2025 Medical Plan Side-by-Side Comparison

COBBWELL

	Anthem Open Access POS		Anthem Open Access HMO		Kaiser Permanente HMO		
	www.anthem.com		www.anthem.com		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	*CarelonRx*		*CarelonRx*		*Kaiser Pharmacy*		
	www.anthem.com		www.anthem.com		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
2025 BI-WEEKLY PREMIUMS **Surcharge if applicable:** Tobacco $35/Spouse $46.15*	*Employer*	*Employee*	*Employer*	*Employee*	*Employer*	*Employee*	
Single	$467.22	$96.17	$413.94	$41.34	$305.15	$19.98	
Single + Spouse	$865.05	$259.10	$767.94	$140.33	$563.35	$86.92	
Single + Child(ren)	$821.80	$246.15	$729.55	$133.32	$535.17	$82.58	
Family	$1,210.35	$363.45	$1,074.08	$197.46	$788.69	$121.68	

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

Anthem Open Access POS:
**Coinsurance thereafter*
***90-day supply*
****30-day supply only*

Anthem Open Access HMO:
**Coinsurance thereafter*
***90-day supply*
****30-day supply only*

Kaiser Permanente HMO:
**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.

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- 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

2025 BI-WEEKLY PREMIUMS

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

	EMPLOYER	EMPLOYEE
Single	$438.31	$27.88
Single + Spouse	$811.31	$118.52
Single + Child(ren)	$770.76	$112.61
Family	$1,134.68	$167.05

***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