# GAHP PPO, PPO D-2 & High Deductible Plan
# Out-of-Network Comparison
*Effective 7/1/26 - 6/30/27*

| | GAHP PPO Plan | GAHP PPO D-2 Plan | GAHP High Deductible |
|---|---|---|---|
| **Plan Features** | | | |
| **Primary Care Physician (PCP)** | Not Required | Not Required | Not Required |
| **Referrals** | Not Required | Not Required | Not Required |
| **Network** | BCBS PPO 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. | 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 | Coverage provided worldwide through the BlueCard® program |
| **Student/Dependent Coverage** | Qualified dependents covered to age 26 | Qualified dependents covered to age 26 | Qualified dependents covered to age 26 |
| **Domestic Partner Coverage** | Not Covered | Not Covered | Not Covered |
| **Plan Cost Sharing Highlights** | | | |
| **Office Visit Copay *(PCP)*** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Office Visit Copay *(Specialist)*** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Coinsurance** | 20% | 40% | 40% |
| **Deductible (Calendar Year)** | $250 per member,<br>$500 per 2-person and<br>$750 per family in the aggregate | $750 per member,<br>$1,500 per 2-person and<br>$2,250 per family in the aggregate | $1,870 Single, and<br>$3,740 per family<br>**Projected 1/1/2027:**<br>$1,925 Single, and<br>$3,850 per family |

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

# GAHP PPO, PPO D-2 & High Deductible Plan
# Out-of-Network Comparison
*Effective 7/1/26 - 6/30/27*

| | GAHP PPO Plan | GAHP PPO D-2 Plan | GAHP High Deductible |
|---|---|---|---|
| **Annual Out-of-Pocket (OOP) Maximum (Calendar Year)**<br><br>All cost shares will accumulate to the out-of-pocket maximum for either in-network or out-of-network, to include deductibles, coinsurances, office visit copayments and prescription copayments. | $3,300 per member<br>$6,600 per 2-person and<br>$9,900 per family in the aggregate<br><br>There are certain out-of-network benefits that accumulate towards the in-network annual out-of-pocket maximum as noted in the Benefit Booklets pages 2-6 | $2,475 per member<br>$4,950 per 2-person and<br>$7,425 per family in the aggregate<br><br>There are certain out-of-network benefits that accumulate towards the in-network annual out-of-pocket maximum as noted in the Benefit Booklets pages 2-6 | $3,740 Single, and<br>$7,480 per family<br>**Projected 1/1/2027:**<br>$3,850 Single, and<br>$7,700 per family |
| **Lifetime Maximum** | None | None | None |
| **Plan Benefits** | | | |
| **Routine Preventive Healthcare Services**<br>All Routine Preventive Services follow Federal Guidelines and American Pediatric Guidelines | | | |
| **Well Child Visits** | Routine covered in full | Routine covered in full | Routine covered in full |
| **Routine Adult Physical** | Routine covered in full | Routine covered in full | Routine covered in full |
| **Adult Immunizations** | Routine covered in full | Routine covered in full | Routine covered in full |
| **Mammography** | Routine covered in full | Routine covered in full | Routine covered in full |
| **Cervical Cancer Screening** | Routine covered in full | Routine covered in full | Routine covered in full |
| **OB/GYN Exam** | Routine covered in full | Routine covered in full | Routine covered in full |
| **Prostate Cancer Screening** | Routine covered in full | Routine covered in full | Routine covered in full |
| **Colonoscopy** | Routine covered in full | Routine covered in full | Routine covered in full |
| **Physician's Office Services** | | | |
| **Diagnostic Office Visits** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Telemedicine (MDLive)** | No Benefit Available. | No Benefit Available. | No Benefit Available. |

# GAHP PPO, PPO D-2 & High Deductible Plan
# Out-of-Network Comparison
*Effective 7/1/26 - 6/30/27*

| | GAHP PPO Plan | GAHP PPO D-2 Plan | GAHP High Deductible |
|---|---|---|---|
| **Diagnostic X-Rays * (MRI, MRA, PET, CAT scans)** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Diagnostic Laboratory and Pathology** | Covered in full | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Allergy Tests** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Allergy Injections** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Chemotherapy** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Radiation Therapy** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Maternity Services** | | | |
| **Prenatal and Postnatal Office Visits** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Hospital and Physician Care for Mother (including delivery)** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Newborn Nursery Care** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Fertility Treatment** For PPO and D-2, see Benefit Booklet (page 16) for more details. | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| | **GAHP PPO Plan** | **GAHP PPO D-2 Plan** | **GAHP High Deductible** |
| **Inpatient Hospital Services** | | | |
| **Hospital Services *** | Covered at 80%, subject to the deductible for unlimited days in semi-private room and all medically necessary services | Covered at 60%, subject to the deductible for unlimited days in semi-private room and all medically necessary services | Covered at 60%, subject to the deductible for unlimited days in semi-private room and all medically necessary services |

