Amalgamated Local 426 Health and Welfare Fund | Powered By capcare

CDA | In partnership with ASSOCIATION OF UNITED MEMBERS

Member Benefit Program Plan and Rate Options Through 12/31/2027

PLAN OPTION	Option 1	Option 2	Option 3	Option 4	Option 5
PLAN NAME	Local 426 - Base Plan	Local 426 - Bronze 4000 Plan	Local 426 - Bronze Plan	Local 426 - Silver 2500 Plan	Local 426 - Liberty 1500 Plan
CONTRACTED FEE SCHEDULE	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 (Individual/Family)	$3,000 / $6,000	$4,000/$10,000	None	$2,500/$7,500	$1,500/$3,000
Coinsurance (Plan Pays/Member Pays)	50% / 50%	80% / 20%	60% / 40%	80% / 20%	Plan Pays 100% after Ded/Copays
Max Out of Pocket (individual/Family)	$5,350/$10,700	$9,100/$18,200	$7,350/$14,700	$9,100/$18,200	$5,350/$10,700
Physician/Specialist Copay	Ded then 50% coinsurance	$45 PCP& Specialist copay - Ded does not apply	40% coinsurance	$30 PCP& Specialist copay - Ded does not apply	Ded then $30 PCP/ $50 Specialist copay
Preventative Care & Services	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Inpatient Hospital Services	Ded then 50% coinsurance	Ded then 20% coinsurance	40% coinsurance	Ded then 20% coinsurance	Ded. Then $500/Day - Max $1,000 copay then 100%
Outpatient Hospital Services	Ded then 50% coinsurance	Ded then 20% coinsurance	40% coinsurance	Ded then 20% coinsurance	Ded. Then $150 copay then 100%
Outpatient Mental Health Services	Not Covered	$45 copay - Ded does not apply	40% coinsurance	$30 copay - Ded does not apply	$30 copay
Diagnostic Laboratory (Office)	Ded then 50% coinsurance	Ded then $30 copay	40% coinsurance	Ded then $30 copay	Ded. then $20 copay/Physicians Office $75 copay/Outpatient Hospital then 100%
Diagnostic X-ray/Imaging (Office)	Ded then 50% coinsurance	Ded then 20% coinsurance	40% coinsurance	Ded then 20% coinsurance	Ded. then $50 copay/CT Scan $75 copay/MRI or PET then 100%
Emergency Room (Accident & Illness)	Ded then 50% coinsurance	$350 copay - Ded does not apply	40% coinsurance	$200 copay - Ded does not apply	Ded. Then $150 copay then 100%
Urgent Care	Ded then 50% coinsurance	$45 copay/office visit - Ded does not apply	40% coinsurance	$30 copay /office visit - Ded does not apply	Ded. Then $30 copay then 100%
OUT - OF - NETWORK BENEFITS	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**
Deductible (Individual/Family)	Not Covered	$5,000/$15,000	Not Covered	$5,000/$15,000	Not Covered
Coinsurance (Plan Pays/Member Pays)	Not Covered	50% /50%	Not Covered	50% /50%	Not Covered
Max Out of Pocket (individual/Family)	Not Covered	$13,500/$36,000	Not Covered	$13,500/$36,000	Not Covered
PRESCRIPTION BENEFITS	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**
Deductible (Individual/Family)	None	None	None	None	$100/$300
Retail (HarmonyRx)	$10/$35/$70 (Max 30 days)	$10/$50/$75 (Max 30 days)	40% coinsurance (30 days)	$10/$50/$100 (Max 30 days)	$15/$35/$75 (Max 30 days)
Mail Order (Affordable Pharmacy)	$25/$87.50/$175 (Max 60 Days)	$25/$87/$175 (31 to 90 Days)	40% coinsurance (31 to 90 Days)	$20/$100/$200 (31 to 90 Days)	$30/$70/$150 (Max 60 Days)
Specialty Medication	Not Covered (1)	Not Covered (1)	Not Covered (1)	Not Covered (1)	Not Covered (1)
Specialty Medication Patient Assistance Program Vendor	HealthCare Advantage 1-888-623-5120	HealthCare Advantage 1-888-623-5120	HealthCare Advantage 1-888-623-5120	HealthCare Advantage 1-888-623-5120	HealthCare Advantage 1-888-623-5120
Max Out of Pocket (individual/Family)	$1,000/$2000	None	$3,000/$6,000 (2)	None	$1,000/$2000

Total Billed Monthly Rates	Option 1	Option 2	Option 3	Option 4	Option 5
Rates Effective 1/1/2027 through 12/31/2027	Local 426 - Base Plan	Local 426 - Bronze 4000 Plan	Local 426 - Bronze Plan	Local 426 - Silver 2500 Plan	Local 426 - Liberty 1500 Plan
Employee Rate	$920.00	$1,052.00	$1,070.00	$1,176.00	$1,198.00
Employee & Child Rate	$1,514.00	$1,615.00	$1,782.00	$1,692.00	$1,933.00
Employee & Spouse Rate	$1,801.00	$2,161.00	$2,078.00	$2,198.00	$2,380.00
Employee & Family Rate	$2,266.00	$2,522.00	$2,519.00	$2,686.00	$2,894.00

