ROYAL STATE INSURANCE
Live happy. Insure smart.™

819 S.Beretania Street
Honolulu, Hawaii 96813
Phone: 808.539.1677
Fax: 808.521.3807
www.cgishawaii.com

Thank you very much for your interest in our Retiree Health Care Package. This health benefits program is designed for retirees and includes the following options:

Package 1 - Includes the HMSA vision and dental and the Chiropractic Benefit (ChiroPlan Hawaii).

Package 2 - Includes Kaiser medical plan A and vision 1, and the Chiropractic Benefit (ChiroPlan Hawaii) and HDS dental.

Package 3 - HDS dental.

The Retiree Health Care Package is an exclusive Credit Union product and is available through Aloha Pacific Federal Credit Union. This plan is for members, their spouse and eligible dependents. For additional information on this plan visit our website: www.royalstate.com. Enrolling is simple! Complete the enrollment form and mail it to Royal State Insurance (RSI).

Once you are enrolled in this program, your monthly premiums will be automatically deducted from your credit union account. For assistance, please call RSI Customer Service at 539-1677 or toll free at 1-888-942-2447.

Sincerely,

Venus Gabuyo

Venus Gabuyo
Plan Administrator

ROYAL STATE INSURANCE

Live happy. Insure smart.™

Retiree Health Care Program Exclusively for Credit Union Members!

2011

3 Comprehensive Packages to Choose From

HMSA, Kaiser and Hawaii Dental Service (HDS) Health Benefit Plans

PACKAGE 1

Royal Retiree Vision, Dental, Chiropractic Package

Includes:
HMSA Vision
HMSA Dental
ChiroPlan Hawaii, Inc.

(Must be enrolled in own medical plan)

Monthly Premium Rates	
Single	$ 36.65
2-Party	$ 71.83

PACKAGE 2

Kaiser Health Package*

Includes:
Kaiser Medical Plan A
Kaiser Vision 1
ChiroPlan Hawaii, Inc.
HDS Dental

(Subscribers 49 through 64 years of age)

Monthly Premium Rates	
Single	$ 523.72
2-Party	$ 1,044.97
Family	$ 1,579.32

PACKAGE 3

HDS Group Dental Plan*

Includes:
HDS Dental

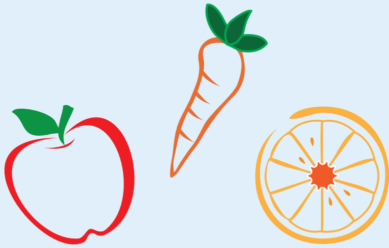
(Must be enrolled in own medical and drug plan(s))

Monthly Premium Rates	
Single	$ 35.98
2-Party	$ 71.47
Family	$ 121.55

You are not likely to find any individual retiree plan that provides you with DENTAL and VISION coverage!

See coverage highlights on the back panel. (Rates subject to change January 1, 2012)

*Dependent students 19 through 24 years with student certification eligible for packages 2 & 3.



Enrolling is easy! Just follow these instructions:

Eligibility Requirements:

- Must be a Member of a participating Credit Union.
- Must have a Credit Union savings or checking account.
- Must reside in Hawaii
- Must be retired

Enrollment/Change Form Instructions:

Please take the time to read the following instructions. It is very important you fill out this form legibly.

Please fill in all information requested.

For Plan enrollment assistance, plan information, changes and payment inquiries, please call the Plan Administrator:

- **ROYAL STATE INSURANCE (RSI)**
  at (808) 539-1677 or
  Toll-free 1-888-942-2447
  email: customerservice@royalstate.com
  Website: www.royalstate.com
- **HMSA**
  (808) 948-6422 or
  Toll-Free 1-800-618-4672
- **KAISER PERMANENTE**
  (808) 597-5955 or
  Toll-Free 1-800-966-5955
- **HDS DENTAL**
  (808) 521-1431 ext. 248 or
  Toll-Free 1-800-232-2533 ext. 248
- **CHIROPLAN HAWAII, INC.**
  (808) 621-4774
  Toll-Free 1-800-414-8845
  Website: www.chiroplanhawaii.com

1-9 Fill in all boxes regarding your personal information.

10-11 Complete Credit Union information, indicating the account that you are authorizing for monthly premium charges.

12 Fill in Date of Retirement and your Former Employer/Company Name.

13 To enroll, make changes, or cancel a Retiree Health Care Package, please check applicable boxes.

*Package #1 is for Medicare subscribers who are covered by other medical plans.

