capcare
Program Manager

AMALGAMATED LOCAL 426
MEMBER BENEFIT PROGRAM OPTIONS

CAPCARE OPTION	Plan Option 1	Plan Option 2	Plan Option 3	Plan Option 4	Plan Option 5
PLAN NAME	Local 426 Fund 1 Base Plan	Local 426 Health Benefit Fund Bronze Plan	Local 426 Fund 1 Blue Liberty 1500 Plan	Local 426 Fund 1 Liberty Plan	Local 426 Health Benefit Fund Gold Plan
CONTRACTED NETWORK	National PPO Network	National PPO Network	National PPO Network	National PPO Network	National PPO Network
IN - NETWORK BENEFITS	**IN - NETWORK**	**IN - NETWORK**	**IN - NETWORK**	**IN - NETWORK**	**IN - NETWORK**
Deductible	$3,000/$6,000	None	$1,500/$3,000	None	None
Coinsurance	50% / 50%	60% / 40%	100%	100%	80% / 20%
Maximum Out of Pocket	$5,350/$10,700	$7,350/$14,700	$5,350/$10,700	$5,350/$10,700	$7,350/$14,700
Physician/Specialist Copay	Ded then 50% coinsurance	40% coinsurance	Ded then $30 PCP/ $50 Specialist copay	$30 PCP/$50 Specialist copay	20% coinsurance, subject to $10 copay
Inpatient Hospital Services	Ded then 50% coinsurance	40% coinsurance	Ded. Then $500/Day - Max $1,000 copay then 100%	$500/Day - Max $1,000 copay then 100%	20% coinsurance
Outpatient Hospital Services	Ded then 50% coinsurance	40% coinsurance	Ded. Then $150 copay then 100%	$150 copay then 100%	20% coinsurance
Diagnostic Laboratory (Office)	Ded then 50% coinsurance	40% coinsurance	Ded. Then $75 copay then 100%	$75 copay	20% coinsurance
Diagnostic X-ray (Office)	Ded then 50% coinsurance	40% coinsurance	Ded. Then $75 copay then 100%	$75 copay	20% coinsurance
Emergency Room (Accident & Illness)	Ded then 50% coinsurance	40% coinsurance	Ded. Then $150 copay then 100%	$150 copay then 100%	20% coinsurance, subject to $35 copay
Urgent Care	Ded then 50% coinsurance	40% coinsurance	Ded. Then $30 copay then 100%	$30 copay then 100%	20% coinsurance, subject to $10 copay
OUT - OF - NETWORK BENEFITS	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**
Deductible	Not Covered	Not Covered	Not Covered	Not Covered	$200/$500
Coinsurance	Not Covered	Not Covered	Not Covered	Not Covered	60% / 40%
Maximum Out of Pocket	Not Covered	Not Covered	Not Covered	Not Covered	Not Applicable
PRESCRIPTION BENEFITS	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**
Deductible	None	None	$100/$300	$100/$300	None
Retail (Broadreach Medical Resources)	$10/$35/$70 (Max 30 days)	40% coinsurance (30 days)	$15/$35/$75 (Max 30 days)	$15/$35/$75 (Max 30 days)	$10/$20/$20 (30 days)
Mail Order (Affordable Pharmacy)	$25/$87.50/$175 (Max 60 Days)	40% coinsurance (31 to 90 Days)	$30/$70/$150 (Max 60 Days)	$30/$70/$150 (Max 60 Days)	$10/$20/$20 (31 to 90 Days)
Specialty Medications (Payer Matrix)	Not Covered (1)	Not Covered (1)	Not Covered (1)	Not Covered (1)	Not Covered (1)
Maximum Out of Pocket	$1,000/$2000	$3,000/$6,000 (2)	$1,000/$2000	$1,000/$2000	$3,000/$6,000 (2)

To receive additional information on the Member Benefits Program

Contact: Member Benefits Representative | capcareenrollment@concordmgt.com or 833-287-4765