Check one:

HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT

☐ Highmark w/UPMC PPO BLUE ☐ Highmark Only Performance Blue PPO

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

EMPLOYEE INFORMATION — Employee must complete items 1 through 17 and sign.

1) Employer Name		Reason for Application ☐ New Hire ☐ Rehire ☐ Act 4 ☐ Other:	☐ Enrollment ☐ COBRA
2) Employee First Name / Middle Initial / Last Name			
3) Street Address	4) City	5) State	6) Zip
7) Social Security Number	8) Effective Date of Coverage Month / Day / Year	9) Employee Status ☐ Active ☐ Retired (Date)	☐ Hourly ☐ Salary
10) Employee Phone #—Home ( )	11) Employee Phone #—Work ( )	12) Employee Hire Date Month / Day / Year	

13) Check Type of Coverage	MEDICAL	DENTAL	VISION	DRUG
Employee Only	☐	☐	☐	☐
Insured & Spouse/Domestic Partner	☐	☐	☐	☐
Family	☐	☐	☐	☐
Parent & Child	☐	☐	☐	☐
Parent & Children	☐	☐	☐	☐

14) **To be completed by Account Administrator only**

Group Number	Report Code Qualifier	Report Code Value

Complete items 15 through 18 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)			Do you have other insurance?	Birth Date Mo	Dy	Yr	Sex F/M	Check If: Student Benefits Apply	Dis-abled	Act 4
15) Self	First Name / Middle Initial / Last Name	Social Security Number	☐ Yes ☐ No If YES, then complete #19							
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Are you an Established Patient? ☐ Yes ☐ No							
16) ☐ Spouse ☐ Dom. Part.*	First Name / Middle Initial / Last Name	Social Security Number	☐ Yes ☐ No If YES, then complete #19							
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Is Spouse/DP an Established Patient? ☐ Yes ☐ No							
17) ☐ Child ☐ Other*	First Name / Middle Initial / Last Name	Social Security Number	☐ Yes ☐ No If YES, then complete #19							
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Is Dependent an Established Patient? ☐ Yes ☐ No							
18) ☐ Child ☐ Other*	First Name / Middle Initial / Last Name	Social Security Number	☐ Yes ☐ No If YES, then complete #19							
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory		c) Is Dependent an Established Patient? ☐ Yes ☐ No							

***If "domestic partner" or "other" applies, complete using one of the following codes: (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner**

19) If you checked YES to other insurance, fill in appropriate line:

Name of Insurance Carrier: ____________

Group No: ____________ Effective Date: ____________

Name of Policy Holder: ____________

Policy Number: ____________

Relationship to Highmark Policy Holder: ____________

Policy Holder Date of Birth: ____________

Policy Holder Employment Status: ☐ Active ☐ Retired (Date) ____________

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare? ☐ Age ☐ Disability ☐ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ☐ Yes ☐ No

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Health Services may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Health Services' Notice of Privacy Practices is available on Highmark Health Services' Web site, or from the Highmark Health Services Privacy Office.

20) ____________________ Authorized Employer Signature Date

21) ____________________ Employee Signature Date

Health Plan Copy

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association

JD-7 (R4-15)

Benefit Comparison Effective 10/1/2023
Cement Masons' Local 526 Welfare Fund Monthly Rates for Highmark and Nonstop Health Total Premium

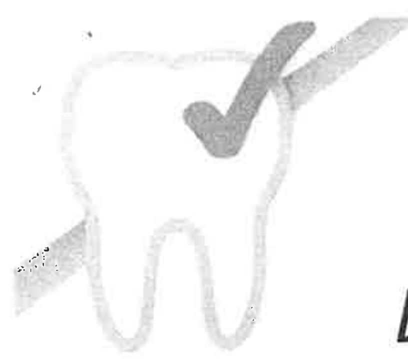
	Highmark W/ UPMC	Highmark Only
	PPO Blue $9,100	Performance Blue $9,100
Deductible (Single/Family)	$9,100/$18,200	$9,100/$18,200
Coinsurance	100%	100%
Out-of-Pocket Maximum Single/2+	Not Applicable	Not Applicable
Total Out of Pocket Max	$9,100/$18,200	$9,100/$18,200
Office Visit Copay	$20	$20
Specialist Copay	$20	$20
eVisit	$20	$20
Urgent Care	$20	$20
Preventive Care	100%	100%
Rx Drug (Generic/Preferred Brand /Non-PreferredBrand)	$15/$25/$40	$15/$25/$40
Mail Order (90 day supply)	$30/$50/$80	$30/$50/$80
Hospital -In Patient	100% after deductible	100% after deductible
Hospital - Out Patient	100% after deductible	100% after deductible
X-Ray/Lab Work	100% after deductible	100% after deductible
Emergency Room	100% after $100 Copay (Waived if admitted)	100% after $100 Copay (Waived if admitted)
Out-of Network Deductible (S/F) Coinsurance	$18,200/$36,400 70% after deductible	$18,200/$36,400 70% after deductible
Rates	**Monthly Cost**	**Monthly Cost**
Employee	**$ 710.00**	**$ 630.00**
Employee/Child(ren)	**$ 1,590.00**	**$ 1,395.00**
Employee/Spouse	**$ 1,740.00**	**$ 1,525.00**
Family	**$ 2,140.00**	**$ 1,875.00**

