Medical Plans

	Anthem BlueCross BlueShield				Kaiser Permanente
Plan Name	**Bronze**	**Silver**	**Gold**	**Platinum**	**Kaiser (CA Only)**
Calendar Year Deductible: Single/Family	$5,000/$10,000	$3,000/$6,000	$1,500/$3,000	$500/$1,000	$500/$1,000
Coinsurance	25%	20%	20%	10%	10%
Maximum Out of Pocket Limit: Single/Family (Includes the deductible)	$6,000/$12,000	$6,250/$12,500	$5,000/$10,000	$3,000/$6,000	$3,000/$6,000
Preventative Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Office Visit	25% after Deductible	$35 Copay	$25 Copay	$20 Copay	$20 Copay
Specialist Office Visit	25% after Deductible	$70 Copay	$50 Copay	$40 Copay	$40 Copay
X-Rays and Lab	25% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Urgent Care Centers	25% after Deductible	$100 Copay	$75 Copay	$75 Copay	$75 Copay
Emergency Medical Care	25% after Deductible	$250 Copay	$250 Copay	$250 Copay	$250 Copay
In-Patient Hospital Services	25% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Out-Patient Hospital Services	25% after Deductible	20% after Deductible	20% after Deductible	10% after Deductible	10% after Deductible
Prescription Drugs					
Retail (30 day supply)	Rx copays apply after Deductible $10/$35/$60/25% up to $250	$10/$35/$70/25% up to $250	$10/$35/$70/25% up to $250	$10/$35/$70/25% up to $250	$10/$35/$70/25% up to $250
Mail Order (90 day supply)	$25/$87/$150	$25/$87/$175	$25/$87/$175	$25/$87/$175	$25/$87/$175
Medical Bi-Weekly Employee Contributions					
Employee Only	$43.20	$84.24	$116.64	$149.04	**$149.04**
Employee + Spouse	$135.00	$194.40	$253.80	$315.36	**$315.36**
Employee + Child(ren)	$102.60	$151.20	$199.80	$246.24	**$246.24**
Family	$189.00	$275.40	$361.80	$442.80	**$442.80**

HSA (HEALTH SAVINGS ACCOUNT) PAYROLL CONTRIBUTION (PRE-TAX):

- If you have selected the Qualified High deductible Health Plan (Bronze) and meet the IRS guidelines to be eligible for a Health Savings Account, you may choose to make a contribution.
- For 2023, CCM will contribute up to $1,000 to the Health Savings Account — participant receives $83.33 per month. In addition, CCM will match any employee contribution up to $1,000 — participant receives $83.33 per month.
- Employees may contribute an additional $1,850 Single / $5,750 Family in 2023 — those over age 55 are eligible for an additional catch-up contribution.

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Plan Name	HMSA
Calendar Year Deductible: Single/Family	$0
Coinsurance	20%
Maximum Medical Out of Pocket Limit: Single/Family	$2,500/$7,500
Maximum Pharmacy Out of Pocket Limit: Single/Family	$3,600/$4,200
Primary Care Office Visit	$14 Copay
Specialist Office Visit	$14 Copay
X-Rays and Lab	20% Coinsurance
Urgent Care Centers	$14 Copay
Emergency Medical Care	20% Coinsurance
In-Patient Hospital Services	20% Coinsurance
Out-Patient Hospital Services	20% Coinsurance
Prescription Drugs:	
Retail (30 day supply)	$7/$30/$30/$100/$100
Medical Bi-Weekly Employee Contributions	
Employee	$149.04
Employee + 1	$315.36
Employee + Family	$442.80

- If you're a resident of Hawaii you have the option to pick the HMSA medical plan.
- This plan is only available to Hawaii residents.

Dental and Vision Plans

Anthem

Dental Plan	
	Preferred In-Network
Calendar Year Deductible: Single/Family	$50/$150
Deductible waived for	Preventive
Annual Maximum	$2,000
Preventive/Basic/Major/Ortho	0%/20%/50%/50%
Orthodontia Lifetime Max	$1,000
Dental Bi-Weekly Employee Contributions	
Employee Only	$9.43
Employee + Spouse	$19.24
Employee + Child(ren)	$24.87
Family	$36.72

Vision Plan		
	In-Network	**Out-of-Network**
Exam *Every 12 months*	$10	Up to $40
Lenses (Single/Bifocal/Trifocal) *Every 12 months*	$20	Up to $40/$60/$80
Contact Lenses *Medically Necessary* *Every 12 months*	$20	Up to $210
Contact Lenses Elective *Every 12 months*	$125 allowance, 15% off any balance	Up to $125
Frames *Every 12 months*	$150 allowance, 20% off any balance	Up to $45
Vision Bi-Weekly Employee Contributions		
Employee Only	$2.93	
Employee + Spouse	$5.13	
Employee + Child(ren)	$5.57	
Family	$8.50	

FSA (FLEXIBLE SPENDING ACCOUNT):

- If you choose to enroll in the FSA, the limit is $3,050.
- If you choose to enroll in the Dependent Care Account, the limit is $5,000 annually per federal guidelines.