Compare Medical Plans

Southeast HCN Options

The data provided in the chart below is for the 2026 plan year.

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.

Background Information

Plan Facts	Southeast HCN Option 1	Southeast HCN Option 2
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
Member Services Phone Number	1-800-621-7336	1-800-621-7336
Website	bcbsil.com/att	bcbsil.com/att
Product name on website	Network S	Network S
Group ID	03277 - For AT&T Benefits Center Use Only	03278 - For AT&T Benefits Center Use Only
Plan description	Health Care Network Option	Health Care Network Option
Cost Sharing	**Southeast HCN Option 1**	**Southeast HCN Option 2**
See SPD for Full Information	Please check with Plan	Please check with Plan
Annual Deductible	**Network** $1,000 Individual; $2,000 Family; combined with MH/SUD; Capped at $1,000 per Individual **Non-Network** $3,000 Individual; $6,000 Family; combined with MH/SUD; Capped at $3,000 per Individual	**Network** $1,700 Individual; $3,400 Family; combined with MH/SUD, Rx and CarePlus **Non-Network** $5,100 Individual; $10,200 Family; combined with MH/SUD, Rx and CarePlus
Annual Out-of-Pocket Maximum	**Network** $3,500 Individual; $7,000 Family; includes Annual Deductible; combined with MH/SUD; capped at $3,500 per Individual	**Network** $6,750 Individual; $13,500 Family; includes Annual Deductible; combined with MH/SUD, Rx and CarePlus; capped at $6,750 per Individual

Cost Sharing	Southeast HCN Option 1	Southeast HCN Option 2
	Non-Network $10,500 Individual; $21,000 Family; includes Annual Deductible; combined with MH/SUD; capped at $10,500 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

Inpatient Services

Inpatient Care Including Mental Health/Substance Use	Southeast HCN Option 1	Southeast HCN Option 2
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

Outpatient Services

Outpatient Care including Mental Health/Substance Use	Southeast HCN Option 1	Southeast HCN Option 2
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 1	Southeast HCN Option 2
Well exams, Mammography, Pap, Colonoscopy	**Network** 0% Coinsurance **Non-Network** Not covered	**Network** 0% Coinsurance **Non-Network** Not covered
Physician Visits	**Southeast HCN Option 1**	**Southeast HCN Option 2**
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** 50% Coinsurance after Annual Deductible	**Network** 10% Coinsurance after Annual Deductible **Non-Network** 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 1**	**Southeast HCN Option 2**
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 1**	**Southeast HCN Option 2**
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 1	Southeast HCN Option 2
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 underlying cause of infertility **Non-Network** 50% Coinsurance after Annual Deductible; Limited to testing and treatment of the underlying cause of infertility	**Network** 10% Coinsurance after Annual Deductible; Limited to testing and treatment of the underlying cause of infertility **Non-Network** 50% Coinsurance after Annual Deductible; Limited to testing and treatment of the underlying 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

Other Services

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

Prescription Drug Coverage

General	Southeast HCN Option 1	Southeast HCN Option 2
Prescription drug vendor	CVS Caremark	CVS Caremark
Prescription drug member services phone number	1-800-378-8851	1-800-378-8851

General	Southeast HCN Option 1	Southeast HCN Option 2
Prescription drug Website	caremark.com	caremark.com
Annual deductible	**Network** Not applicable **Non-Network** Not applicable	**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** 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.
Annual out-of-pocket maximum	**Network** $1,700 Individual; $3,400 Family; Network copays apply **Non-Network** Not applicable	**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
Retail	**Southeast HCN Option 1**	**Southeast HCN Option 2**
Generic Drugs	**Network** $10 copay; up to 30 day supply; 2 Fill max on 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	**Network** $10 copay; up to 30 day supply; two 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
Preferred Brand Drugs	**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	**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

Retail	Southeast HCN Option 1	Southeast HCN Option 2
Non-Preferred Brand Drugs	**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	**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
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 1	Southeast HCN Option 2
Generic Drugs	$20 copay; 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; 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; up to 90 day supply; Retail pickup at specified Retail Pharmacies also available.	$180 copay; up to 90 day supply; Retail pickup at specified 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.

Compare Dental Plans

The data provided in the chart below is for the 2026 plan year.

