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Compare Medical Plans

Medical plan navigation shortcuts

Background Information

Cost

Show more

The Health Plan Comparison Chart is provided for informational purposes. In the event of a conflict between the Health Plan Comparison Chart and plan terms, plan terms will govern.

Compare different plans

Background Information

Plan Facts	Southeast HCN Option 2	Southeast HCN Option 1
Carrier Name	Blue Cross and Blue Shield of Illinois	Blue Cross and Blue Shield of Illinois
Carrier Address	Please check with Plan	Please check with Plan

Plan Facts	Southeast HCN Option 2	Southeast HCN Option 1
Member Services Phone Number	1-800-621-7336	1-800-621-7336
Website	bcbsil.com/att	bcbsil.com/att
Network Name	Network Blue	Network Blue
Group ID	3163 - For AT&T Benefits Center Use Only	3162 - For AT&T Benefits Center Use Only
Plan description	Health Care Network Option	Health Care Network Option
Cost Sharing	**Southeast HCN Option 2**	**Southeast HCN Option 1**
See SPD for Full Information	Please check with Plan	Please check with Plan
Annual Deductible	**Network** $1,750 Individual; $3,500 Family; combined with MH/SUD, Rx and CarePlus **Non-Network** $5,250 Individual; $10,500 Family; combined with MH/SUD, Rx and CarePlus	**Network** $1,050 Individual; $2,100 Family; combined with MH/SUD; Capped at $1,050 per Individual **Non-Network** $3,150 Individual; $6,300 Family; combined with MH/SUD; Capped at $3,150 per Individual

Cost Sharing	Southeast HCN Option 2	Southeast HCN Option 1
Annual Out-of-Pocket Maximum	**Network** $6,750 Individual; $13,500 Family; includes Annual Deductible; combined with MH/SUD, Rx and CarePlus; capped at $6,750 per Individual **Non-Network** $20,250 Individual; $40,500 Family; includes Annual Deductible; combined with MH/SUD, Rx and CarePlus; capped at $20,250 per Individual	**Network** $3,500 Individual; $7,000 Family; includes Annual Deductible; combined with MH/SUD; capped at $3,500 per Individual **Non-Network** $10,500 Individual; $21,000 Family; includes Annual Deductible; combined with MH/SUD; capped at $10,500 per Individual

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Cost

Plan Prices	Southeast HCN Option 2	Southeast HCN Option 1
Individual	$135.00	$177.00
Individual + 1	Not Applicable	Not Applicable
Family	Not Applicable	Not Applicable
Individual + Spouse/Partner	Not Applicable	Not Applicable

Plan Prices	Southeast HCN Option 2	Southeast HCN Option 1
Individual + Child(ren)	Not Applicable	Not Applicable
Family	$367.00	$483.00

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Inpatient Services

Inpatient Care Including Mental Health/Substance Use	Southeast HCN Option 2	Southeast HCN Option 1
Hospital, Physician Services, Lab and X-ray	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible
Mental Health/Substance Use Inpatient Services	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible

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Outpatient Services

Outpatient Care including Mental Health/Substance Use	Southeast HCN Option 2	Southeast HCN Option 1

Outpatient Care including Mental Health/Substance Use	Southeast HCN Option 2	Southeast HCN Option 1
Surgery, Therapeutic Treatments/PT, Lab, X-Ray, Diag. Tests	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible
Mental Health/Substance Use Outpatient Services	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible
Preventive Care	**Southeast HCN Option 2**	**Southeast HCN Option 1**
Well exams, Mammography, Pap, Colonoscopy	**Network** 0% Coinsurance **Non-Network** Not covered	**Network** 0% Coinsurance **Non-Network** Not covered
Physician Visits	**Southeast HCN Option 2**	**Southeast HCN Option 1**
Office Visit (Non-Specialist)	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible
Office Visit (Specialist)	**Network** 10% Coinsurance after Annual Deductible **Non-Network**	**Network** 10% Coinsurance after Annual Deductible **Non-Network**

