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Medical Plans: Blue Cross Blue Shield - PPO Value Plus , PPO Value, and Consumer Directed Health Plan (CDHP)

Coverage	Blue Cross Blue Shield PPO Value Plus Plan 2018		Blue Cross Blue Shield PPO Value Plus Plan 2019	
	In-Network Ind/Fam	Out-of-Network Ind/Fam	In-Network Ind/Fam	Out-of-Network Ind/Fam
Maxim HSA Contribution	N/A		N/A	
Deductible	$250/$750	$500/$1,500	$250/$750	$500/$1,500
Co-Insurance	10%	40%	10%	40%
Out-of-Pocket Max Medical	$2,000/$6,000	$6,000/$19,000	$2,500/$7,500	$7,000/$21,000
Out-of-Pocket Max Pharmacy	$500/$1,000	N/A	$500/$1,000	N/A
Preventative Care	Covered 100%, no deductible	40% after deductible	Covered 100%, no deductible	40% after deductible
Primary Physician Visit	$20 co-pay	40% after deductible	$20 co-pay	40% after deductible
Specialty Physician Visit	$40 co-pay	40% after deductible	$40 co-pay	40% after deductible

Employee Premiums	Blue Cross Blue Shield PPO Value Plus Plan	
	Your Bi-weekly Payroll Deductions	
	2018	2019
Employee Only	$ 51.03	$ 54.60
Employee + Spouse/Domestic Partner	$ 117.22	$ 125.41
Employee + Spouse/Domestic Partner (+ surcharge)	$ 167.22	$ 175.41
Employee + Child(ren)	$ 103.42	$ 110.65
Employee + Family	$ 166.86	$ 178.52
Employee + Family (+ Surcharge)	$ 216.86	$ 228.52

Coverage	Blue Cross Blue Shield PPO Value Plan 2018		Blue Cross Blue Shield PPO Value Plan 2019	
	In-Network Ind/Fam	Out-of-Network Ind/Fam	In-Network Ind/Fam	Out-of-Network Ind/Fam
Maxim HSA Contribution	N/A		N/A	
Deductible	$500/$1,500	$1,000/$3,000	$500/$1,500	$1,000/$3,000
Co-Insurance	20%	50%	20%	50%
Out-of-Pocket Max Medical	$3,500/$10,500	$7,000/$21,000	$3,500/$10,500	$7,000/$21,000
Out-of-Pocket Max Pharmacy	$500/$1,000	N/A	$500/$1,000	N/A
Preventative Care	Covered 100%, no deductible	50% after deductible	Covered 100%, no deductible	50% after deductible
Primary Physician Visit	$20 co-pay	50% after deductible	$20 co-pay	50% after deductible
Specialty Physician Visit	$40 co-pay	50% after deductible	$40 co-pay	50% after deductible

Employee Premiums	Blue Cross Blue Shield PPO Value Plan	
	Your Bi-weekly Payroll Deductions	
	2018	2019
Employee Only	$ 26.19	$ 27.64
Employee + Spouse/Domestic Partner	$ 58.32	$ 61.55
Employee + Spouse/Domestic Partner (+ surcharge)	$ 108.32	$ 111.55
Employee + Child(ren)	$ 52.37	$ 55.26
Employee + Family	$ 86.89	$ 91.69
Employee + Family (+ Surcharge)	$ 136.89	$ 141.69

Coverage	Blue Cross Blue Shield Consumer Directed Health Plan (CDHP) 2018		Blue Cross Blue Shield Consumer Directed Health Plan (CDHP) 2019	
	In-Network Ind/Fam	Out-of-Network Ind/Fam	In-Network Ind/Fam	Out-of-Network Ind/Fam
Maxim HSA Contribution	N/A		$500/$1,000	
Deductible	$1,500/$4,500	$3,000/$9,000	$1,500/$4,500	$3,000/$9,000
Co-Insurance	20%	50%	20%	50%
Out-of-Pocket Max Medical	$2,000/$6,000	$4,000/$12,000	$2,250/$6,500	$4,250/$12,500
Out-of-Pocket Max Pharmacy	Combined w/ medical maximum	Combined w/ medical maximum	Combined w/ medical maximum	Combined w/ medical maximum
Preventative Care	Covered 100%, no deductible	50% after deductible	Covered 100%, no deductible	50% after deductible
Primary Physician Visit	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Specialty Physician Visit	20% after deductible	50% after deductible	20% after deductible	50% after deductible

