

GAHP PPO, PPO D-2 & High Deductible Plan Out-of-Network Comparison

	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, \$500 per 2-person and \$750 per family	\$500 per member, \$1,000 per 2-person and \$1,500 per family	\$1,650 Single, and \$3,300 per family

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Annual Out-of-Pocket (OOP) Maximum (Calendar Year) 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.	\$6,985 per member \$13,970 per 2-person and per family 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 1-5.	\$2,200 per member \$4,400 per 2-person and \$6,600 per family 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 1-5.	\$3,300 single and \$6,600 per family
Lifetime Maximum	None	None	None
Plan Benefits			
<u>Routine Preventive Healthcare Services</u> All Routine Preventive Services follow Federal Guidelines and American Pediatric Guidelines			
Well Child Visits	Covered in full	Covered in full	Covered in full
Routine Adult Physical	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible.
Adult Immunizations	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible.
Mammography	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible.
Cervical Cancer Screening	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible.
OB/GYN Exam	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible.
Prostate Cancer Screening	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible.



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Colonoscopy	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible.
<u>Physician's Office Services</u>			
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
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
<u>Maternity Services</u>			
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%, not subject to the deductible
Fertility Treatment For PPO and D-2, see Benefit	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible



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Booklet (page 16) for more details.			
<u>Inpatient Hospital Services</u>			
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.
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 days.	Covered at 60%, subject to the deductible, for 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 60%, subject to the deductible.	Covered at 60%, subject to the deductible
<u>Emergency Services</u>			
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	Covered at 80%, subject to the 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	\$50 copay	Covered at 80%, subject to the deductible
Air Ambulance	Covered in full up to \$250, then covered at 80% coinsurance	Covered at 60%, subject to the deductible.	Covered at 80%, subject to the deductible
<u>Outpatient Hospital Services</u>			



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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
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
<u>Mental Health and Chemical Dependency Services</u>			
Inpatient Mental Health Care	Covered at 80%, subject to deductible.	*Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible
Outpatient Mental Health Care	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.	Covered at 60%, subject to the deductible
Inpatient Chemical Dependency Care	Covered at 80%, subject to deductible.	*Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible
Outpatient Chemical Dependency Care	Covered at 80%, subject to deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible
<u>Other Services</u>			
Prescription Drug	No Benefit Available	No Benefit Available	No Benefit Available
Diabetic Insulin & Supplies	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible.



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Diabetic Equipment	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the 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 of semi-private room.
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 fee, 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.

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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 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. No coverage for routine eye exams or refractions.	Diagnostic, related to disease or injury, covered at 60%, subject to the deductible. No coverage for routine eye exams or refractions.	Diagnostic, related to disease or injury, covered at 60%, subject to the deductible. No coverage for routine eye exams or refractions.
Hearing (Diagnostic)	Covered at 80%, subject to the deductible for diagnostic hearing exams. No coverage for routine hearing exams. Hearing aids not covered.	Covered at 60%, subject to the deductible for diagnostic hearing exams. No coverage for routine hearing exams. Hearing aids not covered.	Covered at 60%, subject to the deductible diagnostic hearing exams. Hearing aids not covered.
Hearing (Routine)	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.	Covered at 60%, subject to the deductible for one routine hearing exam per calendar year.

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.

* Pre-certification required. A penalty of \$500 or 50% of the Excellus BCBS allowed amount, whichever is less, will apply if pre-certification is not obtained.



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