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| **BOWDOIN COLLEGE**  **2024 CIGNA HEALTH PLAN COMPARISON CHART**  **(Effective January 1, 2024)** | **Open Access Plus**  **Health Plan** | **Open Access Plus**  **High Deductible Health Plan (HDHP) #1** | **Open Access Plus**  **High Deductible Health Plan**  **(HDHP) #2** |
|  | **Health Savings Account (HSA) College Contribution**  $800 per Individual  $1,600 per Family | **Health Savings Account (HSA) College Contribution**  $1,600 per Individual  $2,700 per Family |
|  | **In-Network** | **In-Network** | **In-Network** |
| **Preventive Services** | **Covered at 100%** | **Covered at 100%** | **Covered at 100%** |
| Deductible | $800 per Individual  $1,600 per Family | $1,600 per Individual  $3,200 per Family | $3,200 per Individual  $5,400 per Family |
| Coinsurance | Services are covered at **80%** after the deductible | Services are covered at **80%** after the deductible | Services are covered at **80%** after the deductible |
| Out-of-Pocket Maximum  (all covered medical expenses are paid at 100% once maximum is reached) | $3,000 per Individual  $6,000 per Family  (deductible + coinsurance +medical copays) | $3,000 per Individual  $6,000 per Family  (deductible + coinsurance) | $6,550 per Individual  $10,000 per Family  (deductible + coinsurance) |
| Office Visit Copay | $20 PCP / $50 Specialist | Services are covered at **80%** after the deductible | Services are covered at **80%** after the deductible |
| Emergency Room Copay | $200  ($50 Urgent Care Facility) | Services are covered at **80%** after the deductible | Services are covered at **80%** after the deductible |
|  | **\*Out-of-Network** | **\*Out-of-Network** | **\*Out-of-Network** |
| Deductible | $800 per Individual  $1,600 per Family | $1,600 per Individual  $3,200 per Family | $3,200 per Individual  $5,400 per Family |
| Coinsurance | Services are covered at **60%** after the deductible | Services are covered at **60%** after the deductible | Services are covered at **60%** after the deductible |
| Out-of-Pocket Maximum  (all covered medical expenses are paid at 100% once maximum is reached) | $3,000 per Individual  $6,000 per Family | $3,000 per Individual  $6,000 per Family | $6,550 per Individual  $10,000 per Family |
|  | **In-Network Pharmacy Benefit** | **In-Network Pharmacy Benefit** | **In-Network Pharmacy Benefit** |
| Rx Retail Copay-30 day supply  (step therapy and/or prior authorization applies to some prescriptions) | Tier 1 Generic $10  Tier 2 Brand $40  Tier 3 Non-Preferred $90 | Services are covered at **80%** after the deductible | Services are covered at **80%** after the deductible |
| Rx Mail Order-90 day supply  (step therapy and/or prior authorization applies to some prescriptions) | Tier 1 Generic $20  Tier 2 Brand $100  Tier 3 Non-Preferred $195 | Services are covered at **80%** after the deductible | Services are covered at **80%** after the deductible |
| Rx Out-of-Pocket Maximum | $ 6,450 per Individual  $ $12,900 per Family  (separate from medical  out-of-pocket maximum) | Out-of-pocket maximums listed above are inclusive of all services including Rx | Out-of-pocket maximums listed above are inclusive of all services including Rx |
|  | **Embedded Deductible & Out-of-Pocket Maximum** | **Non-Embedded Deductible & Out-of-Pocket Maximum** | **Embedded Deductible & Out-of-Pocket Maximum** |
| **Note:** A family plan includes the following coverage levels: Employee + Spouse,  Employee + Child(ren) and Employee + Family | No single individual on a family plan will have to pay a deductible or out-of-pocket maximum higher than the individual amount. | For a family plan the family deductible and family out-of-pocket maximum must be met by claims from a single family member or several different members combined. | No single individual on a family plan will have to pay a deductible or out-of-pocket maximum higher than the individual amount. |

Out-of-Network coverage is subject to maximum allowances – balance billing allowed. Revised 10/20/2023

Deductible and Out-of-Pocket maximums cross accumulate between in-network and out-of-network

**Employee Monthly Contributions effective January 1, 2024:**

Employee with an annual salary of $45,000 and under:

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| **Open Access Plus Health Plan** | **Open Access Plus HDHP #1** | **Open Access Plus HDHP #2** |
| Employee - $97 | Employee - $53 | Employee - $29 |
| Employee + Child(ren) - $292 | Employee + Child(ren) - $155 | Employee + Child(ren) - $117 |
| Employee + Spouse - $401 | Employee + Spouse - $247 | Employee + Spouse - $158 |
| Employee + Family - $401 | Employee + Family - $247 | Employee + Family - $158 |

Employee with an annual salary of $45,001 to $90,000:

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| **Open Access Plus Health Plan** | **Open Access Plus HDHP #1** | **Open Access Plus HDHP #2** |
| Employee - $103 | Employee - $56 | Employee - $32 |
| Employee + Child(ren) - $336 | Employee + Child(ren) - $187 | Employee + Child(ren) - $152 |
| Employee + Spouse - $462 | Employee + Spouse - $303 | Employee + Spouse - $207 |
| Employee + Family - $462 | Employee + Family - $303 | Employee + Family - $207 |

Employee with an annual salary of $90,001 to $150,000:

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| **Open Access Plus Health Plan** | **Open Access Plus HDHP #1** | **Open Access Plus HDHP #2** |
| Employee - $114 | Employee - $62 | Employee - $37 |
| Employee + Child(ren) - $390 | Employee + Child(ren) - $230 | Employee + Child(ren) - $200 |
| Employee + Spouse - $534 | Employee + Spouse - $365 | Employee + Spouse - $275 |
| Employee + Family - $534 | Employee + Family - $365 | Employee + Family - $275 |

Employee with an annual salary of $150,001 and over:

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| **Open Access Plus Health Plan** | **Open Access Plus HDHP #1** | **Open Access Plus HDHP #2** |
| Employee - $120 | Employee - $66 | Employee - $42 |
| Employee + Child(ren) - $407 | Employee + Child(ren) - $244 | Employee + Child(ren) - $214 |
| Employee + Spouse - $563 | Employee + Spouse - $390 | Employee + Spouse - $294 |
| Employee + Family - $563 | Employee + Family - $390 | Employee + Family - $294 |