugs may require preauthorization; if preauthorization is not obtained, the drug may not be covered. Deductible does not apply to prescription coverage. Certain preventive medications covered for $0 copay.
	Preferred brand drugs (Tier 2)	20% subject to the following maximums: Retail: $75 / $150 / $225 (30 / 60 / 90-day supply) Mail Order: $150 per prescription (up to 90-day supply)		
	Non-preferred brand drugs (Tier 3)	Not Covered	Not Covered	
	Specialty drugs (Tier 4)	$0 copay for participating members in PrudentRx; 30% coinsurance for non-participating members	Must use CVS Specialty Pharmacy for fill.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital & Hospital: Deductible, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
	Physician/surgeon fees	Non-Hospital & Hospital: Deductible, then 10% of Allowed Benefit	Non-Hospital & Hospital: Deductible, then 30% of Allowed Benefit	None
If you need immediate medical attention	Emergency room care	Deductible, then $250 copay per visit, then 10% of Allowed Benefit	Paid As In-Network	Limited to Emergency Services or unexpected, urgently required services; Additional professional charges may apply; Copay waived if admitted
	Emergency medical transportation	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit	None
	Urgent care	10% of Allowed Benefit	30% of Allowed Benefit	Limited to unexpected, urgently required services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $150 copay per admission, then 10% of Allowed Benefit	Deductible, then $150 copay per admission, then 30% of Allowed Benefit	Prior authorization is required
	Physician/surgeon fees	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: Deductible, then $10 copay per visit Hospital Facility: Deductible, then No Charge	Office Visit & Hospital Facility: Deductible, then 10% of Allowed Benefit	For treatment at an Outpatient Hospital Facility, additional charges may apply
	Inpatient services	Deductible, then $150 copay per admission, then 10% of Allowed Benefit	Deductible, then $150 copay per admission, then 10% of Allowed Benefit	Prior authorization is required; Additional professional charges may apply
If you are pregnant	Office visits	No Charge	30% of Allowed Benefit	For routine pre/postnatal office visits only. For non-routine obstetrical care or complications of pregnancy, cost sharing may apply.
	Childbirth/delivery professional services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Childbirth/delivery facility services	Deductible, then $150 copay per admission, then 10% of Allowed Benefit	Deductible, then $150 copay per admission, then 30% of Allowed Benefit	Additional professional charges may apply
If you need help recovering or have	Home health care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required Benefits are limited to 90 days per benefit period.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
other special health needs	Rehabilitation services	Provider: Deductible, then $20 copay per visit Hospital Facility: Deductible, then No Charge	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	If a service is rendered at a Hospital Facility, the additional Facility charge may apply Benefits for Speech, Physical and Occupational Therapies are limited to 90 visits per benefit period
	Habilitation services	Provider: Deductible, then $20 copay per visit Hospital Facility: Deductible, then No Charge	Provider & Hospital Facility: Deductible, then 30% of Allowed Benefit	Prior authorization is required If a service is rendered at a Hospital Facility, the additional Facility charge may apply
	Skilled nursing care	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	Prior authorization is required Benefits are limited to 120 days per benefit period combined with Inpatient Rehabilitation
	Durable medical equipment	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit	None
	Hospice services	Inpatient and Outpatient Facility: Deductible, then 10% of Allowed Benefit	Inpatient and Outpatient Facility: Deductible, then 30% of Allowed Benefit	Prior authorization is required
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery	• Long-term care	• Routine foot care
• Dental care (Adult)	• Routine eye care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Chiropractic care	• Infertility treatment
• Acupuncture	• Coverage provided outside the US. See www.carefirst.com	• Non-emergency care when travelling outside the US
• Bariatric surgery	• Hearing aids	• Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor Employee Benefits Security Administration, http://www.dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272); or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, http://www.cciio.cms.gov, or call 1-877-267-2323 x61565.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6518.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6518.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-855-258-6518.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6518.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in network pre natal care and a hospital delivery)

- **The plan's overall deductible** **$300**
- **Specialist** **$20**
- **Hospital (facility)** ***[cost sharing]*** **$150**
- **Other** **10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic test (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$710**

Managing Joe's type 2 Diabetes
(a year of routine in network care of a well controlled condition)

- **The plan's overall deductible** **$300**
- **Primary care physician** ***[cost sharing]*** **$10**
- **Hospital (facility)** ***[cost sharing]*** **$150**
- **Other** ***[cost sharing]*** **10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic test- *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$450
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,780**

Mia's Simple Fracture
(in network emergency room visit and follow up care)

- **The plan's overall deductible** **$300**
- **Specialist** ***[cost sharing]*** **$20**
- **Hospital (facility)** ***[cost sharing]*** **$150**
- **Other** ***[cost sharing]*** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$550
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.