

**GAHP PPO & PPO D-2**  
**In Network Comparison**  
*Effective 7/1/26 - 6/30/27*

	<b>GAHP PPO Plan</b>	<b>GAHP PPO D-2 Plan</b>
<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>	\$25 copay <b>Effective 1/1/27 - \$30 copay</b>	\$30 copay <b>Effective 1/1/27 - \$35 copay</b>
<b>Office Visit Copay (Specialist)</b>	\$30 copay <b>Effective 1/1/27 - \$35 copay</b>	\$40 copay <b>Effective 1/1/27 - \$45 copay</b>
<b>Coinsurance</b>	None	20%
<b>Deductible (Calendar Year)</b>	None	\$750 per member, \$1,500 per 2-person and \$2,250 per family in the aggregate
<b>Annual Out-of-Pocket (OOP) Maximum (Calendar Year)</b>  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 2-6	\$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 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>	Routine covered in full	Routine covered in full
<b>Routine Adult Physical</b>	Routine covered in full	Routine covered in full
<b>Adult Immunizations</b>	Routine covered in full	Routine covered in full
<b>Mammography</b>	Routine covered in full	Routine covered in full
<b>Cervical Cancer Screening</b>	Routine covered in full	Routine covered in full



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<b>OB/GYN Exam</b>	Routine covered in full	Routine covered in full
<b>Prostate Cancer Screening</b>	Routine covered in full	Routine covered in full
<b>Colonoscopy</b>	Routine covered in full	Routine covered in full
<b><u>Physician's Office Services</u></b>		
<b>Diagnostic Office Visits</b>	\$25 PCP/\$30 Specialist copay <b>Effective 1/1/27:</b> <b>\$30 PCP/\$35 Specialist copay</b>	\$30 PCP/\$40 Specialist copay <b>Effective 1/1/27:</b> <b>\$35 PCP/\$45 Specialist copay</b>
<b>Telemedicine (MDLive)</b>	\$10 copay per visit (MDLive)	\$10 copay per visit (MDLive)
<b>Diagnostic X-Rays * (MRI, MRA, PET, CAT scans)</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Diagnostic Laboratory and Pathology</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Allergy Tests</b>	\$25 PCP/\$30 Specialist copay <b>Effective 1/1/27:</b> <b>\$30 PCP/\$35 Specialist copay</b>	\$30 PCP/\$40 Specialist copay <b>Effective 1/1/27:</b> <b>\$35 PCP/\$45 Specialist copay</b>
<b>Allergy Injections</b>	Covered in full	Covered in full
<b>Chemotherapy</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Radiation Therapy</b>	Covered in full	Covered at 80%, subject to the deductible
<b><u>Maternity Services</u></b>		
<b>Prenatal and Postnatal Office Visits</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Hospital and Physician care for Mother (including delivery)</b>	\$100 copay per stay	Covered at 80%, subject to the deductible
<b>Newborn Nursery Care</b>	Covered in full	Covered at 80%, <b>not</b> subject to the deductible
<b>Fertility Treatment</b> <i>For PPO and D-2, see Benefit Booklet (page 16) for more details.</i>	Covered in full	Covered at 80%, subject to the deductible
<b><u>Inpatient Hospital Services</u></b>		
<b>Hospital Services *</b>	\$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
<b>Physician Visits in the Hospital</b>	Covered in full for unlimited visits	Covered at 80%, subject to the deductible for unlimited visits
<b>Inpatient Physical Rehabilitation *</b>	Covered in full for unlimited days	Covered in full for up to 60 days per calendar year
<b>Surgery</b>	Covered in full	Covered at 80%, subject to the deductible



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<b>Anesthesia</b>	Covered in full	Covered at 80%, subject to the deductible
<b><u>Emergency Services</u></b>		
<b>Emergency Room Care</b>	\$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
<b>Freestanding Urgent Care Center</b>	\$30 copay <b>Effective 1/1/27 - \$35 copay</b>	\$40 copay <b>Effective 1/1/27 - \$45 copay</b>
<b>Ambulance</b>	\$50 copay	\$75 copay
<b>Air Ambulance</b>	Covered in full up to \$500, 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 in full	Covered at 80%, subject to the deductible
<b>Diagnostic Laboratory and Pathology</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Pre-Admission Testing</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Surgical Care</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Diagnostic Colonoscopy</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Chemotherapy</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Radiation Therapy</b>	Covered in full	Covered at 80%, subject to the deductible
<b><u>Mental Health and Chemical Dependency Services</u></b>		
<b>Inpatient Mental Health Care *</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Outpatient Mental Health Care</b>	\$25 copay <b>Effective 1/1/27 - \$30 copay</b>	\$30 copay <b>Effective 1/1/27 - \$35 copay</b>
<b>Inpatient Chemical Dependency Care *</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Outpatient Chemical Dependency Care</b>	\$25 copay <b>Effective 1/1/27 - \$30 copay</b>	\$30 copay <b>Effective 1/1/27 - \$35 copay</b>
<b><u>Other Services</u></b>		
<b>Prescription Drug</b>	\$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
<b>Diabetic Insulin</b>	Covered in full	Covered in full



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<b>Diabetic Supplies</b>	Covered in full	Retail: \$20 copay for a 30-day supply Mail Order: \$40 copay for a 90-day supply
<b>Diabetic Equipment</b>	Covered in full	Retail: \$20 copay for a 30-day supply Mail Order: \$40 copay for a 90-day supply
<b>Outpatient Therapy (PT, OT, Speech)</b>	\$30 copay <b>Effective 1/1/27 - \$35 copay</b>	Covered at 80%, 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 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
<b>Home Care *</b>	Covered in full for unlimited days per calendar year	Covered at 80%, subject to a separate \$50 deductible for unlimited days per calendar year
<b>Hospice</b>	Covered in full for unlimited days per calendar year	Covered at 80% for unlimited days per calendar year
<b>Durable Medical Equipment *</b>	Covered in full	Covered at 80%, subject to the deductible
<b>Internal and External Prosthetics</b>	Covered in full	Covered at 80%, 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 in full	Covered at 80%, subject to the deductible
<b>Chiropractic</b>	\$30 copay <b>Effective 1/1/27 - \$35 copay</b>	\$40 copay <b>Effective 1/1/27 - \$45 copay</b>
<b>Acupuncture</b>	Covered in full	\$50 copay for up to 10 visits per calendar year

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<b>Dental</b>	Covered in full when related to an accidental injury to sound natural teeth when services are rendered within 365 days of the accident	\$40 copay for an office visit for accidental injury to sound natural teeth when services are rendered within 365 days of the accident. Covered at 80%, subject to the deductible for surgery and x-rays. <b>Effective 1/1/27 - \$45 copay</b>
<b>Eye Exams</b>	Diagnostic, related to disease or injury, \$30 copay per visit. No coverage for routine eye exams or refractions. <b>Effective 1/1/27 - \$35 copay</b>	Diagnostic, related to disease or injury, \$40 copay per visit. No coverage for routine eye exams or refractions. <b>Effective 1/1/27 - \$45 copay</b>
<b>Hearing (Diagnostic)</b>	Covered in full for hearing exams. Hearing aids not covered	\$40 copay for hearing exams. Hearing aids not covered. <b>Effective 1/1/27 - \$45 copay</b>
<b>Hearing (Routine)</b>	Covered in full for one hearing exam per calendar year	\$40 copay for one hearing exam per calendar year. <b>Effective 1/1/27 - \$45 copay</b>
<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.		



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