



# Plan Certificate



## Vision Care Rider



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An Independent Licensee of the Blue Cross and Blue Shield Association



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## SECTION 1

## Eligibility

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This Rider provides coverage which is supplementary to coverage provided under HMSA's medical plan. Your coverage under this Rider starts and ends on the same dates as your medical plan coverage.

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## SECTION 2

## Provisions of the Medical Plan Applicable

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All definitions, provisions, limitations, exclusions, and conditions of HMSA's Guide to Benefits shall apply to this Rider, except as specifically modified in this Rider.

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## SECTION 3

## Definitions

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### Ophthalmologist (M.D.)

A physician who is appropriately licensed to practice by the proper government authority and who renders services within the lawful scope of such license.

### Optician

A person who fits, adjusts and dispenses glasses and other optical devices, on the written prescription of a licensed physician or optometrist.

### Optometrist (O.D.)

A person who is appropriately licensed to practice optometry by the proper government authority and who renders services within the lawful scope of such license.

### Participating Provider

A provider of services who agrees with HMSA to collect not more than:

- a specified amount paid by HMSA and
- your Copayment.

As an exception, a Participating Provider does not agree to limit charges for contact lenses or frames. Benefit payment for these services will not exceed the amount specified in Section 4. You are responsible for all charges in excess of HMSA's benefit payment. For a current list of participating providers, call us at one of the phone numbers listed on the back cover of this Rider or visit [www.hmsa.com](http://www.hmsa.com).

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## SECTION 4

## Summary of Benefits and Your Payment Obligations

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### About this Chart

This benefit and payment chart:

- Is a summary of covered services and supplies. It is not a complete description of benefits. For coverage criteria, other limitations of covered services, and excluded services, be sure to read *Section 5: Description of Benefits* and *Section 6: Services Not Covered*.
- Gives you the page number where you can find more details about the service or supply.

Tells you what the copayment percentage or fixed dollar amount is for covered services and supplies.

**Please note:** Special limits may apply to a service or supply listed in this benefit and payment chart. Please read the benefit details on the page referenced.

- \* = An asterisk next to a service or supply means either:
- A service dollar maximum may apply.
  - You may owe amounts in addition to your copayment.

Please read the benefit details on the page referenced.

Vision care services are covered only when services are rendered in connection with an eye exam for correction of a visual defect and when the frame or lenses are required as a result of such exam and as described in Section 5.

\* = see page 1

more  
info.  
on  
page:

**Copayment Is**  
(Percentage copayments are based on eligible charges, except where noted)

Participating

Nonparticipating

### Vision Care Services for Adults

Adult Routine Vision Exam

3

\$10

All charges over \$35

### Vision Care Services for Adults – Appliances

You may choose either prescription contact lenses or frames, subject to the  
limits described in Section 5.2

\* Adult Contact Lenses

3

All charges over \$130\*

All charges over \$65

\* Adult Frames

3

All charges over \$130\*

All charges over \$65

Adult Standard Size Lenses – Single  
Vision

3

\$10

All charges over \$25

Adult Standard Size Lenses – Bifocal

3

\$10

All charges over \$40

Adult Standard Size Lenses – Trifocal  
or Lenticular

3

\$10

All charges over \$55

### Vision Care Services for Adults – Other Services

Services below are covered in addition to covered prescription glasses or  
contact lenses

