

**BOWDOIN COLLEGE
2019 HEALTH PLAN
COMPARISON CHART
(Effective January 1, 2019)**

**See (on reverse) list of
Preferred In-Network
Facilities (Hospitals)**

	PPO Health Plan	High Deductible Health Plan (HDHP – Option 1)	High Deductible Health Plan (HDHP – Option 2)
		Health Savings Account (HSA) College Contribution \$750 per Individual \$1,500 per Family	Health Savings Account (HSA) College Contribution \$1,300 per Individual \$2,500 per Family
	Preferred In-Network (Facilities)	Preferred In-Network (Facilities)	Preferred In-Network (Facilities)
Deductible	\$500 per Individual \$1,000 per Family	\$1,500 Individual \$3,000 Family	\$2,700 per Individual \$5,200 per Family
Coinsurance	Services are covered at 90% 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 if reached)	\$3,000 per Individual \$6,000 per Family (deductible + coinsurance + medical copayments)	\$3,000 Individual \$6,000 Family (deductible + coinsurance)	\$6,550 per Individual \$10,000 per Family (deductible + coinsurance)
OA Centers for Orthopaedics	\$20 Copay Office/Physical Therapy Visits – All other covered services subject to the Preferred In-Network Deductible and Out-of-Pocket Max listed above.	Subject to Preferred In-Network Deductible, Coinsurance and Out-of-Pocket Max listed above.	Subject to Preferred In-Network Deductible, Coinsurance and Out-of-Pocket Max listed above.
	In-Network (Facilities and Providers)	In-Network (Providers)	In-Network (Providers)
Preventive Services	Covered at 100%	Covered at 100%	Covered at 100%
Deductible	\$750 per Individual \$1,500 per Family	\$1,500 Individual \$3,000 Family	\$2,700 per Individual \$5,200 per Family
Coinsurance	Services are covered at 70% 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)	\$4,000 per Individual \$8,000 per Family (deductible + coinsurance + medical copays)	\$3,000 Individual \$6,000 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 (Facilities and Providers)	In-Network Facilities (Non-Preferred) and *Out-of-Network (Facilities and Providers)	In-Network Facilities (Non-Preferred) and *Out-of-Network (Facilities and Providers)
Deductible	\$750 per Individual \$1,500 per Family	\$1,500 Individual \$3,000 Family	\$2,700 per Individual \$5,200 per Family
Coinsurance	Services are covered at 50% 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)	\$4,000 per Individual \$8,000 per Family	\$3,000 Individual \$6,000 Family	\$6,550 per Individual \$10,000 per Family
	Pharmacy Benefit	Pharmacy Benefit	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 \$70	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 \$175	Services are covered at 80% after the deductible	Services are covered at 80% after the deductible
Preventive Rx (from list of approved medications)		Covered at 100%	Covered at 100%
Rx Out-of-Pocket Maximum	\$3,900 per Individual \$7,800 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.

Preferred In-Network Providers:

The College is concerned about employees' health and well-being and wants to make sure we get the best value for the money that you and the College spend on healthcare while also finding facilities in our community that provide quality care. When you obtain care from a preferred in-network facility you may have lower out-of-pocket costs. Effective January 1, 2019 the following facilities (hospitals) are included as preferred:

- Lincoln County Healthcare (Damariscotta)
- Maine Coast Memorial Hospital (Ellsworth)
- Maine Heart Center (Portland)
- Maine Medical Center (Portland)
- MaineGeneral Health (Augusta/Waterville)
- Memorial Hospital (North Conway, New Hampshire)
- Mid Coast Hospital (Brunswick)
- New England Rehabilitation Hospital (Portland)
- OA Centers for Orthopaedics (Brunswick/Portland/Windham/Saco)
- Pen Bay Medical Center (Rockport)
- Southern Maine Health Care (Biddeford)
- Spring Harbor Hospital (Westbrook)
- St. Mary's Regional Hospital (Lewiston)
- Stephens Memorial Hospital (Norway)
- Waldo County General Hospital (Belfast)
- York Hospital (York)

Employee Monthly Contributions for the PPO Health Plan and the HDHP option effective January 1, 2019:

Employee with an annual salary of \$43,000 and under:

PPO Health Plan	HDHP Option 1	HDHP Option 2
Employee - \$86	Employee - \$49	Employee - \$28
Employee + Child(ren) - \$289	Employee + Child(ren) - \$183	Employee + Child(ren) - \$158
Employee + Spouse - \$398	Employee + Spouse - \$273	Employee + Spouse - \$214
Employee + Family - \$398	Employee + Family - \$273	Employee + Family - \$214

Employee with an annual salary of \$43,001 to \$85,000:

PPO Health Plan	HDHP Option 1	HDHP Option 2
Employee - \$92	Employee - \$52	Employee - \$31
Employee + Child(ren) - \$315	Employee + Child(ren) - \$196	Employee + Child(ren) - \$170
Employee + Spouse - \$433	Employee + Spouse - \$308	Employee + Spouse - \$231
Employee + Family - \$433	Employee + Family - \$308	Employee + Family - \$231

Employee with an annual salary of \$85,001 to \$140,000:

PPO Health Plan	HDHP Option 1	HDHP Option 2
Employee - \$95	Employee - \$55	Employee - \$33
Employee + Child(ren) - \$327	Employee + Child(ren) - \$205	Employee + Child(ren) - \$177
Employee + Spouse - \$450	Employee + Spouse - \$325	Employee + Spouse - \$244
Employee + Family - \$450	Employee + Family - \$325	Employee + Family - \$244

Employee with an annual salary of \$140,001 and over:

PPO Health Plan	HDHP Option 1	HDHP Option 2
Employee - \$98	Employee - \$57	Employee - \$36
Employee + Child(ren) - \$339	Employee + Child(ren) - \$215	Employee + Child(ren) - \$187
Employee + Spouse - \$465	Employee + Spouse - \$340	Employee + Spouse - \$257
Employee + Family - \$465	Employee + Family - \$340	Employee + Family - \$257