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Cost

Plan Prices	AT&T Dental HMO	AT&T Dental PPO
Individual	$9.00	$9.00
Individual + 1	$19.00	$19.00
Individual + 2 or more	$30.00	$30.00

Dental Coverage

Plan Facts	AT&T Dental HMO	AT&T Dental PPO
Carrier Name	Cigna	Cigna
Carrier Address	Please check with Plan	Please check with Plan
Product name on website	Cigna	Cigna
Member Services Phone Number	1-888-722-5505	1-888-722-5505
Website	mycigna.com	mycigna.com
Group ID	40004 - For AT&T Benefits Center Use Only	40023 - For AT&T Benefits Center Use Only
Plan description	Dental HMO Q5IV0	Dental PPO
General Dental Expenses	**AT&T Dental HMO**	**AT&T Dental PPO**
See SPD for Full Information	Please check with Plan	Please check with Plan
Annual Deductible	Not applicable	**Network** $25 Annual Deductible per individual per calendar year **Non-Network** $50 Annual Deductible per individual per calendar year
Annual Maximum Benefit	Maximum does not apply	**Network** $1,750 per individual per calendar year **Non-Network** $1,300 per individual per calendar year

Preventive Care	AT&T Dental HMO	AT&T Dental PPO
Routine exams and cleanings, fluoride, x-ray, sealants	$5 Office Visit Co-pay then 0% Coinsurance	**Network** 0% Coinsurance **Non-Network** 0% of Reasonable and Customary charge. Member owes difference between Provider's fee and Program payment
Emergency Treatment for Pain Management Only	$5 Office Visit Co-pay then 0% Coinsurance	**Network** 0% Coinsurance **Non-Network** 0% of Reasonable and Customary charge. Member owes difference between Provider's fee and Program payment
Basic Services	**AT&T Dental HMO**	**AT&T Dental PPO**
Fillings, Extractions, Endodontics, Periodontics, Surgery	$5 Office Visit Co-pay then 0% Coinsurance	**Network** 10% Coinsurance **Non-Network** 30% of Reasonable and Customary charge
Major Services	**AT&T Dental HMO**	**AT&T Dental PPO**
Inlays, Onlays, Crowns, Bridges and Dentures	$5 Office Visit Co-pay then 50% Coinsurance	**Network** 20% Coinsurance **Non-Network** 50% of Reasonable and Customary charge
Dental Implants	$5 Office Visit Co-pay then 50% Coinsurance	**Network** 20% Coinsurance **Non-Network** 50% of Reasonable and Customary charge
Orthodontia	**AT&T Dental HMO**	**AT&T Dental PPO**
Orthodontia Services	$5 Office Visit Co-pay then 50% Coinsurance	**Network** 20% Coinsurance **Non-Network** 50% of Reasonable and Customary charge
Orthodontia Lifetime Maximum Benefit	Limited to 24 months of treatment per individual per lifetime	**Network** Maximum reimbursement: $2,000 per individual Network/Non-Network combined. **Non-Network** Maximum reimbursement: $1,400 per individual Network/Non-Network combined.

Vision Plan Details - AT&T Vision Program

The data provided in the chart below is for the 2026 plan year.

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Cost

Plan Prices	AT&T Vision Program
Individual	$3.00
Individual + 1	$7.50
Individual + 2 or more	$12.50

Vision Coverage

Plan Facts	AT&T Vision Program
Carrier Name	EyeMed Vision Care, LLC
Carrier Address	Please check with Plan
Product name on website	EyeMed
Member Services Phone Number	1-800-638-4288
Website	eyemedvisioncare.com/att
Group ID	50015- For AT&T Benefits Center Use Only
Plan description	PPO
General Vision Expenses	**AT&T Vision Program**
See SPD for Full Information	Please check with Plan
Annual Maximum Benefit	**Network** Amounts are determined by Co-Payment or Allowance depending on the service or material **Non-Network** Dollar amounts below are what the Program pays up to.
Preventive Care (Routine vision exams)	**Network** No cost **Non-Network** $28 Reimbursement

Glasses	AT&T Vision Program
Frame benefits	**Network** First Pair Benefit: $130 Allowance; Second Pair Benefit: $105 Allowance **Non-Network** $30 Reimbursement
Single, Bifocal, Trifocal, Progressive Lenses	**Network** Standard plastic, Single, Bifocal, Trifocal. - No cost 1st pair benefit & $30 Copay 2nd pair benefit. $112 Allowance for Progressive Lenses for 1st pair benefit & $95 Copay 2nd pair benefit. **Non-Network** Single: $30 Reimbursement; Bifocal:$52 Reimbursement; Trifocal: $72 Reimbursement; Lenticular: $80 Reimbursement and Progressive: $52 Reimbursement. Refer to SPD for details.
Standard Lens Options	**Network** Polycarbonate First Pair No cost; Second Pair Adults: Not covered, Children < age 19 No cost. Lens options Not covered, includes tints, UV coatings, transition, anti-reflective, scratch resist, etc. **Non-Network** Not covered
Contact Lens	**AT&T Vision Program**
Contact Lenses	**Network** $150 Allowance. See SPD for details on 2nd pair benefit. **Non-Network** $150 Reimbursement
Contact lens fit and follow-up	**Network** Not covered **Non-Network** Not covered
Medically necessary lenses	**Network** First Pair Benefit: No cost; Second Pair Benefit: No cost. **Non-Network** $150 Reimbursement
LASIK Eye surgery	**Network** Not covered **Non-Network** Not covered