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EYE PHYSICIANS & SURGEONS OF COLUMBIA

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STATE HEALTH PLAN / EYE MED PATIENTS

If you are a beneficiary of the SC State Health Plan (BCBS-State) and have EyeMed for vision coverage, we have two options for you. It is possible that if you have any medical eye diagnoses (diabetes, cataracts, etc) that your medical BCBS State insurance will cover your eye exam according to your benefit package. In this scenario we would file BCBS-State for your exam, you would be responsible for the $30 refraction and the $35 contact lens exam (if applicable) and whatever remaining portion not covered by BCBS-State (such as if you have not met your deductible or if you have any co-pays).

If you prefer we NOT file your BCBS-State, or you have no medical eye problems (for example, you have healthy normal eyes but just need an updated glasses or contact lens prescription), we will charge you a flat rate of $100 (basic exam and glasses only) or $135 (basic exam and additional charge for contact lens exam). This scenario may make sense if you do not typically meet your deductible in a year and would be responsible for a bigger portion of the exam anyway. You can also take your receipt and file an out of network claim with your EyeMed insurance which will give you a partial reimbursement. In this case we would NOT file your BCBS-State, and it is your responsibility to verify with EyeMed what information is needed in order for you to file a claim with them if you desire.

We offer a 20% discount in our Optical Department for members of the State Health Plan.

FOR TODAY'S VISIT (please sign one):

- ☐ I elect today to file my MEDICAL BCBS-State insurance. I understand I will be responsible for any co-pays or unmet deductibles after my insurance has paid its portion. I understand I am also responsible for the refraction fee of $30, and the contact lens exam fee of $35 (if applicable).

Signature _____ Date: _____

I elect today to pay the flat rate of (check one):

- ☐ $100 for a basic eye exam and glasses prescription
- ☐ $135 for a basic eye exam and the additional contact lens prescription

I understand that my medical insurance WILL NOT be filed for this visit, and any reimbursement or negotiation with EyeMed (if applicable) is my responsibility.

Signature _____ Date: _____