GAHP PPO & PPO D-2
In Network Comparison
Effective 7/1/25 - 6/30/26

	GAHP PPO Plan	GAHP PPO D-2 Plan
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
Domestic Partner Coverage	Not Covered	Not Covered
Plan Cost Sharing Highlights		
Office Visit Copay *(PCP)*	$25 copay	$30 copay
Office Visit Copay *(Specialist)*	$30 copay	$35 copay Effective 1/1/26 - $40 copay
Coinsurance	None	20%
Deductible (Calendar Year)	None	$750 per member, $1,500 per 2-person and $2,250 per family in the aggregate
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.	$3,000 per member $6,000 per 2-person and $9,000 per family in the aggregate 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 2-7	$2,250 per member $4,500 per 2-person and $6,750 per family in the aggregate 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
Lifetime Maximum	None	None
Plan Benefits		
Routine Preventive Healthcare Services All Routine Preventive Services follow Federal Guidelines and American Pediatric Guidelines		
Well Child Visits	Routine covered in full	Routine covered in full
Routine Adult Physical	Routine covered in full	Routine covered in full
Adult Immunizations	Routine covered in full	Routine covered in full
Mammography	Routine covered in full	Routine covered in full
Cervical Cancer Screening	Routine covered in full	Routine covered in full
OB/GYN Exam	Routine covered in full	Routine covered in full

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Prostate Cancer Screening	Routine covered in full	Routine covered in full
Colonoscopy	Routine covered in full	Routine covered in full
Physician's Office Services		
Diagnostic Office Visits	$25 PCP/$30 Specialist copay	$30 PCP/$35 Specialist copay Effective 1/1/26 - $40 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	$25 PCP/$30 Specialist copay	$30 PCP/$35 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
Hospital and Physician care for Mother (including delivery)	$100 copay per stay	Covered at 80%, subject to the deductible
Newborn Nursery Care	Covered in full	Covered at 80%, ***not*** subject to the deductible
Fertility Treatment *For PPO and D-2, see Benefit Booklet (page 16) for more details.*	Covered in full	Covered at 80%, subject to the deductible
Inpatient Hospital Services		
Hospital Services *	$100 copay per stay 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

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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
Freestanding Urgent Care Center	$30 copay	$35 copay Effective 1/1/26 - $40 copay
Ambulance	$50 copay	$75 copay
Air Ambulance	Covered in full up to $500, then covered at 80% coinsurance	Covered at 80%, subject to the deductible
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
Diagnostic Colonoscopy	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	$30 copay
Inpatient Chemical Dependency Care *	Covered in full	Covered at 80%, subject to the deductible
Outpatient Chemical Dependency Care	$25 copay	$30 copay
Other Services		
Prescription Drug	$5/$35/$70 – Retail $10/$70/$140 – Mail Order° °Covered by Wegmans and Express Scripts.	$5/$45/$90 – Retail $10/$90/$180 – Mail Order° °Covered by Wegmans and Express Scripts.
Diabetic Insulin	Covered in full	Covered in full

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Diabetic Supplies	Covered in full	Retail: $20 copay for a 30-day supply Mail Order: $40 copay for a 90-day supply
Diabetic Equipment	Covered in full	Retail: $20 copay for a 30-day supply Mail Order: $40 copay for a 90-day supply
Outpatient Therapy (PT, OT, Speech)	$30 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
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
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 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 in full	Covered at 80%, subject to the deductible
Chiropractic	$30 copay	$35 copay Effective 1/1/26 - $40 copay
Acupuncture	Covered in full	$50 copay 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. $35 copay for an office visit

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Eye Exams	Diagnostic, related to disease or injury, $30 copay per visit. No coverage for routine eye exams or refractions	Diagnostic, related to disease or injury, $35 copay per visit. No coverage for routine eye exams or refractions. Effective 1/1/26 - $40 copay
Hearing (Diagnostic)	Covered in full for hearing exams. Hearing aids not covered	$35 copay for hearing exams. Hearing aids not covered. Effective 1/1/26 - $40 copay
Hearing (Routine)	Covered in full for one hearing exam per calendar year	$35 copay for one hearing exam per calendar year. Effective 1/1/26 - $40 copay
*** 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.		