HMO Options

You may be eligible for an HMO, also referred to as a Fully-Insured Managed Care Option (FIMCO), based on your home ZIP code. In addition to the current Kaiser West plan, 2 new Kaiser options are being introduced; a High Deductible plan (HSA eligible) and a low deductible plan.

It is important that you compare all of your options and choose what works best for you and your family.

	Kaiser High Deductible Plan	Kaiser Low Deductible Plan	Kaiser West Plan
Monthly Contributions			
Current Employee	*Hired/rehired/transferred on/before 5/29/2020*		
Individual:	$97.00	$215.42	$292.18
Family:	$268.00	$549.01	$757.67
New Hire:	*Hired/rehired/transferred after 5/29/2020*		
Individual:	$124.00	$244.42	$316.18
Family:	$343.00	$623.01	$817.67
Medical Coverage	1-800-464-4000	1-800-464-4000	1-800-464-4000
Annual Deductible	$3,300 Individual; $6,600 Family	$1,000 Individual; $2,000 Family; inpatient hospital, outpatient surgery, emergency department visits	$0 Individual; $0 Family
Annual Out-of-Pocket Maximum	$7,050 Individual; $14,100 Family; includes deductible; Copays apply; any amounts the member pays toward the deductible apply toward the annual out-of-pocket maximum	$5,000 Individual; $10,000 Family; includes deductible; copays apply; any amounts the member pays toward the deductible apply toward the annual out-of-pocket maximum	$1,500 Individual; $3,000 Family; Plan year deductible included in out-of-pocket maximum amounts; Copays apply to out-of-pocket maximum
Office Visit (Non-Specialist)	30% Coinsurance after deductible is met	$25 copay; per visit	$20 copay; Per Visit
Office Visit (Specialist)	30% Coinsurance after deductible is met	$50 copay; per visit	$20 copay; Per Visit
Virtual Care	0% Coinsurance after deductible is met	0% Coinsurance	0% Coinsurance

Prescription drug coverage	1-800-464-4000	1-800-464-4000	1-800-464-4000
Annual deductible	Not Applicable	Not Applicable	Not Applicable
Annual out-of-pocket maximum	Not Applicable	Not Applicable	Not Applicable
Generic Drugs	30% Coinsurance after deductible is met; $50 maximum copay; 100 day supply; Preventive generic 0% Coinsurance	10% Coinsurance; $50 maximum copay; 100 day supply	$10 copay; 30 day supply
Preferred Brand Drugs	30% Coinsurance after deductible is met; $100 maximum copay; 100 day supply	10% Coinsurance; $100 maximum copay; 100 day supply	$20 copay; 30 day supply; must be medically necessary, prescribed by a Plan physician , and obtained at Plan Pharmacies
Non-Preferred Brand Drugs	30% Coinsurance after deductible is met; $100 maximum copay; 100 day supply	10% Coinsurance; $100 maximum copay; 100 day supply	$20 copay; 30 day supply; must be medically necessary, prescribed by a Plan physician, and obtained at Plan Pharmacies
Generic Drugs	30% Coinsurance after deductible is met; $50 maximum copay; 100 day supply	10% Coinsurance; $50 maximum copay; 100 day supply	$20 copay; 100 day supply
Preferred Brand Drugs	30% Coinsurance after deductible is met; $100 maximum copay; 100 day supply	10% Coinsurance; $100 maximum copay; 100 day supply	$40 copay; 100 day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order
Non-Preferred Brand Drugs	30% Coinsurance after deductible is met; $100 maximum copay; 100 day supply	10% Coinsurance; $100 maximum copay; 100 day supply	$40 copay; 100 day supply; must be medically necessary, prescribed by a Plan physician, and obtained through Plan mail order
This is intended to provide a high level summary of network coverage details. See SPD for full information			

Important: If your dependents meet the eligibility rules for coverage under your company self-insured option, they will likely be eligible for HMOs/FIMCOs. However, for some dependents (e.g., partners and disabled dependents), certain HMOs/FIMCOs may need more information or may not provide coverage. Before you enroll or re-enroll in an HMO/FIMCO for 2025, it's important to review and compare all your 2025 medical plan options. If you have questions, call the HMO/FIMCO service center (not the AT&T Benefits Center). Phone numbers and your reference number are listed on your online medical plan options chart. Have the reference number from your medical plan options chart handy and be sure to tell the service representative that you are an AT&T participant.