Adult Standard Plastic Scratch-  
Resistant Coating

3

None

All charges over \$5

| SECTION 5                                                                                              | Description of Benefit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                        | <p>Vision care services are covered only when services are rendered in connection with an eye exam for correction of a visual defect and when the frame or lenses are required as a result of such exam and as described in this Rider.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Section 5.1                                                                                            | Vision Care Services for Adults                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p><b>Adult Routine Vision Exam</b></p>                                                                | <p>Adult vision care services are covered, but only as described in the <i>Vision Care Services for Adults</i> sections.</p> <p>Vision care services for children through age 18 are covered only as specified in Chapters 3 and 4 of HMSA's Guide to Benefits in the section labeled "Pediatric Vision Care Services".</p> <p>Benefits for Vision Care Services for Adults (routine vision exam, frames, and lenses) will not be available in the same calendar year you received similar benefits allowed under HMSA's Guide to Benefits <i>Pediatric Vision Care Services</i> sections.</p> <p>Covered, but limited to one exam per calendar year.</p>                                                                                                                                                                                                                                                                                                                                                                                      |
| Section 5.2                                                                                            | Vision Care Services for Adults – Appliances                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p><b>Adult Contact Lenses</b></p> <p><b>Adult Frames</b></p> <p><b>Adult Standard Size Lenses</b></p> | <p>You may choose either contact lenses or frames, subject to the limits described in this section.</p> <p>Covered, but limited to one of the following per calendar year:</p> <ul style="list-style-type: none"> <li>• One pair of non-disposable contact lenses from a participating provider up to \$130, or</li> <li>• Disposable contact lenses from a participating provider up to \$130.</li> </ul> <p><b>Please note:</b> If benefits for a frame have already been paid, no benefits are payable for contact lenses in the same calendar year.</p> <p>Covered, but limited to one frame every other calendar year, up to \$130 from a participating provider. Charges for repair or replacement of a portion of the frame or cost of accessories are not covered.</p> <p><b>Please note:</b> If benefits for contact lenses have already been paid, no benefits are payable for frames in the same calendar year.</p> <p>Covered, but limited to one pair per calendar year for standard size single vision or multifocal lenses.</p> |
| Section 5.3                                                                                            | Vision Care Services for Adults – Other Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <p><b>Adult Standard Plastic Scratch-Resistant Coating</b></p>                                         | <p>Payments for services in this section are made in addition to the benefit payment for covered lenses described in Section 5.2.</p> <p>Covered for standard plastic scratch-resistant coating.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| SECTION 6                                                                                              | Services Not Covered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p><b>Eyeglasses and Contacts</b></p>                                                                  | <p>Except as described in Sections 4 and 5, you are not covered for:</p> <ul style="list-style-type: none"> <li>• Contact lens fitting and follow-up visits.</li> <li>• Contact lenses following cataract surgery.</li> <li>• Lenses including: <ul style="list-style-type: none"> <li>– Nonstandard items for lenses including: <ul style="list-style-type: none"> <li>• anti-reflective coating,</li> <li>• scratch-resistant coating,</li> </ul> </li> </ul> </li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

- tinting,
- UV treatment, and
- blending.
- Oversized lenses.
- Invisible bifocals or trifocals.
- Progressive lenses.
- Polycarbonate lenses.
- Telescopic lenses.
- Low vision lenses.
- Corrective low vision lenses.
- Nonprescription industrial safety goggles.
- Pediatric vision care services are not covered in this Rider. Refer to Chapters 3 and 4 of HMSA’s Guide to Benefits in the sections labeled “Pediatric Vision Care Services” for pediatric vision care benefits.
- Prescription inserts for diving masks or other protective eyewear.
- Repair and replacement of frame parts and accessories.
- Sunglasses.

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## SECTION 7

## Coordination of Benefits

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The coordination of benefits described in Chapter 9 of HMSA’s Guide to Benefits in the section labeled "Coverage that Provides Same or Similar Coverage" is modified as follows:

You may have other benefit coverage that provides benefits that are the same or similar to this plan. No coordination rules apply to vision care services, except for routine vision exam benefits.



# Serving you

Meet with knowledgeable, experienced health plan advisers. We'll answer questions about your health plan, give you general health and well-being information, and more. Hours of operation may change. Please go to [hmsa.com/contact](https://hmsa.com/contact) before your visit.

## HMSA Center in Honolulu

818 Keeaumoku St.

Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.

## HMSA Center in Pearl City

Pearl City Gateway | 1132 Kuala St., Suite 400

Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

## HMSA Center in Hilo

Waiakea Center | 303A E. Makaala St.

Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

## HMSA Center in Kahului

Puunene Shopping Center | 70 Hookele St.

Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

## HMSA Center in Lihue

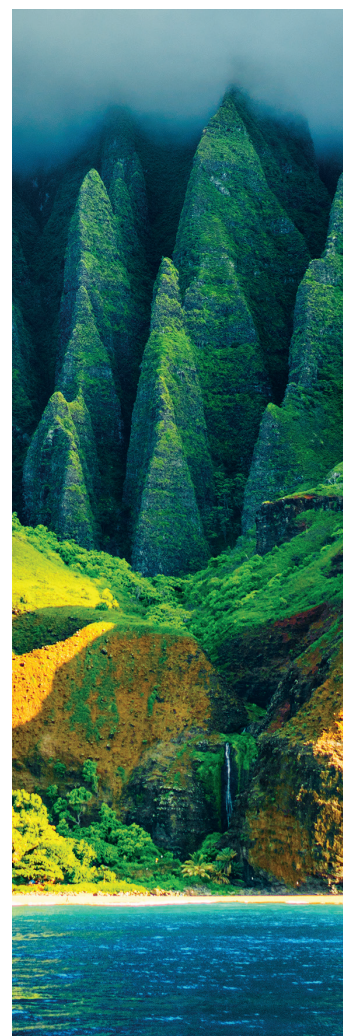
Kuhio Medical Center | 3-3295 Kuhio Highway, Suite 202

Monday–Friday, 8 a.m.–4 p.m.

## Contact HMSA. We're here with you.

Call (808) 948-6111 or 1 (800) 776-4672.

[hmsa.com](https://hmsa.com)



Together, we improve the lives of our members and the health of Hawaii.  
Caring for our families, friends, and neighbors is our privilege.