Blue Edge Dental-084067-90

Employee	$26.10
Emp+1	$66.17
Family	$84.08

Blue Edge Vision-084067-91

Employee	$6.56
Employee &children	$9.95
Employee & spouse	$9.95
Family	$17.49



Monthly Cost	
Employee	$26.10
Emp+1	$66.17
Family	$84.08

2023

Effective Date: 10/01/2023
Benefit Year: Calendar Year

Summary of Benefits: *Blue Edge Dental Preferred*

Blue Edge Dental Preferred plan options provide you maximum cost savings. Benefits are increased when participating dentists are utilized. The listed percentages represent the portion of the maximum allowable charge (MAC) for which the plan is responsible. Network providers agree to accept the MAC as payment in full and agree to file your claims. ***If you receive covered services from an out-of-network provider, the plan will apply the percentages shown to the MAC for covered services and you will be responsible for the difference, up to the provider's charge****. Standard deductibles, exclusions and limitations apply. Network dentists may elect to discount non-covered services and services above the annual maximum. Discounts vary by service and region and when agreed to by the provider; not permitted in all jurisdictions.*

Cement Masons Local 526 - Blue Edge Dental Preferred 10W (No Ortho) - NS # 084067-90		
	In-Network	**Out-of-Network**
Network	Advantage Plus	MAC
Deductible – Individual/Family (waived for In-network Class I services)	$0	$50 / $150
Benefit Period Maximum per member	$1,000	
Class I Services		
Exams	100%	100%
X-rays	100%	100%
Cleanings	100%	100%
Fluoride Treatment	100%	100%
Sealants	100%	100%
Space Maintainers	100%	100%
Palliative Treatment (Emergency)	100%	100%
Class II Services		
Basic Restorative (Fillings), Posterior Resins	100%	80%
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	100%	80%
Periodontics (Surgical and Nonsurgical)	100%	80%
Oral Surgery (including Simple and Surgical Extractions)	100%	80%
General Anesthesia	100%	80%
Endodontics	100%	80%
Class III Services		
Inlays, Onlays, Crowns	60%	50%
Prosthetics (Bridges, Dentures)	60%	50%
Orthodontics (dependents to age 19)		
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered
Orthodontic Lifetime Maximum per covered dependent	Not Applicable	
Implants		
Implant Surgery, Supported Restoration	60%	50%

Additional Features

- ☐ TMD/TMJ*
- ☒ Annual Maximum Rollover*
- ☐ Occlusal Guard*
- ☒ Smile for Health®--Wellness
- ☒ College Tuition Benefit
- ☒ Pregnancy
- ☐ Preventive Incentive*

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association. United Concordia is a separate company that administers Highmark dental benefits.

Smile for Health–Wellness is a registered service mark of United Concordia Companies, Inc.

*These features are for Large Group only. Additional fees may apply.

Summary of Limitations:
Blue Edge Dental

This is an abbreviated list of Highmark's Standard Limitations.
Please refer to your specific benefit design as to what services are covered.