Coverage	Blue Cross Blue Shield Consumer Directed Health Plan (CDHP)	
	Your Bi-weekly Payroll Deductions	
	2018	2019
Employee Only	$ 5.95	$ 6.28
Employee + Spouse/Domestic Partner	$ 11.90	$ 12.56
Employee + Spouse/Domestic Partner (+ surcharge)	$ 61.90	$ 62.56
Employee + Child(ren)	$ 9.52	$ 10.05
Employee + Family	$ 15.47	$ 16.32
Employee + Family (+ Surcharge)	$ 65.47	$ 66.32

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Medical Plans: Kaiser - California HMO and Oregon HMO

Coverage	Kaiser of California HMO 2019 (Northern CA Only)	Kaiser of California HMO 2019 (Northern CA Only)
	Network Providers	Network Providers
Maxim HSA Contribution	N/A	
Deductible	None	None
Out-of-Pocket Max Medical (Ind/Fam)	$1500/$3000	$1500/$3000
Preventative Care	Covered 100%	Covered 100%
Primary Physician Visit	$20 co-pay	$20 co-pay
Specialty Physician Visit	$20 co-pay	$20 co-pay
ER Co-pay	$100	$100
Pharmacy (30-day supply)	$15 generic / $30 brand	$15 generic / $30 brand
Mail Order Pharmacy	$30 generic / $60 brand	$30 generic / $60 brand

Employee Premiums	Kaiser of California HMO	
	Your Bi-weekly Payroll Deductions	
	2018	2019
Employee Only	$ 39.85	$ 39.85
Employee + Spouse/Domestic Partner	$ 87.65	$ 87.65
Employee + Spouse/Domestic Partner (+ surcharge)	$ 137.65	$ 137.65
Employee + Child(ren)	$ 71.71	$ 71.71
Employee + Family	$ 116.13	$ 116.13
Employee + Family (+ Surcharge)	$ 166.13	$ 166.13

Coverage	Kaiser of Oregon HMO 2018 (OR Only)	Kaiser of Oregon HMO 2019 (OR Only)
	Network Providers	Network Providers
Maxim HSA Contribution	N/A	
Deductible	None	None
Out-of-Pocket Max Medical (Ind/Fam)	$2,000/$4,000	$2,000/$4,000
Preventative Care	Covered 100%	Covered 100%
Primary Physician Visit	$20 co-pay	$20 co-pay
Specialty Physician Visit	$40 co-pay	$40 co-pay
ER Co-pay	$100	$100
Pharmacy (30-day supply)	$15 generic / $30 brand	$15 generic / $30 brand
Mail Order Pharmacy	$30 generic / $60 brand	$30 generic / $60 brand

Employee Premiums	Kaiser of Oregon HMO	
	Your Bi-weekly Payroll Deductions	
	2018	2019
Employee Only	$ 37.67	$ 39.89
Employee + Spouse/Domestic Partner	$ 81.13	$ 85.91
Employee + Spouse/Domestic Partner (+ surcharge)	$ 131.13	$ 135.91
Employee + Child(ren)	$ 66.66	$ 70.58
Employee + Family	$ 104.31	$ 110.45
Employee + Family (+ Surcharge)	$ 154.31	$ 160.45

Dental Plans: Cigna - Dental PPO and HMO

Coverage	CIGNA Dental Choice Plan 2018 (Out of Network Based)		CIGNA Dental Choice Plan 2019 (Out of Network Based)
	In-Network Ind/Fam	Out-of-Network Ind/Fam	
Maxim HSA Contribution	N/A		Plan no longer part of Maxim's benefit offering
Deductible	$50/$150	$50/$150	
Calendar Year Maximum	$2,000	$2,000	
Preventative Care	Covered 100%	Covered 100% (of Maximum Allowable Charge)	
Basic Services	20%	20% (of Maximum Allowable Charge)	
Major Services	50%	50% (of Maximum Allowable Charge)	
Orthodontia Services	50%	50% (of Maximum Allowable Charge)	
Orthodontia Lifetime Maximum	$1,500	$1,500	