Physician Visits	Southeast HCN Option 2	Southeast HCN Option 1
	50% Coinsurance after Annual Deductible	50% Coinsurance after Annual Deductible
Virtual Care	**Network** 0% Coinsurance **Non-Network** Not Applicable	**Network** 0% Coinsurance **Non-Network** Not Applicable
Emergency Care	**Southeast HCN Option 2**	**Southeast HCN Option 1**
Emergency room, Ambulance	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 10% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 10% Coinsurance after Annual Deductible
Non-Emergency Care	**Southeast HCN Option 2**	**Southeast HCN Option 1**
Urgent Care, Ambulance	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible
Emergency Room - Non-Emergency	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible

Family Planning/Maternity Care	Southeast HCN Option 2	Southeast HCN Option 1
Family Planning, Pre-natal & In-hospital Delivery Services	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 50% Coinsurance after Annual Deductible
Infertility services	**Network** 10% Coinsurance after Annual Deductible; Limited to testing and treatment of the under-lying cause of infertility **Non-Network** 50% Coinsurance after Annual Deductible; Limited to testing and treatment of the under-lying cause of infertility	**Network** 10% Coinsurance after Annual Deductible; Limited to testing and treatment of the under-lying cause of infertility **Non-Network** 50% Coinsurance after Annual Deductible; Limited to testing and treatment of the under-lying cause of infertility
Fertility services	**Network** 10% Coinsurance after Annual Deductible; if provided by the Fertility Benefits Administrator **Non-Network** Not covered	**Network** 10% Coinsurance after Annual Deductible; if provided by the Fertility Benefits Administrator **Non-Network** Not covered

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Other Services

Additional Services	Southeast HCN Option 2	Southeast HCN Option 1
Skilled Home Health Care, Durable Medical	**Network**	**Network**

Additional Services	Southeast HCN Option 2	Southeast HCN Option 1
Equip, etc	10% Coinsurance after Annual Deductible; See SPD for Additional Services, limitations and exceptions. **Non-Network** 50% Coinsurance after Annual Deductible; See SPD for Additional Services, limitations and exceptions.	10% Coinsurance after Annual Deductible; See SPD for Additional Services, limitations and exceptions. **Non-Network** 50% Coinsurance after Annual Deductible; See SPD for Additional Services, limitations and exceptions.

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Prescription Drug Coverage

General	Southeast HCN Option 2	Southeast HCN Option 1
Prescription drug vendor	CVS Caremark	CVS Caremark
Prescription drug member services phone number	1-800-378-8851	1-800-378-8851
Prescription drug Website	caremark.com	caremark.com
Prescription drug additional information	Check drug costs https://info.caremark.com/oe/att-se	Check drug costs https://info.caremark.com/oe/att-se
Annual deductible	**Network**	**Network** Not applicable

General	Southeast HCN Option 2	Southeast HCN Option 1
	Medical, MH/SUD, Rx and CarePlus; see Annual Deductible Individual/Family section for amount; deductible must be met before Co-payment applies except for certain preventive care drugs. **Non-Network** Medical, MH/SUD, Rx and CarePlus; see Annual Deductible Individual/Family section for amount; deductible must be met before Co-payment applies except for certain preventive care drugs.	**Non-Network** Not applicable
Annual out-of-pocket maximum	**Network** Medical, MH/SUD, Rx and CarePlus; see Annual out-of-pocket maximum Individual/Family section for amount **Non-Network** Medical, MH/SUD, Rx and CarePlus; see Annual out-of-pocket maximum Individual/Family section for amount	**Network** $1,700 Individual; $3,400 Family; Network copays apply **Non-Network** Not applicable
Retail	**Southeast HCN Option 2**	**Southeast HCN Option 1**
Generic Drugs	**Network** $10 copay after deductible; up to 30 day	**Network** $10 copay; up to 30 day supply; two Fill max on

