



## 2024 Saratoga County PBA POS \$30/\$40

	In-Network	Out-of-Network
<b>Annual Deductible</b>		
Individual Coverage	N/A	\$500
Family Coverage	N/A	\$1,000
<b>Coinsurance</b>		
	N/A	30%
<b>Out-of-Pocket Maximum</b>		
Individual Coverage	\$5,080	\$2,500
Family Coverage	\$12,700	\$5,000
<b>Lifetime Maximum Coverage</b>		
	N/A	N/A
<b>Physician Services</b>		
Office visits - PCP	\$30 copayment	Deductible then 30% coinsurance
Office visits – Specialist	\$40 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
<b>Hospital Services</b>		
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
<b>Diagnostic Testing</b>		
Laboratory services	Covered in Full	Deductible then 30% coinsurance
Radiology and Imaging (X-rays, MRI's)	Covered in Full	Deductible then 30% coinsurance
<b>Maternity</b>		
Physician services (pre/post natal care)	\$40 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

Benefit Summary Continued

	In-Network	Out-of-Network
<b>Emergency Care</b>		
Hospital Facility	\$250 copayment ( waived if admitted)	
Ambulance	Covered in Full	
<b>Urgent Care</b>	\$25 copayment	Deductible then 30% coinsurance
<b>Physical Therapy, Occupational Therapy and Speech Therapy</b>	\$25 copayment	Deductible then 30% coinsurance
Maximum 60 aggregate visits per calendar year		
<b>Durable Medical Equipment</b>		
	20% Coinsurance	Deductible then 50% coinsurance
Prior authorization required for items in excess of \$1,000		
<b>Prosthetic Devices</b>	20% Coinsurance	Deductible then 50% coinsurance
<b>Chemical Abuse &amp; Dependency</b>		
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
<b>Mental Health</b>		
Inpatient*	Covered in Full	Deductible then 30% coinsurance
Outpatient	Covered in Full	Deductible then 30% coinsurance
<b>Vision</b>		
Eye Exam *Once every 24 months	\$40 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	
<b>Prescription Drug Coverage</b>		
Retail	Retail: \$10 Tier 1/\$40 Tier 2/ \$60 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](http://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.