14a Complete if enrolling in Package 1.

14b If you are enrolling in package 1, read this section carefully, sign your name and date the form.

14c This line must be signed for package 1.

15 List spouse or dependent for those enrolling in a 2-party or family plan. Enter the appropriate letter "A" to add, or "D" to delete. Fill in your spouse or dependent's social security number, name, relationship to you, and date of birth in the appropriate columns. (Do not fill in Medical Record Number. For office use only.)

16 Read this section carefully then sign your name and date the form. **THIS ENROLLMENT/CHANGE REQUEST CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE.** Tear off at perforation and return in the enclosed envelope. A confirmation statement will be sent to you shortly after your enrollment form is processed.

Mail form(s) to: Royal State Insurance
819 S. Beretania Street, Honolulu, HI 96813

Phone: (808) 539-1677 • Toll Free 1-888-942-2447
Business Hours: M - F, 8:00 am – 4:30 pm

RETIREE HEALTH CARE PACKAGE

Enrollment / Change Form

Complete by Typing or Printing Legibly with Ball Point Pen

1. Social Security Number

2. Member's Name (Last, First, Middle Initial)

3. Age

4. Date of Birth (Mo./Day/Yr.) / /

5. Sex ❑ M ❑ F

6. Marital Status ❑ Single ❑ Married ❑ Widowed

7. Phone Number (Home)

8. Mailing Address (Street/P.O. Box) (City) (State) (Zip)

9. Email Address

10. Name of Credit Union

11. Credit Union Account Number To Be Debited ❑ Savings ❑ Checking

12. Date of Retirement (Mo./Day/Yr.) Former Employer/Company Name

Other Insurance ❑ Medical ❑ Dental Health Plan Provider Policy No.

13. **PLAN DESIRED:** Enroll in, make changes to, or cancel the **Retiree Health Care Package** below.
If you select 2-Party or family coverage, be sure to complete spouse and/or dependent information in section 15.

Package #1. . ❑ **RSN Royal Retiree** ....HMSA Vision, HMSA Dental and ChiroPlan Hawaii .... ❑ Single ❑ 2-Party ❍ Cancel
(Medicare subscribers enrolled in other medical plans)

Package #2. . ❑ **Kaiser Medical Plan A**....Kaiser Medical and Vision with HDS Dental and ChiroPlan Hawaii...... ❑ Single ❑ 2-Party ❑ Family ❍ Cancel
(Subscribers less than age 65. Must complete medical questionnaire/approval may take up to 60 days)

Package #3. . ❑ **HDS Dental** ....(Subscribers with own medical & drug plans)... ❑ Single ❑ 2-Party ❑ Family ❍ Cancel

Option #4 . . . ❑ **Change My Enrollment**

14a. **IF YOU CHOOSE PACKAGE 1:**

Current or former HMSA Number ___________________________ Are you converting from another HMSA or HPHP Plan? ❑ Yes ❑ No

14b. **CONDITIONS OF ENROLLMENT OF PLAN:** If I am accepted for coverage under a medical plan that requires selection of a personal care physician, all benefits must be provided or arranged by my personal health care physician. I further understand that as an HMSA member, I agree: (a) to abide by the constitution, bylaws, and terms and conditions of the health/dental plan; (b) to provide information to HMSA about my medical treatment or condition; and (c) to appoint my employer or group as my agent for dues payment and for sending and receiving all notices to and from HMSA concerning the health/dental plan. I also agree that HMSA shall set the date on which my health/dental plan coverage shall begin and agree to abide by any waiting periods in my health/dental plan which must be satisfied before any benefits can be paid for specified illness, injuries or conditions.

14c. **Signature of Applicant:** ______________________________ Date: ____________

15. **LIST YOUR SPOUSE AND/OR DEPENDENTS:** Indicate Action Code: **A** (Add) or **D** (Delete) listed dependents.
Indicate Relationship Code: **1** = Spouse, **2** = Son, **3** = Daughter, **9** = Disabled Child

A=Add D=Delete	Social Security Number	Dependent's Last Name	First	M.I.	Relationship Code	Birthdate Mo./Day/Yr.	Medical Record Number
1.							
2.							
3.							

