2024 Medical Plan Side-by-Side Comparison

COBBWELL

BENEFIT FEATURES	Anthem Open Access POS www.anthem.com *IN-NETWORK*	Anthem Open Access POS www.anthem.com NON-NETWORK	Anthem Open Access HMO www.anthem.com *NETWORK ONLY*	Kaiser Permanente HMO www.my.kp.org/cobb 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	CarelonRx www.anthem.com *Retail*	CarelonRx www.anthem.com *Mail Order***	CarelonRx www.anthem.com Retail	CarelonRx www.anthem.com Mail Order**	Kaiser Pharmacy www.my.kp.org/cobb *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

2024 BI-WEEKLY PREMIUMS **Surcharge if applicable:** Tobacco $35/Spouse $46.15*	*Employer*	*Employee*	*Employer*	*Employee*	*Employer*	*Employee*
Single	$453.61	$93.37	$401.88	$40.14	$292.18	$19.13
Single + Spouse	$839.86	$251.55	$745.58	$136.24	$539.40	$83.23
Single + Child(ren)	$797.87	$238.98	$708.30	$129.44	$512.42	$79.07
Family	$1,175.10	$352.86	$1,042.80	$191.71	$755.17	$116.51

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

*Coinsurance thereafter
**90-day supply
***30-day supply only

*Coinsurance thereafter
**90-day supply
***30-day supply only

*Coinsurance thereafter
**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)	HRA 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 covered out-of-pocket costs for prescriptions and medical services.

2
- Once the HRA funds are exhausted, the member will continue to pay for covered medical services that apply toward the deductible until satisfied.
- Prescriptions are subject to co-payments which do not count toward the deductible, but are applied toward the annual out-of-pocket maximum.

3
- After the deductible has been met by a member or members of the family, traditional health coverage will begin, with the member sharing the cost of covered service (coinsurance).
- Unused HRA funds roll over year-to-year to help offset future out-of-pocket costs. The maximum HRA balance that can be accumulated is $3,500 for employee only; $4,250 for employee + spouse or child(ren); and $6,500 for family coverage.
- 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.

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

CarelonRx 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

2024 BI-WEEKLY PREMIUMS

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

	EMPLOYER	EMPLOYEE
Single	$425.54	$27.07
Single + Spouse	$787.68	$115.07
Single + Child(ren)	$748.31	$109.33
Family	$1,101.63	$162.18

***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)	$1,500 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.

2024 BI-WEEKLY DENTAL PREMIUMS

	Employer	Employee
Single	$16.59	$0
Family	$16.59	$24.77