GAHP PPO & PPO D-2 Plan
Out-of-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)*	Covered at 80%, 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
Coinsurance	20%	40%
Deductible (Calendar Year)	$250 per member, $500 per 2-person and $750 per family in the aggregate	$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.	$3,300 per member $6,600 per 2-person and $9,900 per family in the aggregate There are certain out-of-network benefits that accumulate towards the in-network annual out-ofpocket maximum as noted in the Benefit Booklets pages 2-7	$2,475 per member $4,950 per 2-person and $7,425 per family in the aggregate There are certain out-of-network benefits that accumulate towards the in-network annual out-ofpocket maximum as noted in the Benefit Booklets pages 2-7
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

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Cervical Cancer Screening	Routine covered in full	Routine covered in full
OB/GYN Exam	Routine covered in full	Routine covered in full
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	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Telemedicine (MDLive)	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
Diagnostic Laboratory and Pathology	Covered in full	Covered at 60%, subject to the deductible
Allergy Tests	Covered at 80%, 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
Chemotherapy	Covered at 80%, 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
Maternity Services		
Prenatal and Postnatal Office Visits	Covered at 80%, 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
Newborn Nursery Care	Covered at 80%, 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

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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
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
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
Surgery	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
Anesthesia	Covered in full	Covered at 80%, subject to the 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
Freestanding Urgent Care Center	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible
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 at 80%, 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
Pre-Admission Testing	Covered at 80%, 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
Diagnostic Colonoscopy	Covered at 80%, 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
Radiation Therapy	Covered at 80%, subject to the deductible	Covered at 60%, subject to the deductible

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Mental Health and Chemical Dependency Services		
Inpatient Mental Health Care *	Covered at 80%, 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
Inpatient Chemical Dependency Care *	Covered at 80%, 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
Other Services		
Prescription Drug	No Benefit Available	No Benefit Available
Diabetic Insulin	Covered at 80%, 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
Diabetic Equipment	Covered at 80%, 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
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
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
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
Durable Medical Equipment *	Covered at 80%, 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
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.	

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Foot Orthotics	Covered at 80%, 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
Acupuncture	Covered at 80%, subject to the deductible	Covered at 50%, subject to 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
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
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
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
*** 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.		