

**Diocese of New Jersey Health Plan Comparison 2021**

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
<b>Preventive Care</b>						
Preventive Services & Well-Child Care	\$0 copay	50% coinsurance	\$0 copay	50% coinsurance	\$0 copay	45% coinsurance
<b>Physician Services</b>						
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
<b>Hospital Services</b>						
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
<b>Mental Health/Substance Abuse</b>						
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
<b>Other Medical Services</b>						
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

Coverage added for 2021: Hearing Aids up to \$1,500 per ear every 3 years.