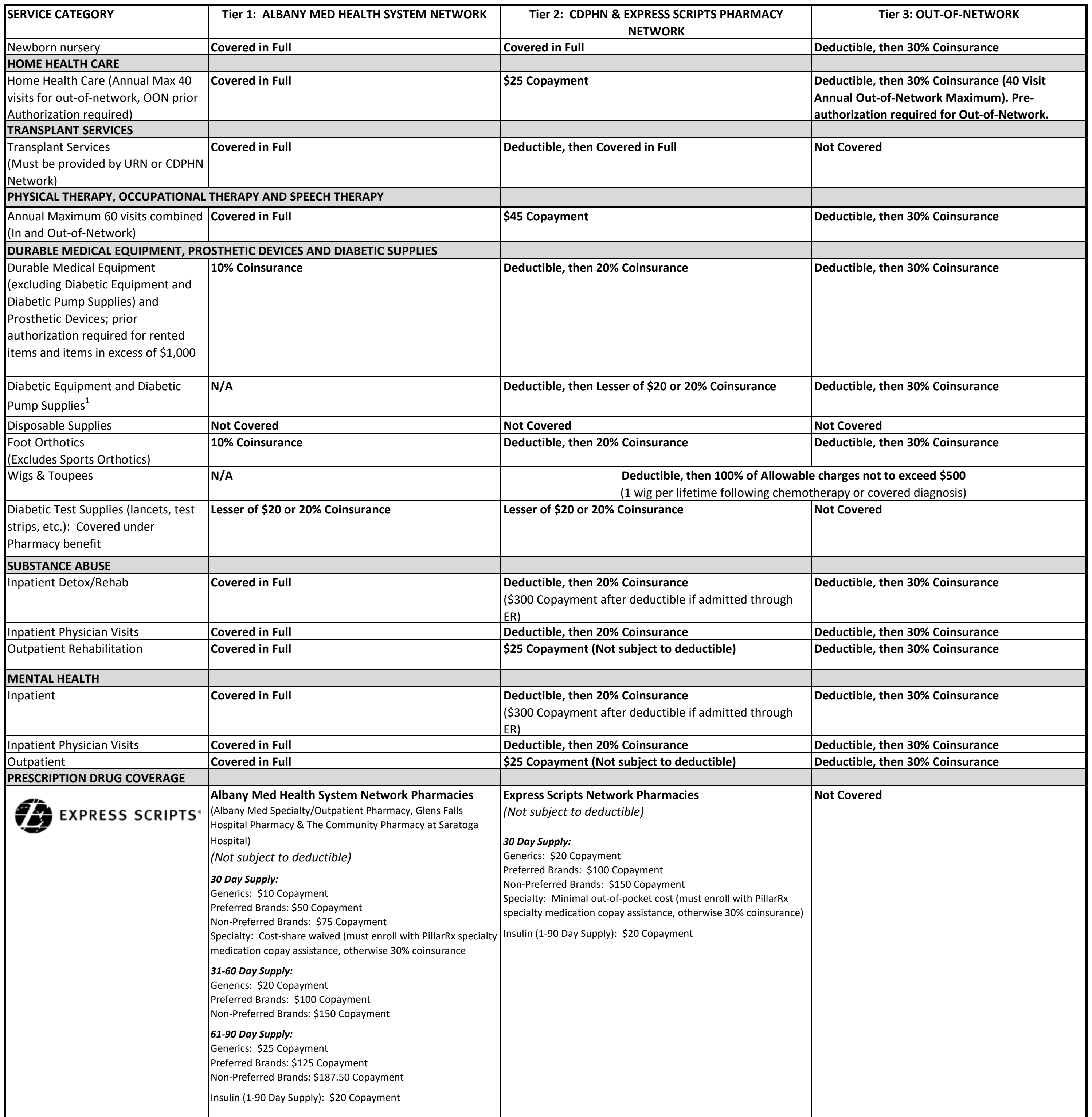
Albany Med Employee Medical Plan:
2024 PREMIER ACCESS PLAN

