# GAHP PPO Plan vs. GAHP PPO D-2 Plan

| | GAHP PPO Plan In-Network | GAHP PPO D-2 Plan In-Network |
|---|---|---|
| **Plan Features** | | |
| **Primary Care Physician (PCP)** | Not Required | Not Required |
| **Referrals** | Not Required | Not Required |
| **Network** | BCBS PPO Network | BCBS PPO Network |
| **Out-of-Network Benefits** | Covered at 80%, subject to the deductible. | Covered at 60%, subject to the deductible. |
| **Out-of-Area Benefits** | Coverage provided worldwide through the BlueCard® program. | Coverage provided worldwide through the BlueCard® program. |
| **Student/Dependent Coverage** | Qualified dependents covered to age 26. | Qualified dependents covered to age 26. |
| **Plan Cost Sharing Highlights** | | |
| **Office Visit Copay *(PCP)*** | $20 copay | $20 copay |
| **Office Visit Copay *(Specialist)*** | $25 copay | $25 copay |
| **Coinsurance** | None | 20% |
| **Deductible (Calendar Year)** | In-Network: None<br>Out-of-Network:<br>$250 per member,<br>$500 per 2-person and<br>$750 per family | $500 per member,<br>$1,000 per 2-person and<br>$1,500 per family |
| **Annual Out-of-Pocket Maximum (Calendar Year)** | $6,350 per member<br>$12,700 per 2-person and<br>$12,700 per family<br>All cost shares will accumulate to the OOP maximum, to include deductibles, coinsurances, office visit copayments and prescription copayments. | $2,000 per member<br>$4,000 per 2-person and<br>$6,000 per family<br>All cost shares will accumulate to the OOP maximum, to include deductibles, coinsurances, office visit copayments and prescription copayments. |
| **Lifetime Maximum** | None | None |
| **Plan Benefits** | | |
| **Preventive Healthcare Services** | | |
| **Well Child Visits** | Covered in full | Covered in full |

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# GAHP PPO Plan vs. GAHP PPO D-2 Plan

| | GAHP PPO Plan In-Network | GAHP PPO D-2 Plan In-Network |
|---|---|---|
| **Adult Routine Physicals** | Covered in full once per calendar year | Covered in full once per calendar year |
| **Adult Immunizations** | Routine covered in full. $20 PCP/$25 Specialist copay | Routine covered in full. $20 PCP/$25 Specialist copay |
| **Mammography** | Covered in full | Covered in full |
| **Routine Cervical Cancer Screening (Pap smear)** | Covered in full once per calendar year | Covered in full once per calendar year |
| **Routine OB/GYN Exam** | Covered in full once per calendar year | Covered in full once per calendar year |
| **Prostate Cancer Screening** | Covered in full | Covered in full |
| **Routine Colonoscopy** | Covered in full | Covered in full |
| **Diagnostic Colonoscopy** | Covered in full | Covered at 80%, subject to the deductible |
| **Physicians Office Services** | | |
| **Diagnostic Office Visits** | $20 PCP/$25 Specialist copay | $20 PCP/$25 Specialist copay |
| **Telemedicine (MDLive)** | $10 copay per visit (MDLive) | $10 copay per visit (MDLive) |
| **Diagnostic X-Rays (MRI, MRA, PET, CAT scans)** | Covered in full | *Covered at 80%, subject to the deductible |
| **Diagnostic Laboratory and Pathology** | Covered in full | Covered at 80%, subject to the deductible |
| **Allergy Tests** | $20 PCP/$25 Specialist copay | $20 PCP/$25 Specialist copay |
| **Allergy Injections** | Covered in full | Covered in full |
| **Chemotherapy** | Covered in full | Covered at 80%, subject to the deductible |
| **Radiation Therapy** | Covered in full | Covered at 80%, subject to the deductible |
| **Maternity Services** | | |
| **Prenatal and Postnatal Office Visits** | Covered in full | Covered at 80%, subject to the deductible |

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# GAHP PPO Plan vs. GAHP PPO D-2 Plan

