

Diocese of New Jersey Health Plan Comparison 2020

Plan	Anthem BCBS BlueCard or Cigna OAP PPO 100		Anthem BCBS BlueCard or Cigna OAP PPO 90		Anthem BCBS or Cigna CDHP 20/HSA	
	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Annual Medical Deductible	\$0 per person \$0 per family	\$500 per person \$1,000 per family	\$500 per person \$1,000 per family	\$1,000 per person \$2,000 per family	\$2,800 per person \$5,450 per family	\$3,000 per person \$6,000 per family
Annual Out-of-Pocket Limit	\$2,000 per person \$4,000 per family	\$4,000 per person \$8,000 per family	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family	\$4,200 per person \$8,450 per family	\$7,000 per person \$13,000 per family
Preventive Care						
Preventive Services & Well-Child Care	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	45% coinsurance
Physician Services						
Office Visit	\$30 copay	50% coinsurance	\$30 copay	50% coinsurance	20% coinsurance	45% coinsurance
Diagnostic Services (outpatient)	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Specialist Care	\$45 copay	50% coinsurance	\$45 copay	50% coinsurance	20% coinsurance	45% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	\$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Outpatient Surgery	\$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Emergency Room Care	\$250 copay	\$250 copay	\$250 copay	\$250 copay	20% coinsurance	20% coinsurance
Ambulance Services	\$0 copay	\$0 copay	10% coinsurance	10% coinsurance	20% coinsurance	20% coinsurance
Mental Health/Substance Abuse						
Outpatient Services	\$30 copay	30% coinsurance	\$30 copay	30% coinsurance	20% coinsurance	45% coinsurance
Inpatient Services	\$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Other Medical Services						
Durable Medical Equipment	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Home Health Care	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Outpatient Therapy	\$30 copay PCP/\$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	\$30 copay PCP/\$45 copay specialist (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	50% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	20% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	45% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
Skilled Nursing / Acute Rehabilitation Facility	\$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	45% coinsurance
Urgent Care Services	\$50 copay	\$50 copay	\$50 copay	\$50 copay	20% coinsurance	20% coinsurance

This chart is a general description and is provided for informational purposes only. It should not be viewed as an offer of coverage. In the event of a conflict between this chart and the official Plan documents, the official Plan documents will govern.