For complete terms and conditions of your benefits, please see your Summary Plan Description (SPD).

Current Employee *(hired, rehired or transferred on/before 5/29/2020)*		
($monthly)	**Employee Coverage**	**Family Coverage**
2025 Employee Base Contribution	$158	$394
PLUS Amount that the Kaiser West total premium exceeds the West HCN Option 1 total cost	+ $134.18	+ $363.67
2025 Kaiser West Contribution	**$292.18**	**$757.67**

New Hire *(hired, rehired or transferred after 5/29/2020)*		
($monthly)	**Employee Coverage**	**Family Coverage**
2025 Employee Base Contribution	$187	$468
PLUS Amount that the Kaiser West total premium exceeds the West HCN Option 1 total cost	+ $129.18	+ $349.67
2025 Kaiser West Contribution	**$316.18**	**$817.67**

Your 2025 Coverage: Much Like 2024

While your medical plan options for 2025 haven't changed, your monthly contributions may have.

Remember, if your preferred providers are not in-network, you could pay more for medical services.

You can check to see if your doctor is in your network or search for new doctors by visiting Blue Cross and Blue Shield of Illinois (BCBSIL*) at **www.bcbsil.com/att**. Even if you are currently a BCBSIL member, follow the prompts on the home page to locate the correct network based on your bargaining region and state of residence.

For More Information

- Review and compare all your **2025 medical plan options and their costs**, and **prescription drug coverage**.
- Go to **Your Personal Healthcare Team** by **Included Health** (includedhealth.com/att) to connect with specialists who can help you navigate your medical plan options and find high-quality providers in-network and/or who meet your needs. This support will be available Dec 17 - Dec. 20.

*Blue Cross and Blue Shield of Illinois (BCBSIL) provides national coverage.

	West HCN Option 1	**West HCN Option 2**
Monthly Contributions Current Employee Individual: Family: New Hire: Individual: Family:	*Hired/rehired/transferred on/before 5/29/2020* $158 $394 *Hired/rehired/transferred after 5/29/2020* $187 $468	 $97 $268 $124 $343
Medical Coverage	1-800-621-7336	1-800-621-7336
Annual Deductible	$950 Individual; $1,900 Family; combined with MH/SUD; capped at $950 per Individual	$1,750 Individual; $3,500 Family; combined with MH/SUD, Rx and CarePlus
Annual Out-of-Pocket Maximum	$3,950 Individual; $7,900 Family; includes Annual Deductible; combined with MH/SUD; capped at $3,950 per Individual	$6,900 Individual; $13,800 Family; Includes Annual Deductible; combined with MH/SUD, Rx and CarePlus; capped at $6,900 per Individual
Copay/Coinsurance	10% Coinsurance after Annual Deductible	10% Coinsurance after Annual Deductible
Prescription drug coverage	1-800-378-8851	1-800-378-8851

Annual deductible	Not applicable	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	$1,700 Individual; $3,400 Family; Network copays apply	Medical, MH/SUD, Rx and CarePlus; see Annual out-of-pocket maximum Individual/Family section for amount
Retail:		
Generic Drugs	$10 copay; up to 30 day supply; two Fill max on maintenance drug, mandatory mail order	$10 copay; up to 30 day supply; 2 Fill max on maintenance drug then Mail Order required.
Preferred Brand Drugs	$45 copay; up to 30 day supply; 2 Fill max on maintenance drug then Mail Order required.	$45 copay; up to 30 day supply; generic avail, pay generic copay + drug cost difference; 2 Fill max on maintenance drug then Mail Order required.
Non-Preferred Brand Drugs	$90 copay; up to 30 day supply; 2 Fill max on maintenance drug then Mail Order required.	$90 copay; up to 30 day supply; generic avail, pay generic copay + drug cost difference; 2 Fill max on maintenance drug then Mail Order required.
Mail Order:		
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; if generic available, pay generic copay plus drug cost difference. 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; if generic available, pay generic copay plus drug cost difference. Retail pickup at specified Retail Pharmacies also available.

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