Albany Med Employee Medical Plan: 2024 PREMIER ACCESS HDHP

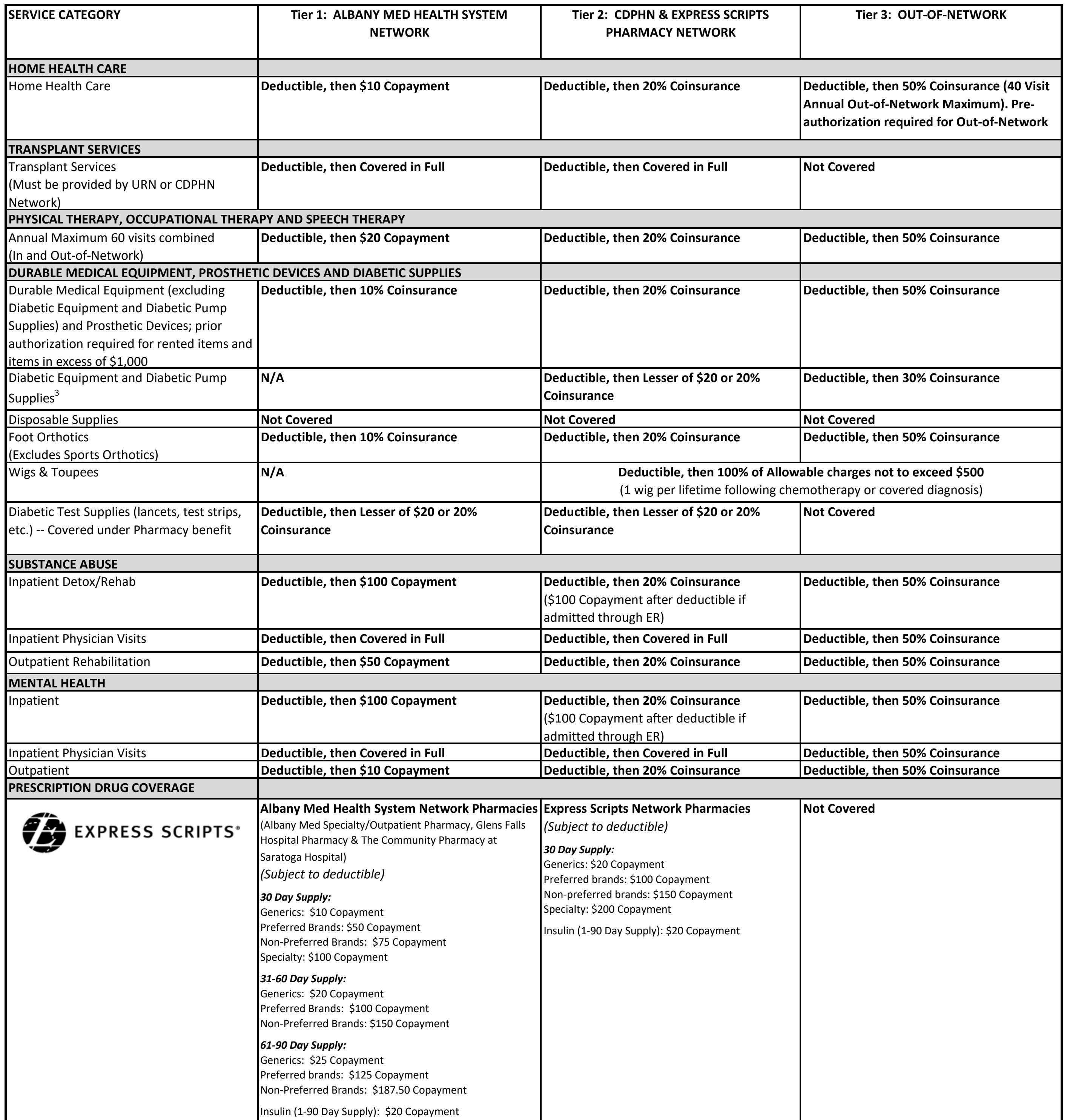
SERVICE CATEGORY	Tier 1: ALBANY MED HEALTH SYSTEM NETWORK	Tier 2: CDPHN & EXPRESS SCRIPTS PHARMACY NETWORK	Tier 3: OUT-OF-NETWORK
ANNUAL DEDUCTIBLE	*The in-network deductible applies to all covered medical and pharmacy expenses, except for certain preventive services*		
Individual	**$1,600 Combined Medical & Rx**		**$4,500**
Family[1, 2]	**$3,200 Combined Medical & Rx**		**$9,000**
OUT-OF-POCKET MAXIMUM	*Includes deductibles, coinsurance and copays*		
Individual	**$4,000 Combined Medical & Rx**		**$8,000**
Family[1, 3]	**$8,000 Combined Medical & Rx**		**$15,000**
PREVENTIVE SERVICES - *Not subject to Deductible (Please contact CDPHP for a full listing of covered Preventive Care Benefits)*			
Well Baby/Well Child Exam	**Covered in Full**	**Covered in Full**	**Not Covered**
Well Adult Annual Physical	**Covered in Full**	**Covered in Full**	**Not Covered**
Well Woman Exam	**Covered in Full**	**Covered in Full**	**Not Covered**
Routine Mammogram	**Covered in Full**	**Covered in Full**	**Not Covered**
Routine Colonoscopy	**Covered in Full**	**Covered in Full**	**Deductible, then 50% Coinsurance**
OFFICE SERVICES			
Office visits - PCP	**Deductible, then $10 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Office visits - Specialist	**Deductible, then $20 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Allergy testing	**Deductible, then $20 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Allergy Injections	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
Chiropractic Care	**Deductible, then $20 Copayment**	**Deductible, then 20% Coinsurance**	**Not Covered**
Acupuncture (15 visit limit)	**Deductible, then $20 Copayment**	**Deductible, then 20% Coinsurance**	**Not Covered**
Laboratory and X-Ray	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
High End Radiology (MRI, CAT, PET & Nuclear Medicine Scans)	**Deductible, then Covered in Full**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Hearing Testing & Evaluations (Hearing Aids Not Covered)	**Deductible, then $20 Copayment**	**Deductible, then 20% Coinsurance**	**Not Covered**
Routine Vision Exam (1 Visit every 2 Calendar Years)	**Deductible, then $20 Copayment**	**Deductible, then 20% Coinsurance**	**Not Covered**
Vision Frames	**Not Covered**	**Not Covered**	**Not Covered**