Retail	Southeast HCN Option 2	Southeast HCN Option 1
	supply; 2 Fill max on maintenance drug then Mail Order required. **Non-Network** The Network Retail Co-payment or 25% of the Network Retail Cost, whichever is less, plus any amount above the Network Retail Cost; up to a 30-day supply	maintenance drug, mandatory mail order **Non-Network** The Network Retail Co-payment or 25% of the Network Retail Cost, whichever is less, plus any amount above the Network Retail Cost; up to a 30-day supply
Preferred Brand Drugs	**Network** $45 copay after deductible; up to 30 day supply; 2 Fill max on maintenance drug then Mail Order required. **Non-Network** The Network Retail Co-payment or 25% of the Network Retail Cost, whichever is less, plus any amount above the Network Retail Cost; up to a 30-day supply	**Network** $45 copay; up to 30 day supply; 2 Fill max on maintenance drug then Mail Order required. **Non-Network** The Network Retail Co-payment or 25% of the Network Retail Cost, whichever is less, plus any amount above the Network Retail Cost; up to a 30-day supply
Non-Preferred Brand Drugs	**Network** $90 copay after deductible; up to 30 day supply; 2 Fill max on maintenance drug then Mail Order required. **Non-Network** The Network Retail Co-payment or 25% of the Network Retail Cost, whichever is less, plus any amount above the Network Retail Cost; up to a 30-day supply	**Network** $90 copay; up to 30 day supply; 2 Fill max on maintenance drug then Mail Order required. **Non-Network** The Network Retail Co-payment or 25% of the Network Retail Cost, whichever is less, plus any amount above the Network Retail Cost; up to a 30-day supply

Retail	Southeast HCN Option 2	Southeast HCN Option 1
Specialty Prescription Drug Services	**Network** Specialty Drugs must be filled by the Rx Benefit Admin Specialty Pharmacy, after first retail Fill. Some drugs covered under medical program, as determined by medical Admin. **Non-Network** Specialty Drugs must be filled by the Rx Benefit Admin Specialty Pharmacy, after first retail Fill. Some drugs covered under medical program, as determined by medical Admin.	**Network** Specialty Drugs must be filled by the Rx Benefit Admin Specialty Pharmacy, after first retail Fill. Some drugs covered under medical program, as determined by medical Admin. **Non-Network** Specialty Drugs must be filled by the Rx Benefit Admin Specialty Pharmacy, after first retail Fill. Some drugs covered under medical program, as determined by medical Admin.
Mail Order	**Southeast HCN Option 2**	**Southeast HCN Option 1**
Generic Drugs	$20 copay after deductible; up to 90 day supply. Retail pickup at specified Retail Pharmacies also available.	$20 copay; up to 90 day supply. Retail pickup at specified Retail Pharmacies also available.
Preferred Brand Drugs	$90 copay after deductible; up to 90 day supply; Retail pickup at specified Retail Pharmacies also available.	$90 copay; up to 90 day supply; Retail pickup at specified Retail Pharmacies also available.
Non-Preferred Brand Drugs	$180 copay after deductible; up to 90 day supply; Retail pickup at specified Retail	$180 copay; up to 90 day supply; Retail pickup at specified

Mail Order	Southeast HCN Option 2	Southeast HCN Option 1
	Pharmacies also available.	Retail Pharmacies also available.
Specialty Prescription Drug Services	Specialty Drugs are automatically processed through the Rx Benefit Admin Specialty Pharmacy when you use the Admin Mail Order Rx Drug Service.	Specialty Drugs are automatically processed through the Rx Benefit Admin Specialty Pharmacy when you use the Admin Mail Order Rx Drug Service.

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Compare different plans

The comparison charts are compiled using information that applies to a large number of health plan users and is commonly reported by the health plans. Depending on the chart type, such as charts for dental and vision plans, certain information and/or sections won't appear because the necessary data isn't available. If you have questions about a topic that isn't covered in the charts, contact the plan's member services department for additional information. Also, keep in mind that the information on access and quality of care is provided by the health plans. Neither AT&T nor Alight Solutions is responsible for the accuracy of this information. If there is a discrepancy between the information displayed on these charts and the official plan documents, the official plan documents will control. AT&T reserves the right to amend, suspend, or terminate the plan(s) or program(s) at any time.