| | GAHP PPO Plan In-Network | GAHP PPO D-2 Plan In-Network |
|---|---|---|
| **Hospital and Physician care for Mother (including delivery)** | Covered in full | Covered at 80%, subject to the deductible |
| **Newborn Nursery Care** | Covered in full | Covered at 80%, ***not*** subject to the deductible |
| **Prescription Drug** | Covered by Wegmans and Express Scripts.<br>$5/$35/$70 – Retail<br>$10/$70/$140 – Mail Order | Covered by Wegmans and Express Scripts.<br>$5/$35/$70 – Retail<br>$10/$70/$140 - Mail Order |
| **Inpatient Hospital Services** | | |
| **Hospital Services** | Covered in full for unlimited days in semi-private room and all medically necessary services. | *Covered at 80%, subject to the deductible for unlimited days in semi-private room and all medically necessary services. |
| **Physician Visits in the Hospital** | Covered in full for unlimited visits | Covered at 80%, subject to the deductible for unlimited visits |
| **Inpatient Physical Rehabilitation** | Covered in full for unlimited days | Covered in full for up to 60 days per calendar year |
| **Surgery** | Covered in full | Covered at 80%, subject to the deductible |
| **Anesthesia** | Covered in full | Covered at 80%, subject to the deductible |
| **Emergency Services** | | |
| **Emergency Room Care** | $100 copay per visit, unless admitted as an inpatient to the hospital within 24 hours | $100 copay per visit, unless admitted as an inpatient to the hospital within 24 hours |
| **Freestanding Urgent Care Center** | $25 copay | $25 copay |
| **Ambulance** | $50 copay | $50 copay |
| **Air Ambulance** | Covered in full up to $250, then covered at 80% coinsurance | Covered at 80%, subject to the deductible |

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# GAHP PPO Plan vs. GAHP PPO D-2 Plan

| | GAHP PPO Plan In-Network | GAHP PPO D-2 Plan In-Network |
|---|---|---|
| **Outpatient Hospital Services** | | |
| **Diagnostic X-Rays (MRI, MRA, PET, CAT scans)** | Covered in full | *Covered at 80%, subject to the deductible |
| **Diagnostic Laboratory and Pathology** | Covered in full | Covered at 80%, subject to the deductible |
| **Pre-Admission Testing** | Covered in full | Covered at 80%, subject to the deductible |
| **Surgical Care** | Covered in full | Covered at 80%, subject to the deductible |
| **Chemotherapy** | Covered in full | Covered at 80%, subject to the deductible |
| **Radiation Therapy** | Covered in full | Covered at 80%, subject to the deductible |
| **Mental Health and Chemical Dependency Services** | | |
| **Inpatient Mental Health Care** | Covered in full | *Covered at 80%, subject to the deductible |
| **Outpatient Mental Health Care** | $25 copay | $25 copay |
| **Inpatient Chemical Dependency Care** | Covered in full | *Covered at 80%, subject to the deductible |
| **Outpatient Chemical Dependency Care** | $25 copay | $25 copay |
| **Other Services** | | |
| **Diabetic Insulin & Supplies** | Covered in full | Retail:<br>$20 copay for a 30-day supply<br>Mail Order:<br>$40 copay for a 90-day supply |
| **Diabetic Equipment** | Covered in full | Retail:<br>$20 copay for a 30-day supply<br>Mail Order:<br>$40 copay for a 90-day supply |

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# GAHP PPO Plan vs. GAHP PPO D-2 Plan

| | GAHP PPO Plan In-Network | GAHP PPO D-2 Plan In-Network |
|---|---|---|
| **Skilled Nursing Facility** | Covered in full for unlimited days in semi-private room. | Covered at 80%, subject to the deductible for up to 120 days per calendar year of semi-private room. |
| **Home Care** | Covered in full for unlimited days per calendar year. | *Covered at 80%, subject to a separate $50 deductible for unlimited days per calendar year |
| **Hospice** | Covered in full for unlimited days per calendar year. | Covered at 80% for unlimited days per calendar year. |
| **Outpatient Therapy (PT, OT, Speech)** | $25 copay, no maximum. | Covered at 80%, subject to the deductible. Up to 45 visits for physical, speech, and occupational therapy combined per member per calendar year. |
| **Durable Medical Equipment** | Covered in full | *Covered at 80%, subject to the deductible |
| **Internal and External Prosthetics** | Covered in full | Covered at 80%, subject to the deductible |
| **Foot Orthotics** | Covered in full | Covered at 80%, subject to the deductible |
| **Chiropractic** | $25 copay | $25 copay |
| **Acupuncture** | Covered in full | Covered at 50%, subject to the deductible, for up to 10 visits per calendar year. |
| **Dental** | Covered in full when related to an accidental injury to sound natural teeth when services are rendered within 365 days of the accident. | Covered at 80%, subject to the deductible for accidental injury to sound natural teeth. $25 copay for an office visit. |
| **Eye Exams** | Diagnostic, related to disease or injury, $25 copay per visit. No coverage for routine eye exams or refractions. | Diagnostic, related to disease or injury, $25 copay per visit. No coverage for routine eye exams or refractions. |
| **Hearing** | Covered in full for diagnostic hearing exams.<br>Covered in full for one routine hearing exam per calendar year. Hearing aids not covered. | $25 copay for diagnostic hearing exams.<br>No coverage for routine hearing exams. Hearing aids not covered. |

This is not a contract or binding agreement; it is a summary of benefits and services.
For complete details, please refer to your member contract.
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