Employee Premiums	Cigna Dental Choice	
	Your Bi-weekly Payroll Deductions	
	2018	2019
Employee Only	$ 8.28	Plan no longer part of Maxim's benefit offering
Employee + One	$ 13.32	
Employee + Family (2 or more dependents)	$ 17.37	

Coverage	Cigna Dental PPO Plan 2018 (In Network Based Plan)		Cigna Dental PPO Plan 2019 (In Network Based Plan)	
	In-Network Ind/Fam	Out-of-Network Ind/Fam	In-Network Ind/Fam	Out-of-Network Ind/Fam
Maxim HSA Contribution	N/A		N/A	
Deductible	$50/$150	$50/$150	$50/$150	$50/$150
Calendar Year Maximum	$2,000	$2,000	$2,000	$2,000
Preventative Care	Covered 100%	Covered 100% (of contracted fee schedule)	Covered 100%	Covered 100% (of Maximum Allowable Charge)
Basic Services	Covered 100%	Covered 100% (of contracted fee schedule)	Covered 100%	Covered 100% (of Maximum Allowable Charge)
Major Services	40%	40% (of contracted fee schedule)	40%	40% (of Maximum Allowable Charge)
Orthodontia Services	50%	50% (of contracted fee schedule)	50%	50% (of Maximum Allowable Charge)
Orthodontia Lifetime Maximum	$1,500	$1,500	$1,500	$1,500

Employee Premiums	Cigna Dental PPO	
	Your Bi-weekly Payroll Deductions	
	2018	2019
Employee Only	$ 3.79	$ 4.17
Employee + One	$ 6.90	$ 7.59
Employee + Family (2 or more dependents)	$ 10.61	$ 11.67

Coverage	Cigna Dental HMO 2018 (Network Providers Only)	Cigna Dental HMO 2019 (Network Providers Only)
Maxim HSA Contribution	Refer to Cigna Dental DHMO Patient Charge Schedule	Refer to Cigna Dental DHMO Patient Charge Schedule
Deductible		
Calendar Year Maximum		
Preventative Care		
Basic Services		
Major Services		
Orthodontia Services		
Orthodontia Lifetime Maximum		

Coverage	Cigna Dental HMO	
	Your Bi-weekly Payroll Deductions	
	2018	2019
Employee Only	$ 1.38	$ 1.38
Employee + One	$ 3.23	$ 3.23
Employee + Family (2 or more dependents)	$ 4.62	$ 4.62

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Vision Plan: Eyemed

Vision Care Services	EyeMed Vision 2018		EyeMed Vision 2019	
	In-Network	Out-of_Network	In-Network	Out-of-Network
Maxim HSA Contribution	N/A		N/A	
Exam	$10 co-pay	Up to $49	$10 co-pay	Up to $49
Vision Materials				
Frequency Exam Lenses Frames	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Frames	$0 co-pay: $130 allowance; 80% of charge over $130	Up to $65	$0 co-pay: $130 allowance; 80% of charge over $130	Up to $65
Lenses Single vision lenses Bifocal lenses Trifocal lenses	 $25 co-pay $25 co-pay $25 co-pay	 Up to $35 Up to $49 Up to $74	 $25 co-pay $25 co-pay $25 co-pay	 Up to $35 Up to $49 Up to $74
Medically necessary contact lenses	$0 co-pay	Up to $200	Reasonable and customary charges	Up to $200
Elective contact lenses in lieue of glasses	Up to $150 (co-pay doesn't apply)	Up to $120 (co-pay doesn't apply)	Up to $150 (co-pay doesn't apply)	Up to $120 (co-pay doesn't apply)

Employee Premiums	EyeMed Vision	
	Your Bi-weekly Payroll Deductions	
	2018	2019
Employee Only	$ 2.77	$ 2.77
Employee + One	$ 4.15	$ 4.15
Employee + Family	$ 5.54	$ 5.54