Vision Lenses (limited to post-cataract surgery corrective lenses)	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
URGENT CARE, EMERGENCY ROOM AND AMBULANCE			
Urgent Care	**Deductible, then $20 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Emergency Room	**Deductible, then $200 Copayment**	**Deductible, then $200 Copayment**	**Deductible, then $200 Copayment**
Ambulance	**N/A**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
HOSPITAL/ FACILITY SERVICES			
Inpatient Hospital	**Deductible, then $100 Copayment**	**Deductible, then 20% Coinsurance** ($100 Copayment after deductible if admitted through ER)	**Deductible, then 50% Coinsurance**
Inpatient Hospice (90-day Lifetime Max)	**N/A**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
Skilled Nursing Facility (150-day Lifetime Max)	**N/A**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Outpatient Surgery Hospital	**Deductible, then $50 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Inpatient Physician Visits	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
Outpatient Physician Services (post surgical)	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
Hospital Outpatient Cardiac Rehab	**Deductible, then $50 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Hospital Outpatient Chemotherapy	**Deductible, then $50 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Radiation Therapy, Dialysis, Infusion Therapy, Home Infusion	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
Laboratory and X-Ray	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
High End Radiology (MRI, CAT, PET & Nuclear Medicine Scans)	**Deductible, then $50 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
FAMILY PLANNING & MATERNITY			
Fertility (Basic & Advanced Services)	**Covered; Cost-share will vary based on place of service; Member lifetime limit of 3 cycles of IVF & associated services**		
Physician Services (Pre/post natal care)	**Covered in Full**	**Covered in Full**	**Deductible, then 50% Coinsurance**
Inpatient Hospital Services (For Delivery Only - all other inpatient hospital services covered as outlined under Hospital/Facility Services.)	**Deductible, then $100 Copayment**	**Deductible, then 20% coinsurance**	**Deductible, then 50% Coinsurance**
Newborn nursery	**Covered in Full**	**Covered in Full**	**Deductible, then 50% Coinsurance**