SERVICE CATEGORY	Tier 1: ALBANY MED HEALTH SYSTEM NETWORK	Tier 2: CDPHN & EXPRESS SCRIPTS PHARMACY NETWORK	Tier 3: OUT-OF-NETWORK
ANNUAL DEDUCTIBLE			
Individual	**$0**	**$1,000 Medical only**	**$2,000**
Family[1]	**$0**	**$2,000 Medical only**	**$4,000**
OUT-OF-POCKET MAXIMUM	*Includes deductible, copays, and coinsurance; Albany Med Health System Network and CDPHN/CVS Caremark Network OOP Maximums will cross-accumulate*		
Individual	**$1,000 Combined Medical & Rx**	**$4,000 Combined Medical & Rx**	**$8,000**
Family [1]	**$2,000 Combined Medical & Rx**	**$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 30% Coinsurance**
OFFICE SERVICES			
Office visits - PCP	**Covered in Full**	**$25 Copayment**	**Deductible, then 30% Coinsurance**
Office visits - Specialist	**Covered in Full**	**$45 Copayment**	**Deductible, then 30% Coinsurance**
Allergy Testing	**Covered in Full**	**$25 Copayment**	**Deductible, then 30% Coinsurance**
Allergy Injections	**Covered in Full**	**Covered in Full**	**Deductible, then 30% Coinsurance**
Chiropractic Care	**Covered in Full**	**$45 Copayment**	**Not Covered**
Acupuncture (15 visit limit)	**Covered in Full**	**$45 Copayment**	**Not Covered**
Laboratory and X-Ray	**Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 30% Coinsurance**
High End Radiology (MRI, CAT, PET & Nuclear Medicine Scans)	**Covered in Full**	**Deductible, then 20% Coinsurance**	**Deductible, then 30% Coinsurance**
Hearing Testing & Evaluations (Hearing Aids Not Covered)	**Covered in Full**	**$45 Copayment**	**Not Covered**
Routine Vision Exam (1 Visit every 2 Calendar Years)	**Covered in Full**	**$45 Copayment**	**Not Covered**
Vision Frames	**Not Covered**	**Not Covered**	**Not Covered**
Vision Lenses (limited to post-cataract surgery corrective lenses)	**Covered in Full**	**Covered in Full**	**Deductible, then 30% Coinsurance**
URGENT CARE, EMERGENCY ROOM			
Urgent Care	**Covered in Full**	**$75 Copayment**	**Deductible, then 30% Coinsurance**
Emergency Room	**$200 Copayment**	**$200 Copayment**	**$200 Copayment (Not subject to deductible)**
Ambulance	**N/A**	**Deductible, then $50 Copayment**	**Deductible, then 30% Coinsurance**
HOSPITAL/FACILITY SERVICES			
Inpatient Hospital	**Covered in Full**	**Deductible, then 20% Coinsurance** ($300 Copayment after deductible if admitted through ER)	**Deductible, then 30% Coinsurance**
Inpatient Hospice (90-day Lifetime Max)	**N/A**	**Deductible, then Covered in Full**	**Deductible, then 30% Coinsurance**
Skilled Nursing Facility (150-day Lifetime Max)	**N/A**	**Deductible, then 20% Coinsurance**	**Deductible, then 30% Coinsurance**
Outpatient Surgery Hospital	**Covered in Full**	**Deductible, then 20% Coinsurance**	**Deductible, then 30% Coinsurance**
Inpatient Physician Visits	**Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 30% Coinsurance**
Outpatient Physician Visits (Post Surgical)	**Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 30% Coinsurance**
Hospital Outpatient Cardiac Rehab	**Covered in Full**	**$45 Copayment**	**Deductible, then 30% Coinsurance**
Hospital Outpatient Chemotherapy	**Covered in Full**	**$25 Copayment**	**Deductible, then 30% Coinsurance**
Radiation Therapy, Dialysis, Infusion Therapy, Home Infusion	**Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 30% Coinsurance**
Laboratory and X-Ray	**Covered in Full**	**Deductible, then Covered in Full**	**Deductible, then 30% Coinsurance**
High End Radiology (MRI, CAT, PET & Nuclear Medicine Scans)	**Covered in Full**	**Deductible, then 20% Coinsurance**	**Deductible, then 30% 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 service (Pre/post natal care)	**Covered in Full**	**Covered in Full**	**Deductible, then 30% Coinsurance**
Inpatient Hospital Services (For Delivery Only - all other inpatient hospital services covered as outlined under Hospital/Facility Services.)	**Covered in Full**	**Deductible, then $600 Copayment**	**Deductible, then 30% Coinsurance**

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

2024 Premier Access Plan



SERVICE CATEGORY	Tier 1: ALBANY MED HEALTH SYSTEM NETWORK	Tier 2: CDPHN & EXPRESS SCRIPTS PHARMACY NETWORK	Tier 3: OUT-OF-NETWORK
Newborn nursery	**Covered in Full**	**Covered in Full**	**Deductible, then 30% Coinsurance**
HOME HEALTH CARE			
Home Health Care (Annual Max 40 visits for out-of-network, OON prior Authorization required)	**Covered in Full**	**$25 Copayment**	**Deductible, then 30% 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)	**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)	**Covered in Full**	**$45 Copayment**	**Deductible, then 30% 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	**10% Coinsurance**	**Deductible, then 20% Coinsurance**	**Deductible, then 30% Coinsurance**
Diabetic Equipment and Diabetic Pump Supplies[1]	**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)	**10% Coinsurance**	**Deductible, then 20% Coinsurance**	**Deductible, then 30% 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	**Lesser of $20 or 20% Coinsurance**	**Lesser of $20 or 20% Coinsurance**	**Not Covered**
SUBSTANCE ABUSE			
Inpatient Detox/Rehab	**Covered in Full**	**Deductible, then 20% Coinsurance** ($300 Copayment after deductible if admitted through ER)	**Deductible, then 30% Coinsurance**
Inpatient Physician Visits	**Covered in Full**	**Deductible, then 20% Coinsurance**	**Deductible, then 30% Coinsurance**
Outpatient Rehabilitation	**Covered in Full**	**$25 Copayment (Not subject to deductible)**	**Deductible, then 30% Coinsurance**
MENTAL HEALTH			
Inpatient	**Covered in Full**	**Deductible, then 20% Coinsurance** ($300 Copayment after deductible if admitted through ER)	**Deductible, then 30% Coinsurance**
Inpatient Physician Visits	**Covered in Full**	**Deductible, then 20% Coinsurance**	**Deductible, then 30% Coinsurance**
Outpatient	**Covered in Full**	**$25 Copayment (Not subject to deductible)**	**Deductible, then 30% 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) *(Not subject to deductible)* ***30 Day Supply:*** Generics: $10 Copayment Preferred Brands: $50 Copayment Non-Preferred Brands: $75 Copayment Specialty: Cost-share waived (must enroll with PillarRx specialty medication copay assistance, otherwise 30% coinsurance ***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** *(Not subject to deductible)* ***30 Day Supply:*** Generics: $20 Copayment Preferred Brands: $100 Copayment Non-Preferred Brands: $150 Copayment Specialty: Minimal out-of-pocket cost (must enroll with PillarRx specialty medication copay assistance, otherwise 30% coinsurance) Insulin (1-90 Day Supply): $20 Copayment	**Not Covered**

[1] 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.