# 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)<br>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) | $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-networkbenefits 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, but within the remaining parts of the state of Virginia, services will be reimbursed under a select network, Anthem HealthKeepers,fee schedule based on the contracted rates and fee schedule by the local plan. 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



CST2977-1P (11/25)