




2020 Medical Plan Side-by-Side Comparison

	Anthem Open Access POS www.anthem.com		Anthem Open Access HMO www.anthem.com		Kaiser Permanente HMO www.my.kp.org/cobb		
BENEFIT FEATURES	IN-NETWORK	NON-NETWORK	NETWORK ONLY		NETWORK ONLY		
Annual Deductible (per individual/family)	\$500/\$1,500	\$750/\$2,250	\$500/\$1,500		\$500/\$1,500		
Coinsurance (you pay)	20%	40%	10%		10%		
Medical Out-of-Pocket Maximum (Annual)	\$2,500 single \$5,500 family	\$4,750 single \$14,250 family	\$1,700 single \$5,100 family		\$1,700 single \$5,100 family		
Rx Out-of-Pocket Maximum (Annual)	\$3,600 single/ \$7,200 family		\$3,600 single/\$7,200 family		N/A		
Copay(s):							
Office Visit (pcp/specialist)	\$35/\$40	N/A	\$35/\$40		\$35/\$40		
Inpatient Admission/Outpatient surgery	\$300	\$300	\$300		\$300		
Emergency Room	\$200	\$200	\$200		\$200		
Urgent Care	\$75	\$75	\$75		\$75		
Vision Exam	N/A	N/A	N/A		\$40		
PCP Required	No	N/A	No		Yes		
Specialist Referral Required	No	N/A	No		Yes		
PHARMACY COPAYS	IngenioRx www.anthem.com		IngenioRx www.anthem.com		Kaiser Pharmacy www.my.kp.org/cobb		
	<i>Retail</i>	<i>Mail Order*</i>	<i>Retail</i>	<i>Mail Order*</i>	<i>Kaiser Facility</i>	<i>Retail*</i>	<i>Mail Order**</i>
Generic	\$15	\$30	\$15	\$30	\$15	\$25	\$30
Brand Formulary	\$35	\$87.50	\$35	\$87.50	\$35	\$45	\$70
Brand Non-Formulary	\$60	\$150	\$60	\$150	\$60	\$70	\$120
Specialty	\$200	\$200**	\$200	\$200**	\$200	\$200	\$400
2020 BI-WEEKLY PREMIUMS	Employer	Employee	Employer	Employee	Employer	Employee	
Surcharge if applicable: Tobacco \$35/Spouse \$46.15*							
Single	\$338.15	\$69.60	\$299.58	\$29.92	\$242.53	\$16.16	
Single + Spouse	\$626.07	\$187.52	\$555.79	\$101.56	\$407.46	\$70.29	
Single + Child(ren)	\$594.77	\$178.15	\$528.00	\$96.49	\$387.08	\$66.78	
Family	\$875.97	\$263.04	\$777.35	\$142.91	\$570.45	\$98.40	
*Employee elects spouse coverage but spouse has other coverage available to them.	*90-day supply **30-day supply only		*90-day supply **30-day supply only		*Network pharmacy limited to 1 st fill only **90-day supply		

Anthem Open Access HRA

www.anthem.com

How it works:

Health Reimbursement Account (HRA) - Benefit dollars are provided each year by the HRA funded by Cobb County.

Coverage Level	HRA Dollars	Employee Pays (Out-of-Pocket Funds)	CDHP Deductible
Single	\$500	\$1,000	\$1,500
Single + Spouse	\$750	\$1,250	\$2,000
Single + Child(ren)	\$750	\$1,250	\$2,000
Family	\$1,000	\$1,500	\$2,500

- HRA Dollars funded by Cobb County for full out-of-pocket cost of prescriptions, doctor's visits, radiology, lab work, etc.
- The employee pays for full cost of prescriptions, doctor's visits, lab work, etc. toward meeting the CDHP deductible.
 - If enrolled in the Flexible Spending Account, FSA funds can be used to pay these costs if money has been set aside for the plan year.
 - Unused HRA funds roll over year-to-year to help offset future out-of-pocket costs.
- After the deductible has been met by a member or members of the family, traditional health coverage will be covered by the Open Access POS Plan.

BENEFIT FEATURES

	IN-NETWORK	NON-NETWORK
Office Visit Coinsurance (you pay)	20%	40%
Out-of-Pocket Maximum (Annual)	\$3,000 single \$3,500 single+spouse \$3,500 single+child(ren) \$5,500 family	\$3,500 single \$5,000 single+spouse \$5,000 single+child(ren) \$7,500 family
Rx Out-of-Pocket Maximum	\$3,600 single/\$7,200 family	
PCP Required	No	N/A
Specialist Referral Required	No	N/A

IngenioRx PHARMACY COPAYS

	RETAIL	MAIL ORDER*
Generic	\$15	\$30
Brand Formulary	\$35	\$87.50
Brand Non-Formulary	\$60	\$150
Specialty	\$200	\$200**

*90-day supply only

**30-day supply

2020 BI-WEEKLY PREMIUMS

Surcharge if applicable: Tobacco \$35/Spouse \$46.15***

	EMPLOYER	EMPLOYEE
Single	\$317.22	\$20.18
Single + Spouse	\$587.17	\$85.78
Single + Child(ren)	\$557.82	\$81.50
Family	\$821.20	\$120.90

***Employee elects spouse coverage but spouse has other coverage available to them.

Delta Dental Benefits Summary

www.deltadentalins.com

Delta Dental PPO Delta Dental Premier

Benefit Category	In-Network	Non-Network
Class 1- Diagnostic/Preventive Services		
Oral exams and cleanings	100%	100%
Bitewing x-rays		
Full mouth x-rays		
Panoramic x-rays		
Fluoride application		
Sealants (under age 14)		
Class II – Basic Services		
Basic restorative (fillings)	80%	80%
Simple extractions		
Endodontics		
Periodontics		
Class III – Major Services		
Crowns and inlays	50%	50%
Bridges		
Relines and rebases		
Orthodontics for dependent children to age 19		
Diagnostic, active, retention treatment	50%	50%
Maximums & Deductible (applies to the combination of services received from network and non-network dentists)		
Annual program deductible (per person/family)	\$50/\$150	
Annual program maximum (per person)	\$1,000 Excludes orthodontics	
Lifetime orthodontic maximum (per person)	\$1,000	

- Representative sampling of covered services. Please refer to benefit booklet for detailed description of benefits and limitations.
- Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee. Delta Dental's standard exclusions and limitations apply.

2020 BI-WEEKLY DENTAL PREMIUMS

	Employer	Employee
Single	\$15.50	\$0
Family	\$15.50	\$23.15