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

# GAHP PPO, PPO D-2 & High Deductible Plan
## Out-of-Network Comparison
*Effective 7/1/26 - 6/30/27*

| | GAHP PPO Plan | GAHP PPO D-2 Plan | GAHP High Deductible |
|---|---|---|---|
| **Physician Visits in the Hospital** | Covered at 80%, subject to the deductible for unlimited visits | Covered at 60%, subject to the deductible for unlimited visits | Covered at 60%, subject to the deductible for unlimited visits |
| **Inpatient Physical Rehabilitation *** | Covered at 80%, subject to the deductible for unlimited visits | Covered at 60%, subject to the deductible up to 60 days per member per calendar year | Covered at 60%, subject to the deductible for up to 60 days per calendar year |
| **Surgery** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Anesthesia** | Covered in full | Covered at 80%, subject to the deductible | Covered at 80%, subject to the In-Network deductible |
| **Emergency Services** | | | |
| **Emergency Room Care** | $150 copay per visit, unless admitted as an inpatient to the hospital within 24 hours | $250 copay per visit, unless admitted as an inpatient to the hospital within 24 hours | Covered at 80%, subject to the In-Network deductible |
| **Freestanding Urgent Care Center** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Ambulance** | $50 copay | $75 copay | Covered at 80%, subject to the In-Network deductible |
| **Air Ambulance** | Covered in full up to $500, then covered at 80% coinsurance | Covered at 80%, subject to the deductible | Covered at 80%, subject to the In-Network deductible |
| **Outpatient Hospital Services** | | | |
| **Diagnostic X-Rays * (MRI, MRA, PET, CAT scans)** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Diagnostic Laboratory and Pathology** | Covered in full | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Pre-Admission Testing** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |

# GAHP PPO, PPO D-2 & High Deductible Plan
# Out-of-Network Comparison
*Effective 7/1/26 - 6/30/27*

| | GAHP PPO Plan | GAHP PPO D-2 Plan | GAHP High Deductible |
|---|---|---|---|
| **Surgical Care** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Diagnostic Colonoscopy** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Chemotherapy** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Radiation Therapy** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Mental Health and Chemical Dependency Services** | | | |
| **Inpatient Mental Health Care *** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Outpatient Mental Health Care** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Inpatient Chemical Dependency Care *** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Outpatient Chemical Dependency Care** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Other Services** | | | |
| **Prescription Drug** | No Benefit Available | No Benefit Available | No Benefit Available |
| **Diabetic Insulin** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Diabetic Supplies** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Diabetic Equipment** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |

# GAHP PPO, PPO D-2 & High Deductible Plan
## Out-of-Network Comparison
*Effective 7/1/26 - 6/30/27*

| | GAHP PPO Plan | GAHP PPO D-2 Plan | GAHP High Deductible |
|---|---|---|---|
| **Outpatient Therapy (PT, OT, Speech)** | Covered at 80%, subject to the deductible, no maximum | Covered at 60%, subject to the deductible. Up to 45 visits for physical, speech, and occupational therapy combined per member per calendar year | Covered at 60%, subject to the deductible. Up to 45 visits for physical, speech, and occupational therapy combined per member per calendar year |
| **Skilled Nursing Facility *** | Covered at 80%, subject to the deductible, for unlimited days | Covered at 60%, subject to the deductible, for up to 120 days per calendar year | Covered at 60%, subject to the deductible, for up to 45 days per calendar year |
| **Home Care *** | Covered at 80%, subject to a separate $50 deductible, for unlimited days per calendar year | Covered at 75%, subject to a separate $50 deductible for unlimited days per calendar year | Covered at 60%, subject to the deductible |
| **Hospice** | Covered at 80%, subject to the deductible, for unlimited days per calendar year | Covered at 60%, subject to the deductible, for unlimited days per calendar year | Covered at 60%, subject to the deductible, for unlimited days per calendar year |
| **Durable Medical Equipment *** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Internal and External Prosthetics** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Foot Care** | Not covered for services related to routine care of the feet, including but not limited to corns, calluses, flat feet, fallen arches, strain, toenails, or symptomatic complaints of the feet | | |
| **Foot Orthotics** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |
| **Chiropractic** | Covered at 80%, subject to the deductible | Covered at 60%, subject to the deductible | Covered at 60%, subject to the deductible |

# GAHP PPO, PPO D-2 & High Deductible Plan
# Out-of-Network Comparison
*Effective 7/1/26 - 6/30/27*

| | GAHP PPO Plan | GAHP PPO D-2 Plan | GAHP High Deductible |
|---|---|---|---|
| **Acupuncture** | Covered at 80%, subject to the deductible | Covered at 50%, subject to deductible, for up to 10 visits per calendar year. | Covered at 60%, subject to the deductible, for up to 10 visits per calendar year |
| **Dental** | Covered at 80%, subject to the deductible when related to an accidental injury to sound natural teeth when services are rendered within 365 days of the accident | Covered at 60%, subject to the deductible when related to an accidental injury to sound natural teeth when services are rendered within 365 days of the accident | Covered at 60%, subject to the deductible for accidental injury to sound natural teeth |
| **Eye Exams** | Diagnostic, related to disease or injury, covered at 80%, subject to the deductible.<br>No coverage for routine eye exams or refractions | Diagnostic, related to disease or injury, covered at 60%, subject to the deductible.<br>No coverage for routine eye exams or refractions | Diagnostic, related to disease or injury, covered at 60%, subject to the deductible.<br>No coverage for routine eye exams or refractions |
| **Hearing (Diagnostic)** | Covered at 80%, subject to the deductible for hearing exams. Routine evaluation and hearing aids not covered | Covered at 60%, subject to the deductible for hearing exams. Routine evaluation and hearing aids not covered | Covered at 60%, subject to the deductible hearing exams. Hearing aids not covered |
| **Hearing (Routine)** | Covered at 80%, subject to the deductible for one hearing exam per calendar year | Covered at 60%, subject to the deductible for one hearing exam per calendar year | Covered at 60%, subject to the deductible for one hearing exam per calendar year |

*** Prior Authorization required by your provider for benefits as noted with asterisk on all Plans.**

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.