16. **AUTHORIZATION:** I request enrollment, or change in enrollment, and agree to abide by the terms and conditions of the group contracts issued to *MBAH and the above participating Credit Union. I have selected the Retiree Health Care Package checked above and authorize the necessary monthly charges to my account. I understand that coverage will become effective only if there are sufficient funds in my account to pay the premium at the time of deduction (above any minimum required to maintain membership in the Credit Union). I also certify that all information on this form is accurate and all dependents being added to my plan meet all eligibility requirements as set by the applicable group contracts. A photocopy of this application is as valid as the original.

MEMBER'S SIGNATURE: X ______________________________ Date: ____________

FOR OFFICE USE ONLY:

Effective Date: ____________ CU Code: Bank Code: Plan Code: Sub Group Bill Group: [CL]

Comments: ______________________________ [AC]

[PM]

______________________________ [MED]

*Mutual Benefit Association of Hawaii, a non-profit Hawaii mutual benefit society.

Form PSRMED (rev.10/10)

CARRIER ❑ Fax ❑ Mail ❑ Client Letter

2011 Coverage Highlights

(Coverage is described in general terms and is intended for comparison purposes only. Refer to plan certificates for complete information.)

BENEFITS	AMOUNT YOU PAY
Medical Plan Coverages:	**Kaiser Plan A**
Preventive Services:	
• Immunizations	No charge for most
• Physicals	No charge, one per calendar year
Outpatient Services:	
• Office Visits	$15
• Lab, X-ray & Diagnostic Testing	50%
- If outpatient hospital facility	50%
• Same Day Surgery	$15
• Home Health Services	$15
• Prescribed Drugs	Not covered
Inpatient Services:	
• Hospital (Semi Private Room)	$150 per day
• Doctors' Surgical Services	No charge
• Lab, X-ray & Diagnostic Testing	No charge
• Other Services (surgical supplies anesthesia services, drugs)	No charge
• Skilled Nursing Facility (Semi Private Room)	No charge for 60 days
• Hospice Care	No charge for 210 days
Mental Health Services and Substance Abuse Services:	
• Physician Services	
- Outpatient up to 24 sessions per calendar year	$15
- Inpatient up to 30 sessions per calendar year	$150 per day
Emergency Services:	
• Kaiser Designated Facility	$100
• Non-Kaiser Facility/Out of State	20%
Co-payment Maximum per calendar year	$2,500 per member

BENEFITS	AMOUNT YOU PAY	
Dental Coverages:	**RSN/HMSA** ($600 annual limit)	**HDS** ($1,000 annual limit; one month waiting period for HDS benefits)
• Exams	$0 (twice/year)	$0 (twice/year)
• Cleaning	$0 (twice/year)	$0 (twice/year)
• Bitewing X-Rays	$0 (once/year)	$0 (once/year)
• Other covered Dental procedures	50%	50%
• Coverage for Dentures, Bridges, Crowns	yes (after 12 month waiting period)	no
Vision Coverages:	**RSN/HMSA**	**Kaiser Vision 1**
• Eye Examination	$30 annual deductible	$15
• Vision Care Appliances:	Plan Pays:	Plan Pays:
Single Lens	$25 annual deductible	100% (every 12 months if prescription has changed)
MultiFocal Lens	$25 annual deductible	100% (every 12 months if prescription has changed)
Contacts	$45 annual deductible plus remaining eligible charge after $75 plan payment	$45 (in lieu of glasses / 2 lenses every 24 months is $45 less than regular cost)
Frames	$20 annual deductible one frame every other calendar year	$40 (once/24 months)

Chiropractic Coverage: ChiroPlan Hawaii, inc.

	ChiroPlan Provider	Non-ChiroPlan Provider
Maximum Number of Office Visits Per Year	20	Not Covered
Office Visit Copay	$15	Not Covered
Therapy Modalities*	No Charge	Not Covered
X-Ray**	No Charge	Not Covered
Alternative Medical Services***	Not Covered	Not Covered

* Therapy Modalities include: Ultrasound, Ice Packs, Heat Packs, Electrical Muscle Stimulation and other approved therapies.

** Routine x-rays: Two (2) views per body region, per calendar year (when performed in a ChiroPlan Doctor's Office).

*** Alternative Medical Services Includes: Hypnotherapy, Acupuncture, Behavior Training, Sleep Therapy, etc.

Consumers Group Insurance Services, Inc. (CGIS) is an insurance agency in business since 1976. CGIS is part of the Royal State Insurance (RSI) who proudly provides extensive insurance programs, benefit plans and community service through its different entities.