2024 Saratoga County POS $25

	In-Network	Out-of-Network
Annual Deductible		
Individual Coverage	**N/A**	**$500**
Family Coverage	**N/A**	**$1,000**
Coinsurance	**N/A**	**30%**
Out-of-Pocket Maximum		
Individual Coverage	**$5,080**	**$2,500**
Family Coverage	**$12,700**	**$5,000**
Lifetime Maximum Coverage	**N/A**	**N/A**
Physician Services		
Office visits - PCP	**$25 copayment**	**Deductible then 30% coinsurance**
Office visits – Specialist	**$25 copayment**	**Deductible then 30% coinsurance**
Well baby and child care	**Covered in Full**	**Deductible then 30% coinsurance**
Well Adult exam	**Covered in Full**	**Not Covered**
Routine GYN exam	**Covered in Full**	**Deductible then 30% coinsurance**
Hospital Services		
Inpatient Hospital (semi-private room)	**Covered in Full**	**Deductible then 30% coinsurance**
Physician	**Covered in Full**	**Deductible then 30% coinsurance**
Outpatient Surgery Hospital	**Covered in Full**	**Deductible then 30% coinsurance**
Outpatient Surgery Facility	**Covered in Full**	**Deductible then 30% coinsurance**
Diagnostic Testing		
Laboratory services	**Covered in Full**	**Deductible then 30% coinsurance**
Radiology and Imaging (X-rays, MRI's)	**Covered in Full**	**Deductible then 30% coinsurance**
Maternity		
Physician services (pre/post natal care)	**$25 copayment, initial visit only**	**Deductible then 30% coinsurance**
Delivery	**Covered in Full**	**Deductible then 30% coinsurance**
Newborn nursery	**Covered in Full**	**Deductible then 30% coinsurance**
Emergency Care		
Hospital Facility	**$25 copayment (waived if admitted)**	
Ambulance	**Covered in Full**	

Benefit summary continued

	In-Network	Out-of-Network
Urgent Care	**$25 copayment**	**Deductible then 30% coinsurance**
Physical Therapy, Occupational Therapy and Speech Therapy	**$25 copayment**	**Deductible then 30% coinsurance**
	Maximum 60 aggregate visits per calendar year	
Durable Medical Equipment		
	20% Coinsurance	**Deductible then 50% coinsurance**
	Prior authorization required for items in excess of $1,000	
Prosthetic Devices	**Not Covered**	**Not Covered**
Chemical Abuse & Dependency		
Inpatient Detoxification	**Covered in Full**	**Deductible then 30% coinsurance**
Inpatient Rehabilitation	**Covered in Full**	**Deductible then 30% coinsurance**
Outpatient Rehabilitation	**Covered in Full**	**Deductible then 30% coinsurance**
Mental Health		
Inpatient	**Covered in Full**	**Deductible then 30% coinsurance**
Outpatient	**Covered in Full**	**Deductible then 30% coinsurance**
Vision		
Eye Exam *Once every 24 months	**$25 Copayment**	**Deductible then 30% coinsurance**
Glasses or Contacts *One pair of glasses or contacts every 24 months	**Standard lenses- $15 Copayment** **Lens upgrades/enhancements- $225 Allowance** **Frames: $175 Allowance** **Standard Contacts- $200 Allowance**	
Prescription Drug Coverage		
Retail	**Retail: $5 Tier 1/ $25 Tier 2/ $50 Tier 3**	
Mail Order	**Up to a 90 day supply for two (2) copayments**	

This plan is sponsored by Saratoga County and administered by Capital District Physicians' Healthcare Network, Inc. (CDPHN).

This summary is provided to highlight some specific provisions of the plan. Some restrictions may apply. This plan does not cover services that are not medically necessary, for example: cosmetic procedures, LASIK surgery. Please refer to your Summary Plan Description for more detailed information including limitations and exclusions. All benefits of the plan are subject to coordination of benefits.

While this material is believed to be accurate as of the print date, it is subject to change without notice. In case of a conflict between the plan documents and this information, the plan documents will govern.

Questions?

CDPHN can answer questions and provide information about the benefits available under this plan. Just visit the Web site at www.cdphp.com or call (518) 641-3100 or 1-877-724-2579 from 8 a.m. to 5 p.m. Eastern Standard Time. The TTY number is 711. For language assistance please call member services.