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| **BOWDOIN COLLEGE**  **2025 CIGNA HEALTH PLAN COMPARISON CHART**  **(Effective January 1, 2025)** | **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**  $825 per Individual  $1,650 per Family | **Health Savings Account (HSA) College Contribution**  $1,650 per Individual  $2,750 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 | $1,650 per Individual  $3,300 per Family | $3,300 per Individual  $5,500 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 | $1,650 per Individual  $3,300 per Family | $3,300 per Individual  $5,500 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 | $ 6,200 per Individual  $12,400 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 10/16/2024

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

**Employee Monthly Contributions effective January 1, 2025: (rates to be determined)**

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 - $100 | Employee - $55 | Employee - $30 |
| Employee + Child(ren) - $301 | Employee + Child(ren) - $160 | Employee + Child(ren) - $121 |
| Employee + Spouse - $413 | Employee + Spouse - $254 | Employee + Spouse - $163 |
| Employee + Family - $413 | Employee + Family - $254 | Employee + Family - $163 |

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 - $108 | Employee - $59 | Employee - $34 |
| Employee + Child(ren) - $353 | Employee + Child(ren) - $196 | Employee + Child(ren) - $160 |
| Employee + Spouse - $485 | Employee + Spouse - $318 | Employee + Spouse - $217 |
| Employee + Family - $485 | Employee + Family - $318 | Employee + Family - $217 |

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 - $122 | Employee - $66 | Employee - $40 |
| Employee + Child(ren) - $417 | Employee + Child(ren) - $246 | Employee + Child(ren) - $214 |
| Employee + Spouse - $571 | Employee + Spouse - $391 | Employee + Spouse - $294 |
| Employee + Family - $571 | Employee + Family - $391 | Employee + Family - $294 |

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 - $131 | Employee - $72 | Employee - $46 |
| Employee + Child(ren) - $444 | Employee + Child(ren) - $266 | Employee + Child(ren) - $233 |
| Employee + Spouse - $614 | Employee + Spouse - $425 | Employee + Spouse - $320 |
| Employee + Family - $614 | Employee + Family - $425 | Employee + Family - $320 |