BlueChoice Advantage 2026 Summary of Benefits

Fairfax County Public Schools

Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
	Visit carefirst.com/doctor to locate providers	
Provider Network	BlueChoice Advantage provider	Non-participating provider
ANNUAL MEDICAL DEDUCTIBLE (Benefit period)[4]		
Individual	$300 combined in- and out-of-network	
Family	$600 combined in- and out-of-network	
ANNUAL OUT-OF-POCKET MAXIMUM (Benefit period)[5]		
Medical[6]	$2,500 Individual/$5,000 Family (combined in- and out-of-network)	
LIFETIME MAXIMUM BENEFIT		
Lifetime Maximum	None	None
PREVENTIVE SERVICES		
Well-Child Care (including exams & immunizations)	No charge*	No deductible, then 30% of Allowed Benefit
Adult Physical Examination (including routine GYN visit)	No charge*	No deductible, then 30% of Allowed Benefit
Cancer Screening (prostate, mammogram, pap test, colorectal)	No charge*	No deductible, then 30% of Allowed Benefit
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	Deductible, then $10 PCP/$20 Specialist per visit	Deductible, then 30% of Allowed Benefit
Imaging (MRA/MRS, MRI, PET & CAT scans)[7]	Deductible, then $10 PCP/$20 Specialist copay per visit (when received at freestanding radiology facility) Deductible, then $75 per visit (when received at outpatient hospital)	Deductible, then 30% of Allowed Benefit
Lab[7]	Deductible, then $10 PCP/$20 Specialist copay	Deductible, then 30% of Allowed Benefit
X-ray[7]	Deductible then $10 PCP/$20 Specialist copay	Deductible, then 30% of Allowed Benefit
Allergy Testing	Deductible, then no copay per visit	Deductible, then 30% of Allowed Benefit
Allergy Shots	Deductible, then $10 PCP/$20 Specialist per visit	Deductible, then 30% of Allowed Benefit
Physical, Speech and Occupational Therapy[8] (limited to 90 visits per therapy, per benefit period)	Deductible, then $20 per visit	Deductible, then 30% of Allowed Benefit
Chiropractic	Deductible, then $20 per visit	Deductible, then 30% of Allowed Benefit
Acupuncture (limited to 20 days per benefit period)	Deductible, then $20 copay per visit	Deductible, then 30% of Allowed Benefit
EMERGENCY SERVICES		
Urgent Care Center	No deductible, 10% of Allowed Benefit	No deductible, 30% of Allowed Benefit
Emergency Room—Facility Services	Deductible, then $250 copay per visit, then 10% of Allowed Benefit (copay waived if admitted)	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	Deductible, then 10% of Allowed Benefit
Ambulance Service to a Hospital—for Emergency Services	Deductible, then 10% of Allowed Benefit	Deductible, then 10% of Allowed Benefit
HOSPITALIZATION (Members are responsible for both physician and facility fees)		
Outpatient Facility Services	Deductible, then 10% of Allowed Benefit per visit	Deductible, then 30% of Allowed Benefit
Outpatient Physician Services	Deductible, then 10% of Allowed Benefit per visit	Deductible, then 30% of Allowed Benefit
Inpatient Facility Services	Deductible, then $150 per admission copay, then 10% of Allowed Benefit	Deductible, then $150 per admission, then 30% of Allowed Benefit
Inpatient Physician Services	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit

Services	In-network You Pay[1,2]	Out-of-network You Pay[1,3]
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then 10% of Allowed Benefit per visit	Deductible, then 30% of Allowed Benefit
Hospice (Facility Services)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hospice (Alternative Setting)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Skilled Nursing Facility (limited to 120 days/benefit period combined with in-patient rehab)	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
MATERNITY		
Preventive Prenatal and Postnatal Office Visits	No charge*	No deductible, then 30% of Allowed Benefit
Delivery and Facility Services	Deductible, then $150 per admission, then 10% of Allowed Benefit	Deductible, then $150 per admission, then 30% of Allowed Benefit
AI/IVF (Facility charge)[9]	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
AI/IVF (Professional charge)[9]	Deductible, then $20 per visit	Deductible, then 30% of Allowed Benefit
MENTAL HEALTH AND SUBSTANCE USE DISORDER (Members are responsible for applicable physician and facility fees)		
Inpatient Facility Services	Deductible, then $150 per admission, then 10% of Allowed Benefit	Deductible, then $150 per admission copay, then 10% of Allowed Benefit
Outpatient Facility Services	Deductible, then no charge	Deductible, then 10% of Allowed Benefit
Outpatient Physician Services	Deductible, then no charge	Deductible, then 10% of Allowed Benefit
Office Visits	Deductible, then $10 per visit	Deductible, then 10% of Allowed Benefit
MEDICAL DEVICES AND SUPPLIES		
Durable Medical Equipment	Deductible, then 10% of Allowed Benefit	Deductible, then 30% of Allowed Benefit
Hearing Aids for Children and Adults (Limited to one pair/set per 36 months; $3,000 maximum combined in and out of network)	Deductible, then 10% of Allowed Benefit. Member may be balanced billed up to the total charge.	Deductible, then 30% of Allowed Benefit. Member may be balanced billed up to the total charge.

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.

[1] When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider.

[2] BlueChoice service area, by a provider in the CareFirst BlueChoice Provider network, care is reimbursed at the in-network level. In-network benefits are based on the CareFirst BlueChoice Allowed Benefit. The CareFirst BlueChoice Allowed Benefit is generally the contracted rates or fee schedules that CareFirst BlueChoice providers have agreed to accept as payment for covered services. These payments are established by CareFirst BlueChoice, Inc., however, in certain circumstances, an allowance may be established by law. Outside of the CareFirst BlueChoice service area, when covered services are rendered by a provider in the preferred provider network, care is also covered at the in-network level. These in-network benefits are based on the contracted rates or fee schedules that preferred providers have agreed to accept as payment for covered services that are established by the local Blue Cross and Blue Shield Plan, however, in certain circumstances, an allowance may be established by law.

[3] Out-of-Network: When covered services are rendered by a provider that is not in the CareFirst BlueChoice network in Maryland, Washington D.C. or Northern Virginia, or is not in the preferred provider network outside of CareFirst BlueChoice service area or the local select network, 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.

[4] For family coverage only: When one family member meets the individual deductible, they can start receiving benefits. Each family member cannot contribute more than the individual deductible amount. The family deductible must be met before the remaining family members can start receiving benefits.

[5] For family coverage only: When one family member meets the individual out-of-pocket maximum, their services will be covered at 100% up to the Allowed Benefit. Each family member cannot contribute more than the individual out-of-pocket maximum amount. The family out-of-pocket maximum must be met before the services for all remaining family members will be covered at 100% up to the Allowed Benefit. The out-of-pocket maximum includes deductibles, copays and coinsurance.

[6] Plan has separate out-of-pocket maximums for medical and drug expenses which accumulate independently.

[7] Members accessing laboratory tests, x-rays, and specialty imaging services inside the CareFirst Service Area (Maryland, D.C., Northern Virginia) must use a designated Contracting Provider and/or Contracting Facility which may include a non-hospital/freestanding facility for In-Network benefits. Services performed by any other provider while inside the CareFirst Service Area will be considered Out-of-Network. Members accessing laboratory tests, x-rays, and specialty imaging services outside the CareFirst Service Area may use any participating BlueCard PPO facility and receive In-Network benefits.

[8] Visit Limitation does not apply when Physical, Speech and Occupational Therapy is for treatment of Autism Spectrum Disorder.

[9] 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.

CareFirst
Family of health care plans

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