2021 Medical Plan Side-by-Side Comparison

COBBWELL

	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**	**$0 /$0** NO DEDUCTIBLES!
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
	Retail	*Mail Order**	*Retail*	Mail Order*	*Kaiser Facility*	*Retail**	*Mail Order***
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
2021 BI-WEEKLY PREMIUMS **Surcharge if applicable:** Tobacco $35/Spouse $46.15*	*Employer*	*Employee*	*Employer*	*Employee*	*Employer*	*Employee*
Single	**$360.13**	**$74.12**	**$319.06**	**$31.86**	**$242.53**	**$16.16**
Single + Spouse	**$666.76**	**$199.71**	**$591.91**	**$108.16**	**$407.46**	**$70.29**
Single + Child(ren)	**$633.43**	**$189.73**	**$562.32**	**$102.76**	**$387.08**	**$66.78**
Family	**$932.91**	**$280.14**	**$827.88**	**$152.20**	**$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 1st 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

1

- HRA Dollars funded by Cobb County for full out-of-pocket cost of prescriptions, doctor's visits, radiology, lab work, etc.

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- 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.

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- 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

2021 BI-WEEKLY PREMIUMS

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

	EMPLOYER	EMPLOYEE
Single	$337.84	$21.49
Single + Spouse	$625.34	$91.36
Single + Child(ren)	$594.08	$86.80
Family	$874.58	$128.76

***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.

2021 BI-WEEKLY DENTAL PREMIUMS

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