

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
EFFECTIVE JANUARY 1, 2015 TO JUNE 30, 2015

		Monthly Premium		Monthly Premium		Monthly Premium
1A	MEDICAL/PRESCRIPTION DRUG	HMSA		Kaiser		UHC
	A. Non-Medicare - Self	<input type="checkbox"/>	\$576.16	<input type="checkbox"/>	\$648.28	
	B. Non-Medicare - 2-Party	<input type="checkbox"/>	\$1,122.62	<input type="checkbox"/>	\$1,314.64	
	C. Non-Medicare - Family	<input type="checkbox"/>	\$1,664.26	<input type="checkbox"/>	\$1,941.88	
	D. Medicare - Self	<input type="checkbox"/>	\$369.14	<input type="checkbox"/>	\$398.12	<input type="checkbox"/> \$224.68
	E. Medicare - 2-Party	<input type="checkbox"/>	\$719.12	<input type="checkbox"/>	\$776.72	<input type="checkbox"/> \$440.10
	F. Medicare - Family	<input type="checkbox"/>	\$1,066.12	<input type="checkbox"/>	\$1,151.32	

If you want medical and prescription drug, select one plan and enter premium amount (go to line 2)
 If you want medical only, go to line 1B. If you want prescription drug only, go to line 1C.

1A \$ _____

1B	MEDICAL ONLY	HMSA		UHC
	A. Non-Medicare - Self	<input type="checkbox"/>	\$424.24	
	B. Non-Medicare - 2-Party	<input type="checkbox"/>	\$826.72	
	C. Non-Medicare - Family	<input type="checkbox"/>	\$1,225.54	
	D. Medicare - Self	<input type="checkbox"/>	\$193.46	<input type="checkbox"/> \$49.00
	E. Medicare - 2-Party	<input type="checkbox"/>	\$377.02	<input type="checkbox"/> \$98.00
	F. Medicare - Family	<input type="checkbox"/>	\$558.90	

Select one plan and enter premium amount
 If you selected a plan in 1A, do not complete this section

1B \$ _____

1C	PRESCRIPTION DRUG ONLY		
	A. Non-Medicare - Self	<input type="checkbox"/>	\$151.92
	B. Non-Medicare - 2-Party	<input type="checkbox"/>	\$295.90
	C. Non-Medicare - Family	<input type="checkbox"/>	\$438.72
	D. Medicare - Self	<input type="checkbox"/>	\$175.68
	E. Medicare - 2-Party	<input type="checkbox"/>	\$342.10
	F. Medicare - Family	<input type="checkbox"/>	\$507.22

Select one plan and enter premium amount
 If you selected a plan in 1A, do not complete this section

1C \$ _____

2	DENTAL	HDS
	Non Medicare/Medicare	
	Self	<input type="checkbox"/> \$30.24
	2-Party	<input type="checkbox"/> \$58.98
	Family	<input type="checkbox"/> \$72.24

Select one plan and enter premium amount

2 \$ _____

3	VISION	VSP
	Non Medicare/Medicare	
	Self	<input type="checkbox"/> \$5.32
	2-Party	<input type="checkbox"/> \$10.64
	Family	<input type="checkbox"/> \$14.28

Select one plan and enter premium amount

3 \$ _____

4 Add lines 1A or 1B and 1C, 2, 3 (Medical, Prescription Drug, Dental, Vision) **4** \$ _____

5	EMPLOYER CONTRIBUTION	0%	50%	75%	100%
	A. Non Medicare - Self	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$368.30	<input type="checkbox"/> \$552.44	<input type="checkbox"/> \$736.60
	B. Non Medicare - 2-Party	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$742.36	<input type="checkbox"/> \$1,113.54	<input type="checkbox"/> \$1,484.72
	C. Non Medicare - Family	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$1,086.52	<input type="checkbox"/> \$1,629.80	<input type="checkbox"/> \$2,173.06
	D. Medicare - Self	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$262.36	<input type="checkbox"/> \$393.54	<input type="checkbox"/> \$524.72
	E. Medicare - 2-Party	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$525.84	<input type="checkbox"/> \$788.78	<input type="checkbox"/> \$1,051.70
	F. Medicare - Family	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$765.88	<input type="checkbox"/> \$1,148.84	<input type="checkbox"/> \$1,531.78

Check your medical selection on line 1A or 1B. (For example, if you selected 1AA, your employer contribution will be non medicare self.) Enter your employer contribution amount (0% or 50% or 75%).

5 \$ _____

6 Line 4 minus line 5, enter the AMOUNT YOU OWE monthly **6** \$ _____

Please keep this sheet for your records. We do not send monthly billings or statements. Your monthly amounts will be on your confirmation notice. Payments are due by the first of the month, you may pay for more than one month of premiums on one check. Please make checks payable to EUTF and mail to P.O. Box 30700, Honolulu, HI 96820-0700.