Highmark Benefit Comparison Effective 10/1/2021
Cement Masons' Local 526 Welfare Fund Monthly Rates w/ $10 admin fee

	084067-00/70	084067-10/80	084067-01/71	084067-11/81	084067-02/72	084067-12/82
	High Option Community Blue (Highmark Only)	**High Option PPO Blue (Highmark & UPMC)**	**Base Option Community Blue (Highmark Only)**	**Base Option PPO Blue (Highmark & UPMC)**	**Alternate Option Community Blue (Highmark Only)**	**Alternate Option PPO Blue (Highmark &UPMC)**
Deductible (Single/Family)	$250/$500	$250/$500	$750/$1,500	$750/$1,500	$1,500/$3,000	$1,500/$3,000
Coinsurance	100%	100%	90% after deductible	90% after deductible	90% after deductible	90% after deductible
Out-of-Pocket Maximum Single/2+	$500/$1,000	$500/$1,000	$1,500/$3,000	$1,500/$3,000	$3,000/$6,000	$3,000/$6,000
Total Out of Pocket Max	$6,350/$12,700	$6,350/$12,700	$2,750/$5,500	$2,750/$5,500	$5,000/$10,000	$5,000/$10,000
Office Visit Copay	$20	$20	$20	$20	$20	$20
Specialist Copay	$20	$20	$20	$20	$20	$20
eVisit	$20	$20	$20	$20	$20	$20
Urgent Care	$20	$20	$20	$20	$20	$20
Preventive Care	100%	100%	100%	100%	100%	100%
Rx Drug (Generic/Preferred Brand /Non-PreferredBrand)	$15/$25/$40	$15/$25/$40	$15/$25/$40	$15/$25/$40	$15/$25/$40	$15/$25/$40
Mail Order (90 day supply)	$30/$50/$80	$30/$50/$80	$30/$50/$80	$30/$50/$80	$30/$50/$80	$30/$50/$80
Hospital -In Patient	100%	100%	90% after deductible	90% after deductible	90% after Deductible	90% after Deductible
Hospital - Out Patient	100%	100%	90% after deductible	90% after deductible	90% after Deductible	90% after Deductible
X-Ray/Lab Work	100%	100%	90% after deductible	90% after deductible	90% after Deductible	90% after Deductible
Emergency Room	100% after $75 Copay (Waived if admitted)	100% after $75 Copay (Waived if admitted)	100% after $75 Copay (Waived if admitted)	100% after $75 Copay (Waived if admitted)	100% after $75 Copay (Waived if admitted)	100% after $75 Copay (Waived if admitted)
Out-of Network Deductible (S/F) Coinsurance	$500/$1,000 70%	$500/$1,000 70%	$1,500/$3,000 70% after deductible	$1,500/$3,000 70% after deductible	$3,000/$6,000 70% after deductible	$3,000/$6,000 70% after deductible
Rates	**Monthly Cost**	**Monthly Cost**	**Monthly Cost**	**Monthly Cost**	**Monthly Cost**	**Monthly Cost**
Employee	**$647.56**	**$684.64**	**$585.23**	**$618.54**	**$538.66**	**$569.20**
Employee/Child(ren)	**$1,543.95**	**$1,633.16**	**$1,393.99**	**$1,474.14**	**$1,281.94**	**$1,355.41**
Employee/Spouse	**$1,727.56**	**$1,827.46**	**$1,559.65**	**$1,649.40**	**$1,434.19**	**$1,516.46**
Family	**$1,982.58**	**$2,097.31**	**$1,789.74**	**$1,892.81**	**$1,645.65**	**$1,740.13**

084067-90 Blue Edge Dental Rates	
Employee	$29.89
Employee + 1 dependent	$75.78
Family	$96.29

084067-91 Blue Edge Vision Rates	
Employee	$6.56
Employee/Child(ren)	$9.95
Employee/Spouse	$9.95
Family	$17.49