Diocese of New Jersey Health Plan Comparison 2024

Plan	Anthem BCBS BlueCard or Cigna OAP PPO 100		Anthem BCBS BlueCard or Cigna OAP PPO 90 (Base plan)		Anthem BCBS or Cigna PPO 80	
	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	$1,000 per person $2,000 per family	$2,000 per person $4,000 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	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	50% coinsurance	$0 copay	50% coinsurance	$0 copay	50% coinsurance
Physician Services						
Office Visit	$30 copay	50% coinsurance	$30 copay	50% coinsurance	20% coinsurance	50% coinsurance
Diagnostic Services (outpatient)	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Specialist Care	$45 copay	50% coinsurance	$45 copay	50% coinsurance	20% coinsurance	50% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Outpatient Surgery	$200 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Emergency Room Care	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay	$250 copay
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	50% coinsurance
Inpatient Services	$250 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Other Medical Services						
Durable Medical Equipment	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Home Health Care	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% 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)	$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)
Skilled Nursing / Acute Rehabilitation Facility	$0 copay	50% coinsurance	10% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Urgent Care Services	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay

Out of Network Providers will also charge balance billing - you pay the difference between the insurance allowable charge and the actual charges.

Plan	Anthem BCBS or Cigna CDHP 15/HSA		Anthem BCBS or Cigna CDHP 20/HSA		Anthem BCBS or Cigna CDHP 40/HSA	
	Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Annual Medical Deductible	$1,600 per person $3,200 per family	$3,200 per person $6,400 per family	$3,200 per person $5,450 per family	$3,200 per person $6,000 per family	$3,500 per person $7,000 per family	$7,000 per person $14,000 per family
Annual Out-of-Pocket Limit	$2,400 per person $4,800 per family	$4,800 per person $9,600 per family	$4,200 per person $8,450 per family	$7,000 per person $13,000 per family	$6,000 per person $12,000 per family	$10,000 per person $20,000 per family
Preventive Care						
Preventive Services & Well-Child Care	$0 copay	40% coinsurance	$0 copay	45% coinsurance	$0 copay	60% coinsurance
Physician Services						
Office Visit	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Diagnostic Services (outpatient)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Specialist Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Hospital Services						
Inpatient Services (including inpatient maternity services)	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Surgery	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Emergency Room Care	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Ambulance Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Mental Health/Substance Abuse						
Outpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Inpatient Services	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Other Medical Services						
Durable Medical Equipment	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Home Health Care	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Outpatient Therapy	15% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	40% 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)	40% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)	60% coinsurance (includes hearing/speech, physical, and occupational) (60 visits per year per each type of therapy)
Skilled Nursing / Acute Rehabilitation Facility	15% coinsurance	40% coinsurance	20% coinsurance	45% coinsurance	40% coinsurance	60% coinsurance
Urgent Care Services	15% coinsurance	15% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance

Out of Network Providers will also charge balance billing - you pay the difference between the insurance allowable charge and the actual charges.

Prescription Drug Benefits			
	Express Scripts		
	Standard		CDHP-20/HSA
	Retail	Home Delivery	Retail and Home Delivery
Annual Prescription Deductible (in-network)	None	None	$2,700 per person $5,450 per family (combined with medical deductible)
Tier 1: Generic	Up to a $10 copay	Up to a $25 copay	You pay 15% after deductible
Tier 2: Preferred Brand Name	25% up to $40 min/$80 max	25% up to $40 min/$80 max	You pay 25% after deductible
Tier 3: Non-Preferred Brand Name	40% up to $100 min/$200 max	40% up to $100 min/$200 max	You pay 50% after deductible
Dispensing Limits Per Copayment	Up to a 30-day supply	Up to a 90-day supply	Up to a 30-day supply (retail) or 90-day supply (mail order)

Delta Dental Benefits Comparison									
	Basic			Comprehensive			Premium		
	PPO Network	Premier Network	Out-of Network	PPO Network	Premier Network	Out-of Network	PPO Network	Premier Network	Out-of Network
Deductible	$0	$0	$0	$0	$0	$100 Individual/$300 Family	$0	$0	$50 Individual/$150 Family
Annual Benefit Maximum	$2,000	$1,500	$1,000	$2,500	$2,000	$1,500	$3,000	$2,500	$2,000
Preventive & Diagnostic	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Basic Restorative Care	20% coinsurance	20% coinsurance	30% coinsurance	15% coinsurance	15% coinsurance	25% coinsurance	15% coinsurance	15% coinsurance	25% coinsurance
Major Restorative Services	60% coinsurance	60% coinsurance	99% coinsurance	50% coinsurance	50% coinsurance	60% coinsurance	15% coinsurance	15% coinsurance	25% coinsurance
Orthodontia Services (includes adults)	N/A	N/A	N/A	50% coinsurance	50% coinsurance	60% coinsurance	50% coinsurance	50% coinsurance	60% coinsurance
Orthodontia Lifetime Max	N/A	N/A	N/A	$1,500	$1,500	$1,000	$2,000	$2,000	$1,500

All plans include 3 cleanings per year