

**GAHP PPO & PPO D-2 Plan  
Out-of-Network Comparison  
Effective 7/1/24-12/31/24**

	GAHP PPO Plan	GAHP PPO D-2 Plan
<b>Plan Features</b>		
<b>Primary Care Physician (PCP)</b>	Not Required	Not Required
<b>Referrals</b>	Not Required	Not Required
<b>Network</b>	BCBS PPO Network	BCBS PPO Network
<b>Out-of-Network Benefits</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Out-of-Area Benefits</b>	Coverage provided worldwide through the BlueCard® program.	Coverage provided worldwide through the BlueCard® program.
<b>Student/Dependent Coverage</b>	Qualified dependents covered to age 26.	Qualified dependents covered to age 26.
<b>Domestic Partner Coverage</b>	Not Covered	Not Covered
<b>Plan Cost Sharing Highlights</b>		
<b>Office Visit Copay (PCP)</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Office Visit Copay (Specialist)</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Coinsurance</b>	20%	40%
<b>Deductible (Calendar Year)</b>	\$250 per member, \$500 per 2-person and \$750 per family	\$500 per member, \$1,000 per 2-person and \$1,500 per family
<b>Annual Out-of-Pocket (OOP) Maximum (Calendar Year)</b>	\$6,985 per member \$13,970 per 2-person and per family	\$2,200 per member \$4,400 per 2-person and \$6,600 per family
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.	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.	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.
<b>Lifetime Maximum</b>	None	None
<b>Plan Benefits</b>		
<b><u>Routine Preventive Healthcare Services</u></b>		
All Routine Preventive Services follow Federal Guidelines and American Pediatric Guidelines		
<b>Well Child Visits</b>	Covered in full	Covered in full
<b>Routine Adult Physical</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Adult Immunizations</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.



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<b>Mammography</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Cervical Cancer Screening</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>OB/GYN Exam</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Prostate Cancer Screening</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Colonoscopy</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b><u>Physician's Office Services</u></b>		
<b>Diagnostic Office Visits</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Telemedicine (MDLive)</b>	No Benefit Available	No Benefit Available
<b>Diagnostic X-Rays * (MRI, MRA, PET, CAT scans)</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Diagnostic Laboratory and Pathology</b>	Covered in full	Covered at 60%, subject to the deductible.
<b>Allergy Tests</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Allergy Injections</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Chemotherapy</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Radiation Therapy</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b><u>Maternity Services</u></b>		
<b>Prenatal and Postnatal Office Visits</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Hospital and Physician Care for Mother (including delivery)</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Newborn Nursery Care</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Fertility Treatment</b> For PPO and D-2, see Benefit Booklet (page 17) for more details.	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.

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<b><u>Inpatient Hospital Services</u></b>		
<b>Hospital Services *</b>	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.
<b>Physician Visits in the Hospital</b>	Covered at 80%, subject to the deductible for unlimited visits.	Covered at 60%, subject to the deductible for unlimited visits.
<b>Inpatient Physical Rehabilitation</b>	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.
<b>Surgery</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Anesthesia</b>	Covered in full.	Covered at 60%, subject to the deductible.
<b><u>Emergency Services</u></b>		
<b>Emergency Room Care</b>	\$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
<b>Freestanding Urgent Care Center</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Ambulance</b>	\$50 copay	\$50 copay
<b>Air Ambulance</b>	Covered in full up to \$250, then covered at 80% coinsurance	Covered at 80%, subject to the deductible.
<b><u>Outpatient Hospital Services</u></b>		
<b>Diagnostic X-Rays * (MRI, MRA, PET, CAT scans)</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Diagnostic Laboratory and Pathology</b>	Covered in full.	Covered at 60%, subject to the deductible.
<b>Pre-Admission Testing</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Surgical Care</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Diagnostic Colonoscopy</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Chemotherapy</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Radiation Therapy</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.

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<b><u>Mental Health and Chemical Dependency Services</u></b>		
<b>Inpatient Mental Health Care *</b>	Covered at 80%, subject to deductible.	Covered at 60%, subject to the deductible.
<b>Outpatient Mental Health Care</b>	Covered at 80%, subject to deductible.	Covered at 60%, subject to deductible.
<b>Inpatient Chemical Dependency Care *</b>	Covered at 80%, subject to deductible.	Covered at 60%, subject to the deductible.
<b>Outpatient Chemical Dependency Care</b>	Covered at 80%, subject to deductible.	Covered at 60%, subject to the deductible.
<b><u>Other Services</u></b>		
<b>Prescription Drug</b>	No Benefit Available	No Benefit Available
<b>Diabetic Insulin &amp; Supplies</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Diabetic Equipment</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Outpatient Therapy (PT, OT, Speech)</b>	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.
<b>Skilled Nursing Facility *</b>	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.
<b>Home Care *</b>	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.
<b>Hospice</b>	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.
<b>Durable Medical Equipment *</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible
<b>Internal and External Prosthetics</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Foot Care</b>	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.	
<b>Foot Orthotics</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>Chiropractic</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.

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<b>Acupuncture</b>	Covered at 80%, subject to the deductible.	Covered at 50%, subject to deductible, for up to 10 visits per calendar year.
<b>Dental</b>	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.
<b>Eye Exams</b>	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.
<b>Hearing (Diagnostic)</b>	Covered at 80%, subject to the deductible for hearing exams. No coverage for routine hearing exams. Hearing aids not covered.	Covered at 60%, subject to the deductible for hearing exams. No coverage for routine hearing exams. Hearing aids not covered.
<b>Hearing (Routine)</b>	Covered at 80%, subject to the deductible.	Covered at 60%, subject to the deductible.
<b>* Prior Authorization required by your provider for benefits as noted with asterisk on all Plans.</b>		
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.		