Blue Edge Dental

Benefit Category	Highmark's Standard Frequency Limitations
Exams	2 every 12 months
X-rays (Bitewings Only)	1 set every 12 months under age 19 and one set every 18 months age 19 and over
X-rays (All Others)	1 every 5 years for Full Mouth and Panoramic X-rays Limitations may apply to other types of X-rays
Cleanings; Fluoride Treatment	2 every 12 months; 1 every 12 months under age 14
Sealants	1 per tooth every 3 years to age 16 on permanent first and second molars
Space Maintainers	1 every 5 years under age 14
Palliative Treatment (Emergency)	2 per 12 months in combination with pulpal debridement
Basic Restorative	Not within 24 months of previous placement. Includes coverage for posterior resins
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	1 per 36 months
Simple Extractions	Any frequency (no limitations)
General Anesthesia	Limited to 60 minutes per session
Endodontics	Pulpal therapy: primary teeth that have no permanent tooth to replace it Root canal treatment: 1 per tooth per lifetime
Periodontics (Nonsurgical)	Full mouth debridement: 1 per lifetime Scaling and root planing: 1 per 36 months (per area of mouth) Periodontal maintenance: 2 every 12 months (in addition to routine prophylaxis following active periodontal therapy)
Periodontics (Surgical)	Surgical periodontal procedures: 1 per 36 months (per area of mouth) Guided tissue regeneration: 1 per tooth per lifetime
Complex Oral Surgery	May vary by procedure
Inlays, Onlays, Crowns	Not within 5 years of previous placement
Prosthetics (Bridges, Dentures)	Not within 5 years of previous placement
Orthodontics (dependents to age 19) Diagnostic, Active, Retention Treatment	Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company.
Alternative Benefit Provision	An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
Smile for Health®--Wellness *Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis and stroke*	• Covers 1 additional periodontal maintenance per year and all are covered at 100% • Scaling and root planing are covered at 100% • 4 periodontal surgery procedures are covered at 100%
Pregnancy Benefit	• Covers 1 additional cleaning during pregnancy • Covers 1 additional periodontal maintenance • Scaling and root planing • 4 periodontal surgery procedures
Preventive Incentive	Class I services do not count toward your annual program maximum
Annual Maximum Rollover	Members can roll over $300 of unused benefit dollars to the following plan year
College Tuition Benefit	• Earn Tuition Rewards® points redeemable for tuition discounts • Receive 2,000 points/year • Each child enrolled receives a one-time bonus of 500 Tuition Rewards points • One Tuition Rewards point = $1 reduction in full tuition • Use Tuition Rewards points at participating private colleges and universities
Occlusal Guard	• 1 per 60 months for members 22 years and older after a 6 month waiting period • Covered at 50% • $1,000 Lifetime maximum

Cement Masons Local 526 – Blue Edge Vision – Designer Value Customized

Effective 10/1/2023
Group # 084067-91

Monthly Cost			
Employee	$6.56	Employee & Children	$9.95
Family	$17.49	Employee & Spouse	$9.95

In-Network Benefits – Voluntary		Designer Value
Frequency – Once Every:		
Eye Examination (including dilation when professionally indicated)		12 months
Spectacle Lenses		12 months
Frame		24 months
Contact Lenses (in lieu of eyeglass lenses)		12 months
Copayments		
Eye Examination		$0
Spectacle Lenses		$20
Contact Lens Evaluation, Fitting & Follow-Up Care		n/a
Eyeglass Benefit - Frame	**Average Retail Value**	
Non-Collection Frame Allowance (Retail):	Up to $135	Up to $120
Enhanced Visionworks Frame Allowance/1		Up to $170
Davis Vision Frame Collection/2 (in lieu of Allowance):		
- Fashion level	Up to $125	Included
- Designer level	Up to $175	Included
- Premier level	Up to $225	$25
Eyeglass Benefit - Spectacle Lenses	**Average Retail Value**	**Member Charges**
Lenses: Single | Lined Bifocal | Trifocal | Lenticular	$60-$120	Included
Oversize Lenses	$20	Included
Tinting of Plastic Lenses	$20	$0
Scratch-Resistant Coating	$25-$40	Included
Scratch Protection Plan: Single Vision | Multifocal Lenses	$60 - $120	$20 | $40
Polycarbonate Lenses/3	$60-$75	$0 or $30
Ultraviolet Coating	$25-$30	$12
Anti-Reflective Coating: Standard | Premium | Ultra | Ultimate	$50-$70	$35 | $48 | $60 | $85
Progressive Lenses: Standard | Premium | Ultra | Ultimate	$150-$300	$50 | $90 | $140 | $175
High-Index Lenses: 1.67 | 1.74	$90-$150	$55 | $120
Polarized Lenses	$95-$110	$75
Plastic Photosensitive Lenses	$95-$150	$65
Blue Light Filtering	$25	$15
Contact Lens Benefit (in lieu of eyeglasses)		
Non-Collection Contact Lenses: Materials Allowance		Up to $120
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types		Included
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types		Up to $60
Collection Contact Lenses/2 (in lieu of Allowance): Materials		
- Disposable		4 boxes
- Planned Replacement		2 boxes
- Evaluation, Fitting & Follow-Up Care		Included

Out-of-Network Reimbursement Schedule: up to			
Eye Examination: $46	Single Vision Lenses: $47	Trifocal Lenses: $85	Elective Contact Lenses: $105
Frame: $47	Bifocal/Progressive Lenses: $66	Lenticular Lenses: $125	Medically Necessary CL: $225

/1Increased frame allowance is only available when frame is purchased through a Visionworks location.
/2Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.
/3Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included