Retiree Specialty Health Benefits
Exclusively for Credit Union Members!

2016

Two Options to Choose From

PACKAGE 1

HMSA Vision and Dental Benefits
Plus
ChiroPlan Hawaii Chiropractic Benefits

(Must be enrolled in own medical plan)

Monthly Premium Rates
Single $ 38.09
2-Party $ 74.73
Family $109.85

PACKAGE 2

HMSA Dental Only
(Includes coverage for major services and $1,000 annual maximum)

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

Monthly Premium Rates
Single $ 39.08
2-Party $ 77.58
Family $124.05

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)
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.

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

• ROYAL STATE INSURANCE (RSI)
at (808) 539-1600 orToll-free 1-800-890-9022
Fax: 808-536-8709email: customerservice@royalstate.comWebsite: www.royalstate.com

• HMSA
(808) 948-6499 orToll-Free 1-800-792-4672

• CHIROPLAN HAWAII, INC.
(808) 621-4774Toll-Free 1-800-414-8845Website: 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, date the form, and mail to Royal State Insurance.
**THIS ENROLLMENT/CHANGE REQUEST CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE.** A confirmation statement will be sent to you shortly after your enrollment form is processed.

Mail form(s) to: Royal State Insurance, Customer Service
819 S. Beretania Street, Honolulu, HI 96813
Phone: (808) 539-1600 • Toll Free 1-800-890-9022
Business Hours: M - F, 8:00 am – 4:30 pm
1. Social Security Number

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

3. Age

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

5. Sex

6. Marital Status

7. Phone Number (Home)

<table>
<thead>
<tr>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>Married</td>
</tr>
</tbody>
</table>

8. Mailing Address (Street/P.O. Box)

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

Health Plan Provider

Policy No.

| Medical | Dental |

13. PLAN DESIRED:

Enroll in, make changes to, or cancel the Retiree Specialty Health Coverage below.

If you select 2-Party or family coverage, be sure to complete spouse and/or dependent information in section 15.


Package #2. HMSA (Dental Only).

Package #3. 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: 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. 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;
(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:

A=Add D=Delete

<table>
<thead>
<tr>
<th>Action Code</th>
<th>(Add) or (Delete) listed dependents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship Code</th>
<th>Birthdate Mo./Day/Yr.</th>
<th>Medical Record Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 = Son</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 = Daughter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 = Disabled Child</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: __________________________


Comments: __________________________________________________________________________

*Mutual Benefit Association of Hawaii, a non-profit Hawaii mutual benefit society. Form PSRMED (rev.12/2013)
## 2016 Coverage Highlights

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

*All benefit coverage listed based on services received by a participating HMSA provider.*

### BENEFITS

<table>
<thead>
<tr>
<th>Dental Coverage:</th>
<th>AMOUNT YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HMSA-1</strong> ($600 annual limit)</td>
<td></td>
</tr>
<tr>
<td>• Exams</td>
<td>$0 (twice/year)</td>
</tr>
<tr>
<td>• Cleaning</td>
<td>$0 (twice/year)</td>
</tr>
<tr>
<td>• Bitewing X-Rays</td>
<td>$0 (once/year)</td>
</tr>
<tr>
<td>• Other covered Dental procedures</td>
<td>50%</td>
</tr>
<tr>
<td>• Coverage for Dentures, Bridges, Crowns</td>
<td>50% (after 12 month waiting period)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision Coverage:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HMSA-1</strong></td>
<td></td>
</tr>
<tr>
<td>• Eye Examination</td>
<td>$30 annual deductible</td>
</tr>
<tr>
<td>• Vision Care Appliances:</td>
<td>Plan Pays:</td>
</tr>
<tr>
<td>Single Lens</td>
<td>$25 annual deductible</td>
</tr>
<tr>
<td>MultiFocal Lens</td>
<td>$25 annual deductible</td>
</tr>
<tr>
<td>Contacts</td>
<td>$45 (copay) plus remaining eligible charge after $75 plan payment</td>
</tr>
<tr>
<td>Frames (standard/selected)</td>
<td>$20 (copay) one frame every 24 mos.</td>
</tr>
</tbody>
</table>

### Chiropractic Coverage: ChiroPlan Hawaii, Inc.

<table>
<thead>
<tr>
<th>ChiroPlan Provider</th>
<th>Non-ChiroPlan Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Number of Office Visits Per Year</td>
<td>20</td>
</tr>
<tr>
<td>Office Visit Copay</td>
<td>$15</td>
</tr>
<tr>
<td>Therapy Modalities*</td>
<td>No Charge</td>
</tr>
<tr>
<td>X-Ray**</td>
<td>No Charge</td>
</tr>
<tr>
<td>Alternative Medical Services***</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*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.