[1] Family deductible and OOP Max apply to coverage with one or more dependents

[2] You must meet the FULL family deductible before the Plan pays for any allowed services other than preventive services

[3] You must meet the FULL family OOP Maximum before the Plan pays for any allowed services at 100%

2024 Premier Access HDHP



SERVICE CATEGORY	Tier 1: ALBANY MED HEALTH SYSTEM NETWORK	Tier 2: CDPHN & EXPRESS SCRIPTS PHARMACY NETWORK	Tier 3: OUT-OF-NETWORK
HOME HEALTH CARE			
Home Health Care	**Deductible, then $10 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance (40 Visit Annual Out-of-Network Maximum). Pre-authorization required for Out-of-Network**
TRANSPLANT SERVICES			
Transplant Services (Must be provided by URN or CDPHN Network)	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Not Covered**
PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY			
Annual Maximum 60 visits combined (In and Out-of-Network)	**Deductible, then $20 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES AND DIABETIC SUPPLIES			
Durable Medical Equipment (excluding Diabetic Equipment and Diabetic Pump Supplies) and Prosthetic Devices; prior authorization required for rented items and items in excess of $1,000	**Deductible, then 10% Coinsurance**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Diabetic Equipment and Diabetic Pump Supplies[3]	**N/A**	**Deductible, then Lesser of $20 or 20% Coinsurance**	**Deductible, then 30% Coinsurance**
Disposable Supplies	**Not Covered**	**Not Covered**	**Not Covered**
Foot Orthotics (Excludes Sports Orthotics)	**Deductible, then 10% Coinsurance**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
Wigs & Toupees	**N/A**	**Deductible, then 100% of Allowable charges not to exceed $500** (1 wig per lifetime following chemotherapy or covered diagnosis)	
Diabetic Test Supplies (lancets, test strips, etc.) -- Covered under Pharmacy benefit	**Deductible, then Lesser of $20 or 20% Coinsurance**	**Deductible, then Lesser of $20 or 20% Coinsurance**	**Not Covered**
SUBSTANCE ABUSE			
Inpatient Detox/Rehab	**Deductible, then $100 Copayment**	**Deductible, then 20% Coinsurance** ($100 Copayment after deductible if admitted through ER)	**Deductible, then 50% Coinsurance**
Inpatient Physician Visits	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
Outpatient Rehabilitation	**Deductible, then $50 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
MENTAL HEALTH			
Inpatient	**Deductible, then $100 Copayment**	**Deductible, then 20% Coinsurance** ($100 Copayment after deductible if admitted through ER)	**Deductible, then 50% Coinsurance**
Inpatient Physician Visits	**Deductible, then Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 50% Coinsurance**
Outpatient	**Deductible, then $10 Copayment**	**Deductible, then 20% Coinsurance**	**Deductible, then 50% Coinsurance**
PRESCRIPTION DRUG COVERAGE			
EXPRESS SCRIPTS®	**Albany Med Health System Network Pharmacies** (Albany Med Specialty/Outpatient Pharmacy, Glens Falls Hospital Pharmacy & The Community Pharmacy at Saratoga Hospital) *(Subject to deductible)* ***30 Day Supply:*** Generics: $10 Copayment Preferred Brands: $50 Copayment Non-Preferred Brands: $75 Copayment Specialty: $100 Copayment ***31-60 Day Supply:*** Generics: $20 Copayment Preferred Brands: $100 Copayment Non-Preferred Brands: $150 Copayment ***61-90 Day Supply:*** Generics: $25 Copayment Preferred brands: $125 Copayment Non-Preferred Brands: $187.50 Copayment Insulin (1-90 Day Supply): $20 Copayment	**Express Scripts Network Pharmacies** *(Subject to deductible)* ***30 Day Supply:*** Generics: $20 Copayment Preferred brands: $100 Copayment Non-preferred brands: $150 Copayment Specialty: $200 Copayment Insulin (1-90 Day Supply): $20 Copayment	**Not Covered**

[3] Omnipod Dash and Omnipod 5 disposable insulin pump/supplies are available through the Pharmacy benefit only (subject to change)

Please refer to your Summary Plan Description for more detailed information including limitations and exclusions. In the event there is any conflict between the underlying contracts and this summary, the contracts prevail. Although Tier 1 includes primary care practices and a wide range of specialists, not all services are available within Tier 1. Albany Medical Center's medical plan does not make exceptions, and any services provided outside Tier 1, regardless of reason, are subject to the deductible and cost-sharing requirements for that Tier. The plan is subject to coordination of benefits. Visit www.CDPHP.com or call (518) 641-3100 or (877) 724-2579 from 8 a.m. to 5 p.m. EST. The TTY is (877) 261-1164. To find participating providers, go to www.CDPHP.com and click on Find-A-Doc: To identify Tier 1 providers, enter "Albany Med Health System for Albany Med employees". For Tier 2 providers, enter "POS National" (includes Tier 1 & Tier 2). To find a participating Express Scripts Network Pharmacy, go online to www.Express-Scripts.com/AlbanyMedHealthSystem or call (877) 800-4034.