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Vision Plan Details - AT&T Vision Program

Vision plan navigation shortcuts

Cost Vision Coverage

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

Cost

Plan Prices	AT&T Vision Program
Individual	$3.00
Individual + 1	$7.50

Plan Prices	AT&T Vision Program
Family	$12.50
Individual + Spouse/Partner	Not Applicable
Individual + Child(ren)	Not Applicable
Family	Not Applicable
Individual + 1 or More	Not Applicable

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Vision Coverage

Plan Facts	AT&T Vision Program
Carrier Name	EyeMed Vision Care, LLC
Carrier Address	Please check with Plan
Network Name	EyeMed
Member Services Phone Number	1-800-638-4288
Website	eyemedvisioncare.com/att

Plan Facts	AT&T Vision Program
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

Glasses	AT&T Vision Program
	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

Contact Lens	AT&T Vision Program
LASIK Eye surgery	**Network** Not covered **Non-Network** Not covered

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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.