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Member Benefit Program Plan and Rate Options Through 12/31/2027

PLAN OPTION	Option 6	Option 7	Option 8	Option 9	Option 10
PLAN NAME	Local 426 - Gold 1000 Plan	Local 426 - Liberty Plan	Local 426 - Gold Plan	Local 426 - ASO Plan	Local 426 - HSA Plan
CONTRACTED FEE SCHEDULE	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 (Individual/Family)	$1,000/$2,000	None	None	None	$7,700 / $15,400
Coinsurance (Plan Pays/Member Pays)	80% / 20%	Plan Pays 100% after copays	80% / 20%	100%	70% /30%
Max Out of Pocket (individual/Family)	$9,100/$18,200	$5,350/$10,700	$7,350/$14,700	None	$8,700/$17,400 (combined with prescription)
Physician/Specialist Copay	$40 PCP/ $40 Specialist copay - Ded does not apply	$30 PCP/$50 Specialist copay	$10 copay/office visit and 20% coinsurance	$25 PCP/$25 Specialist copay	Ded then 30% coinsurance
Preventative Care & Services	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	$10 Child / $25 Adult Preventative Services	Plan Pays 100%
Inpatient Hospital Services	Ded then 20% coinsurance	$500/Day - Max $1,000 copay then 100%	20% coinsurance	$250 copay/stay	Ded then 30% coinsurance
Outpatient Hospital Services	Ded then 20% coinsurance	$150 copay then 100%	$10 copay/office visit and 20% coinsurance	$100 copay	Ded then 30% coinsurance
Outpatient Mental Health Services	$40 copay/office visit - Ded does not apply	$30 copay	$10 copay/office visit and 20% coinsurance	$25 copay	Not Covered
Diagnostic Laboratory (Office)	Ded then 20% coinsurance	$20 copay/Physicians Office $75 copay/Outpatient Hospital then 100%	20% coinsurance	$10 copay/Physicians Office $100 copay/ Hospital	Ded then 30% coinsurance
Diagnostic X-ray/Imaging (Office)	Ded then 20% coinsurance	$75 copay	20% coinsurance	$50 copay/ Physicians Office $100 copay/Hospital	Ded then 30% coinsurance
Emergency Room (Accident & Illness)	$350 copay - Ded does not apply	$150 copay then 100%	$35 copay/visit and 20% coinsurance	$100 copay	Ded then 30% coinsurance
Urgent Care	$40 copay/office visit - Ded does not apply	$30 copay then 100%	$10 copay/office visit and 20% coinsurance	$25 copay	Ded then 30% coinsurance
OUT - OF - NETWORK BENEFITS	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**	**OUT - OF - NETWORK**
Deductible (Individual/Family)	$7,500/$15,000	Not Covered	$200/$500	$1,500/$3,750	Not Covered
Coinsurance (Plan Pays/Member Pays)	50% /50%	Not Covered	60% / 40%	70% / 30%	Not Covered
Max Out of Pocket (individual/Family)	$15,000/$30,000	Not Covered	Not Applicable	Not Applicable	Not Covered
PRESCRIPTION BENEFITS	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**	**PRESCRIPTION BENEFITS**
Deductible (Individual/Family)	None	$100/$300	None	None	$1,000 / $2,000
Retail (HarmonyRx)	$10/$35/$75 (Max 30 days)	$15/$35/$75 (Max 30 days)	$10/$20/$20 (30 days)	$10/$35/$45 (Max 30 days)	Ded then $10/$35/$70 (Max 30 days)
Mail Order (Affordable Pharmacy)	$25/$87/$175 (31 to 90 Days)	$30/$70/$150 (Max 60 Days)	$10/$20/$20 (31 to 90 Days)	$20/$70/$90 (Max 60 Days)	Ded then $25/$87.50/$175 (Max 60 Days)
Specialty Medication	Not Covered (1)	Not Covered (1)	Not Covered (1)	Not Covered (1)	Not Covered (1)
Specialty Medication Patient Assistance Program Vendor	HealthCare Advantage 1-888-623-5120	HealthCare Advantage 1-888-623-5120	HealthCare Advantage 1-888-623-5120	HealthCare Advantage 1-888-623-5120	HealthCare Advantage 1-888-623-5120
Max Out of Pocket (individual/Family)	None	$1,000/$2000	$3,000/$6,000 (2)	None	$8,700/$17,400 (combined with medical)

Total Billed Monthly Rates	Option 6	Option 7	Option 8	Option 9	Option 10
Rates Effective 1/1/2027 through 12/31/2027	Local 426 - Gold 1000 Plan	Local 426 - Liberty Plan	Local 426 - Gold Plan	Local 426 - ASO Plan	Local 426 - HSA Plan
Employee Rate	$1,301.00	$1,318.00	$1,415.00	$1,501.00	$879.00
Employee & Child Rate	$1,935.00	$2,235.00	$2,502.00	$2,652.00	$1,415.00
Employee & Spouse Rate	$2,521.00	$2,689.00	$2,796.00	$2,941.00	$1,740.00
Employee & Family Rate	$3,156.00	$3,239.00	$3,259.00	$3,548.00	$2,217.00