



# Eye Physicians of the East Bay

Medical Corporation  
Diplomates, American Board of Ophthalmology

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## Refraction Policy 2024

### Medicare Deductibles

**The Medicare Part B deductible for 2024 is \$240.** This deductible will reset each year, and the dollar amount may be subject to change. Every year if you're an enrollee in Part B, you have to pay a certain amount out of pocket before Medicare will provide you with coverage for additional costs. Almost any item or service that Part B covers will count toward your deductible. Your deductible is the amount of money you have to pay for your healthcare before Original Medicare or other insurance starts paying for your healthcare expenses.

### Coinsurance

What happens when you reach your Part A or Part B deductible? Typically, you'll pay a 20% coinsurance once you reach your Part B deductible. This coinsurance gets attached to every item or service Part B covers for the rest of the calendar year.

### Non-Covered Services: Refractions

A complete eye examination in our office includes a procedure called a refraction. This measurement lets the doctor and patient know what is the best vision that each eye is capable of and what glasses prescription, if any, would be needed to achieve that level of vision. The fee for a refraction is always covered by routine vision-care insurances, such as VSP (Vision Service Plan).

However, *most medical insurance companies including Medicare or PPO plans will not cover refractions* even if the patient is being seen for medical reasons. Unless you are using an insurance that we know will pay for your refraction, you will be asked to pay for this service at the time of your visit. As a courtesy, we will submit a bill for the refraction fee of \$80 to your insurance company, and any payment that we might receive will be forwarded to you. You are given a discount of \$10 off the refraction fee if you pay on the date of service.

I understand that I am responsible for any charges not covered by my insurance (patient initials) \_\_\_\_\_

### Acknowledgement of Prescription Release

*By signing below you are acknowledging that you received a copy of your eyeglass prescription today at the completion of your examination.*

\_\_\_\_\_  
Print name of patient or person acting on patient's behalf Date of Birth

\_\_\_\_\_  
Signature of patient or person acting on patient's behalf Today's Date

MRN: