



# Personnel Officer Open Enrollment Informational Session



Hawaii Employer-Union Health Benefits Trust Fund

This presentation is a brief summary and does not constitute a legal document or contract and is subject to change.



## AGENDA

- Important Dates
- Changes for 2016
- Completing the EC-1/EC-1H Form
- Understanding Your Benefits
- Contact Information

## Important Dates

- Election Period  
April 1, 2016 through April 29, 2016
- New Coverage and Rate Changes  
Effective July 1, 2016
- New premiums deducted from paycheck:  
July 15, 2016 through June 30, 2017 (County Employees)  
July 20, 2016 through July 5, 2017 (State Employees)
- Deadline for employees to submit EC-1/EC-1H  
is **April 29, 2016**
- Deadline for employers to submit forms to  
EUTF is **May 6, 2016**

## Open Enrollment

- Enroll, cancel or change plans
- Add or remove dependents
- If you do not want to make changes, no action is needed

## HSTA VB

- Only available to those who are currently enrolled in HSTA VB plans (former VEBA members)
- HSTA VB members should complete the EC-1H Enrollment Form if making changes
- HSTA VB members can switch to EUTF plans, but cannot switch back to HSTA VB plans (Complete EC-1 Form)
- HSTA VB members cannot enroll in both EUTF and HSTA VB plans simultaneously

## Reference Guide

- Available at [eutf.hawaii.gov](http://eutf.hawaii.gov)
- Rates and Contribution Amounts
- Dependent Eligibility Criteria
- Health Plan Options
- EC-1/EC-1H Enrollment Form



## Changes for 2016

### Prescription Drug Coverage

#### CVS Caremark (HMSA members)

- *Copayments*
- *Retail 90-Network*
- *Maximum Out-of-Pocket*

#### Kaiser Prescription Drug

- *Kaiser Comprehensive and Standard Plan Copayments*



## Changes for 2016

### Medical Coverage

#### EUTF HMSA Plans

- *Advanced Care Planning*
- *Dr. Dean Ornish Program for heart disease*

#### EUTF HMSA 80/20 & 75/25 plans

- *Office Visit Coinsurance*
- *Outpatient Diagnostic Lab Coinsurance*
- *Out-of-Network Coinsurance*
- *Emergency Room Facility Charges*



## Changes for 2016

### EUTF Qualifying Life Event Changes

#### Birth Event

- Submission deadline changed from 60 days to 180 days

#### Acquisition of Coverage

- Submit letter from insurance carrier or employer detailing:
  - Type of coverage gained (i.e., medical, drug, dental, vision)
  - Effective date of insurance
  - Names of those enrolled under the plan

#### Reinstatement After Termination for Non-Payment

- Employee may be reinstated in plans if full payment of contributions is made within 30 days from date of cancellation notice and employee has not been cancelled in the past 12 months due to non-payment



## Reminders

### Authorized leave of absence without pay (LWOP) lasting more than 30 days:

- Personnel officer/enrollment designee must complete a L-1 form and give the form to the employee and submit a copy to the EUTF
- Employees on LWOP lasting more than 30 days may elect to:
  1. Continue EUTF health coverage while on leave (Employees will be responsible for healthcare premiums)
  2. Cancel EUTF health coverage



## Leave Without Pay

### Employees continuing coverage during LWOP:

- Are responsible for submitting premium payments to the EUTF
- EUTF will NOT send bills

### Employees canceling coverage during LWOP:

- Must submit an EC-1/EC-1H form within 30 days from beginning of leave date to cancel coverage, and may re-enroll in the same benefit plans upon return from LWOP by submitting an EC-1/EC-1H form within 30 days from return date.



## Leave Without Pay

- If an employee does not submit an EC-1/EC1H form within 30 days to cancel their coverage and does not make payments to the EUTF, his or her plans will be cancelled for non-payment and will not be able to re-enroll until the next Open Enrollment period.
- If an employee is on LWOP for a period of less than 30 days the employee could still have a premium shortage. Employees need to check their paystubs to see if they need to submit a premium payment to the EUTF.



## Cancel/Waive Coverage

Employees do not have the option to cancel/waive his or her coverage unless:

- They submit an EC-1/EC-1H form during an Open Enrollment Period
- They are on LWOP for more than 30 days and submit an EC-1/EC-1H form within 30 days from beginning of leave date
- They have gained coverage elsewhere and submit an EC-1/EC-1H form within 30 days from the effective date of gaining coverage elsewhere

EC-1 <small>Rev. April 2016</small>	Hawaii Employer-Union Health Benefits Trust Fund <b>EC-1: Enrollment Form for Active Employees</b> DUE DATE: This form must be submitted to your Personnel Officer or Departmental Personnel Office within 30 days (180 days for newborns) of the event date.	PLEASE SUBMIT THIS EC-1 FORM TO YOUR PERSONNEL OFFICE DOE EMPLOYEES: PO BOX 2360 HONOLULU HI 96804
<b>SECTION 1: EMPLOYEE DATA</b>		
<small>Please complete all applicable fields below. Social security numbers are required to process new hires and dependent(s) enrollments. ** See Section 4 on "Instructions for Completing Form EC-1"</small>		
Name (Last Name, First Name, Middle Initial) <u>Kealoha, John K.</u>	<input type="checkbox"/> New Hire/Newly Eligible Date of Hire/Newly Eligible (MM/DD/YYYY) _____	<input type="checkbox"/> During the Plan Year Qualifying Event (describe) Event Date: ____/____/____
Home Phone (808) <u>555-9999</u>		Marital Status <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single Marriage Date: (MM/DD/YYYY) _____
Mobile Phone (808) <u>555-1234</u>		
Work Phone (808) <u>555-5678</u>	<input checked="" type="checkbox"/> Open Enrollment (effective 07/01/2016)	
Email <u>John.K.Kealoha@hawaii.gov</u>	<input type="checkbox"/> Termination Date of Termination (MM/DD/YYYY) _____	<u>02 / 14 / 2014</u>
Mailing Address <input type="checkbox"/> Check this box if your address has changed	Employee's Social Security Number (SSN) or EUTF ID Number <u>555-44-3333</u>	<input type="checkbox"/> Civil Union Civil Union Date: (MM/DD/YYYY) <input type="checkbox"/> Check this box if status change
Street <u>1234 Aloha Lane</u>		
Line 2 _____		
City <u>Honolulu</u> State <u>HI</u> Zip Code <u>96813</u>		Domestic Partner (DP Status) <input type="checkbox"/> IRS Qualified <input type="checkbox"/> Not Qualified Notary Date: (MM/DD/YYYY) _____
Residence Address (if different from above)	Gender <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female Birth Date: (MM/DD/YYYY) <u>12 / 04 / 1983</u>	
Street _____		
Line 2 _____		
City _____ State _____ Zip Code _____		
<small>Special Note: If your Spouse, Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her Name, Date of Birth and SSN.</small>		
Name: <u>Mary L. Kealoha</u>	DOB: <u>11 / 12 / 1983</u>	SSN: <u>555-99-8888</u>

- Full name
- Contact Information
- Current address

- Mark "Open Enrollment"
- SSN, Gender & DOB

- Marital status
- Civil Union
- Domestic Partner

<b>SECTION 2: COVERAGE AND DEDUCTION START SELECTION</b>					
Leave Section 2 blank					
<b>SECTION 3: PLAN SELECTION</b> <small>Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If no selection is made, EUTF will assume no changes are being made.</small>					
<b>Medical/Prescription Drug Plan Type</b>	<b>Carrier Selection</b>	<b>You may only choose one medical/prescription drug plan</b>			
		Cancel/Waive	Self	2-Party	Family
PPO	PPC-90/10 HMSA Medical, CVS Prescription Drug, Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PPC-80/20 HMSA Medical, CVS Prescription Drug, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	PPC-75/25 HMSA Medical, CVS Prescription Drug, Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO-HMSA CVS Prescription Drug, Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HMO-Kaiaer Standard Prescription Drug, Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO-Kaiaer Comprehensive Prescription Drug, Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Supplemental- Royal State National Insurance Company (Includes Supplemental Drug Coverage), Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental	*** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under another non- EUTF health plan. See Section 5 on "Instructions for Completing Form EC-1"				
<b>Other Plans</b>					
<b>Dental</b>	Hawaii Dental Service <small>if enrolling new dependent ages 19-23 attach student verification</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Vision</b>	Vision Service Plan <small>if enrolling new dependent ages 19-23 attach student verification</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Life</b>	USABLE Life	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For STATE Employees ONLY: Premium Conversion Plan <input checked="" type="checkbox"/> Enroll <input type="checkbox"/> Change Amount <input type="checkbox"/> Cancel PCP <input type="checkbox"/> Do NOT Enroll					

Complete section 3  
 Indicate plan selection & coverage tier

<small>Employee's Name</small> <b>John K. Kealoha</b>										
<b>SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS</b> <small>Please list all dependents you want enrolled</small>										
<small>List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information received/issued by the SSA.</small>										
Continue Coverage	Add	Delete	Dependent <small>Last Name, First Name, Middle Initial</small>	Birth Date <small>(MM/DD/YYYY)</small>	Social Security Number**	Relationship*	Gender <small>M / F</small>	Medical/Drug	Dental	Vision
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Kealoha, Mary L.	11 /12 /1983	555-99-8888	SP	F	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at <http://eutf.hawaii.gov> in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes. Dependent Certification and Student Certification— See Section 4 item 8 on "Instructions for Completing Form EC-1" for more information.

**I certify that my spouse, civil union or domestic partner and/or dependent children meet eligibility requirements for enrollment in the EUTF plans.** JKK (Initials)

**I certify that my dependent child is a full-time student and have attached all documentation as required in Section 4 regarding dependent and student certification in the "instructions for Completing Form EC-1".** \_\_\_\_\_ (initials)

- Proof Documents**

  - Marriage/Civil Union/Domestic Partnership Documentation
  - Birth Certificate
  - Student Certification

**SECTION 5: OTHER INSURANCE INFORMATION** \*\*\* To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under another non-EUTF health plan

If you or any of your dependents are covered under another non-EUTF health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (Self, 2 party, Family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Self	2-Party
			/ /	<input type="checkbox"/>	<input type="checkbox"/>
			/ /	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE**

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Employee Signature: John K. Kealoha Date Signed: 4/3/2016

Department ID# <b>000000</b>	Department <b>Budget and Finance</b>	Division/School <b>EUTF</b>	Bargaining Unit <b>13</b>
Date EC-1 Received in Employing Office	<b>04/18/2016</b>	DPO Phone Number <b>(808)586-5555</b>	DPO Fax Number <b>(808)586-9999</b>
DPO (or employer designee's) Printed Name: <b>Ethan Smith</b>		Date of DPO (or employer designee's) Signature	
DPO (or employer designee's) Signature: <u>Ethan Smith</u>		<b>04/18/2016</b>	
Remarks: <b>Open Enrollment</b>			

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**DEADLINE FOR EMPLOYEES TO SUBMIT  
EC-1/EC-1H IS APRIL 29, 2016**

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

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DPO (or employer designee's) Printed Name: <b>Ethan Smith</b>		Date of DPO (or employer designee's) Signature	
DPO (or employer designee's) Signature: <u>Ethan Smith</u>		<b>04/18/2016</b>	
Remarks: <b>Open Enrollment</b>			

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Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Self	2-Party
_____	_____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE**

**DEADLINE FOR EMPLOYERS TO SUBMIT  
EC-1/EC-1H IS MAY 6, 2016**

**EUTF  
P.O. Box 2121  
Honolulu, HI 96805**

**NO FAX OR EMAIL**

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## Confirmation Notice

- Check for any errors
- Must respond in writing within 10 calendar days of the date of the notice



**HAWAII EMPLOYER-UNION  
HEALTH BENEFITS TRUST FUND**

P.O. Box 2121  
Honolulu, HI 96805-2121  
Phone: (808) 955-7360  
Toll Free: (800) 285-0288  
www.eutf.hawaii.gov

Confirmation Notice Date: May 04, 2016

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SARAH ALOHA ID #: 9999999  
123 KAHALO STREET Agency/Department: Budget and Finance  
HONOLULU, HI 96807 Empowering Unit: 15

This Confirmation Notice details the enrollment changes that were made to your account. Please carefully review its contents to make sure it does not contain any errors. You have a one-time opportunity to correct errors that you made in selecting your coverages (e.g. plan, tier level) and dependents) on your enrollment form by notifying EUTF within 10 calendar days from the date of this notice. Any approved changes will be made retroactively to the effective date of the changes as noted below. You will be responsible for any additional premiums.

Please submit your corrections in writing by completing the attached Corrective Action Request Form. Keep a copy of the Corrective Action Request Form for your records. If the EUTF does not hear from you in writing within 10 calendar days from the date of this notice, the changes will remain in effect as indicated. Any additional changes to your plans will not be allowed until the next Open Enrollment period, unless you experience a mid-year qualifying event that permits changes under the EUTF Administrative Rules.

**Your Benefit Plan Enrollments: as of 01/31/2015**

Plan Type	Benefit Plan	Coverage Type	Effective Date	Pay Period Deductions
PCP	Excel	MA	01/31/2015	\$ 00
Medical	PPO Medical (90/10) w/ Chro	Self	01/31/2015	\$161.52
Dental	Dental	Self	01/31/2015	\$6.42
Vision	Vision	Self	01/31/2015	\$1.28
Prescription Drug	PPO Prescription Drug	Self	01/31/2015	\$17.68
Life	Life Insurance	Self	01/31/2015	\$ 00

**NOTE: Kaiser and HNSA HMO includes prescription drug coverage.**

**Your Total Pay Period Deduction: \$124.90**

The EUTF Notice of Privacy Rules describes how your medical information may be used and disclosed and how you can get access to the information. It is available online at [www.eutf.hawaii.gov](http://www.eutf.hawaii.gov). Please review it carefully.

EUTF's Mission: We care for the health and well-being of our beneficiaries by offering a private quality health plan for its affiliates, stability and well-being through health care services, including medical, behavioral, and administrative.



# Understanding Your Benefits

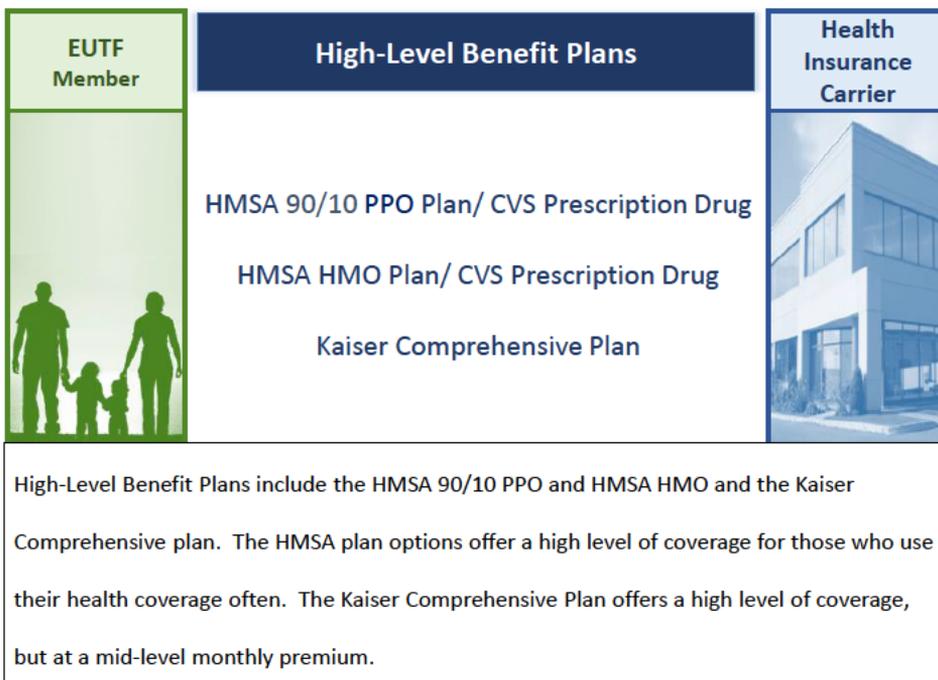
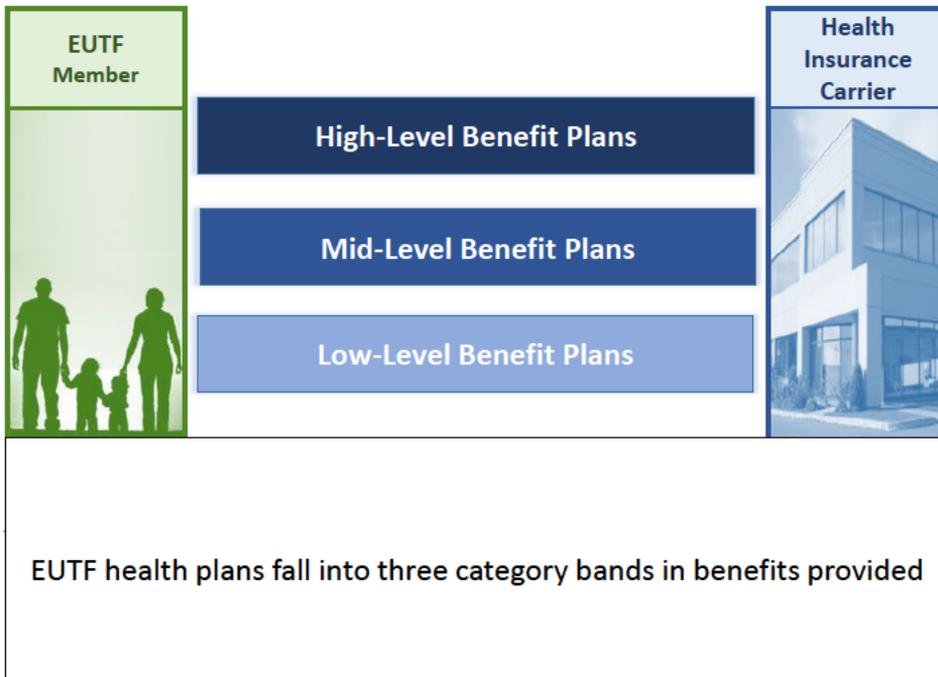
- Selecting the right plan for you
- Prescription drug copayment increases
- How premiums are determined



<b>HMSA: EUTF 90/10</b> Summary of Benefits and Coverage: What This Plan Covers & What It Costs Coverage Period: 07/01/2015 - 06/30/2016 Coverage for: All Coverage Types / Plan Type: PPO	
<b>Kaiser Permanente: EUTF (Comprehensive)</b> Summary of Benefits and Coverage: What This Plan Covers & What It Costs Coverage Period: 07/01/2015-06/30/2016 Coverage for: Individual / Family / Plan Type: HMO	
<b>HMSA: EUTF 80/20</b> Summary of Benefits and Coverage: What This Plan Covers & What It Costs Coverage Period: 07/01/2015 - 06/30/2016 Coverage for: All Coverage Types / Plan Type: PPO	
<b>Kaiser Permanente: EUTF (Standard)</b> Summary of Benefits and Coverage: What This Plan Covers & What It Costs Coverage Period: 07/01/2015-06/30/2016 Coverage for: Individual / Family / Plan Type: HMO	
<p><b>This is only a summary.</b> If you need more detail about your coverage and costs, you can get the complete terms in the plan documents at <a href="http://www.kp.org">www.kp.org</a> or by calling 1-800-432-3933 (toll-free) or 543-896-8933 (long-area toll-free).</p>	
Important Questions	Answers
What is the overall deductible?	\$0
Are there other deductibles for specific services?	No
Are there any out-of-pocket/lifetime cost maximums?	Yes: \$7,500 individual / \$15,000 family (for most members)
What is not included in the guaranteed issue?	Prescription, tobacco-related charges, and health care that is not deemed "reasonable and customary."



With six different health plans to choose from it's important to carefully consider your options and select the plan that best fits your lifestyle and budget. Here are some things to consider when selecting a health plan.



<p><b>EUTF Member</b></p>	<p><b>Mid-Level Benefit Plans</b></p>	<p><b>Health Insurance Carrier</b></p>
	<p>HMSA 80/20 PPO Plan/ CVS Prescription Drug</p> <p>Kaiser Standard Plan</p>	
<p>The HMSA 80/20 PPO and Kaiser Standard plans are Mid-Level Benefit Plans. Fifty percent of EUTF members are enrolled in the HMSA 80/20 plan and enjoy a balance between mid-level monthly premiums and reasonable out-of-pocket expenses. The Kaiser Standard Plan offers a mid-level of coverage, but at a low-level monthly premium.</p>		

<p><b>EUTF Member</b></p>	<p><b>Low-Level Benefit Plan</b></p>	<p><b>Health Insurance Carrier</b></p>
	<p>HMSA 75/25 PPO Plan/ CVS Prescription Drug</p>	
<p>The EUTF Low-Level Benefit Plan is the HMSA 75/25 PPO. This plan is for members who are generally healthy and do not need a mid or high level of coverage. Members have access to comprehensive coverage for unforeseen illness or injury at a low-level monthly premium.</p>		



	HMSA 90/10 PPO	HMSA 80/20 PPO
Annual Employee Premium Contribution	\$11,610	\$7,997
<b>Total Estimated Annual Cost:</b>	<b>\$11,610</b>	<b>\$7,997</b>
	<b>Difference: <u>\$3,613</u></b>	

The annual employee premium contribution for the HMSA 90/10 plan is \$11,610. Under the HMSA 80/20 plan the annual employee premium contribution is \$7,997, resulting in a cost difference of \$3,613 between the two plans.

	HMSA 90/10 PPO	HMSA 80/20 PPO
Annual Employee Premium Contribution	\$11,610	\$7,997
Co-Insurance 10% \$3,000		
MOOP \$4,000 Not met		
<b>Total Estimated Annual Cost:</b>	<b>\$14,610</b>	<b>\$7,997</b>
	<b>Difference: <u>\$3,613</u></b>	

Hospital INVOICE

SR #	PARTICULARS	RATE	DISCOUNT	AMOUNT
	Surgey		\$10,000	
	Room and Board		\$10,000	
	Physician Fees		\$5,000	
COMMENTS/INSTRUCTIONS		SUBTOTAL		\$40,000
1.		TAX RATE		
2.		TAX		
3.		(OTHER) SPECIFY		
4.		(OTHER) SPECIFY		
		(OTHER) SPECIFY		
		(OTHER) SPECIFY		
		TOTAL		\$50,000

Thank You For Your Business!

**Medical Bills \$30,000**

The HMSA 90/10 plan has a co-insurance of 10% which comes out to \$3,000 (plus any tax). The MOOP limit for family under the HMSA 90/10 plan is \$4,000. In this example the MOOP limit has not been met. Kimo's total estimated cost under the HMSA 90/10 plan is \$14,610.

Annual Employee Premium Contribution

SR #	PARTICULARS	RATE	DISCOUNT	AMOUNT
	Co-Insurance			\$10,000
	Health and Welfare			\$10,000
	Physician Fee			\$10,000
SUBTOTAL				\$30,000
TAX RATE				
TAX				
COMMENTS/INSTRUCTIONS				
1.				
2.				
3.				
4.				
TOTAL				\$30,000

**Medical Bills  
\$30,000**

HMSA 90/10 PPO	HMSA 80/20 PPO
\$11,610	\$7,997
Co-Insurance 10% \$3,000	Co-Insurance 20% <b>\$5,000</b>
MOOP \$4,000 Not met	MOOP \$5,000 Met

**Total Estimated Annual Cost: \$14,610 (HMSA 90/10 PPO) vs \$12,997 (HMSA 80/20 PPO)**

**Total annual estimated savings under the HMSA 80/20 plan: \$1,613**

The HMSA 80/20 plan has a co-insurance of 20% which comes out to \$6,000 (plus any tax). The MOOP limit for family under the 80/20 plan is \$5,000. Kimo will only pay \$5,000 because the MOOP limit has been reached. Kimo's total estimated cost under the 80/20 plan is \$12,997. If Kimo were to enroll in the HMSA 80/20 plan he would save \$1,613. However, Kimo's savings may not stop there. Any in-network doctor visits Kimo and his family has for the remainder of the calendar year will be covered at 100% because they have reached the MOOP limit.

Kaiser Comprehensive	Kaiser Comprehensive & Standard	Kaiser Standard																																																				
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Malia is a State employee in BU 13 and covers a family of three. She is currently enrolled in the Kaiser Standard family plan and is anticipating \$100,000 in inpatient hospital costs this year. Malia is considering switching to the Kaiser Comprehensive plan during open enrollment.



Annual Employee Premium Contribution

Hospital Name		INVOICE	
SR #	PARTICULARS	RATE	AMOUNT
	Room and Board		\$40,000
	Physician Fee		\$60,000
COMMENTS/INSTRUCTIONS		SUBTOTAL \$100,000	
1.		TAX RATE	
2.		TAX	
3.		(OTHER) SPECIFY	
4.		(OTHER) SPECIFY	
Thank You For Your Business!		TOTAL \$100,000	

**Hospital Bills  
\$100,000**

Comprehensive	Standard
\$7,963	\$2,573
Inpatient Hospital No Change	Co-Insurance <del>15%</del> <b>\$7,500</b>
MOOP \$6,000 Not met	MOOP \$7,500

**Total Estimated Annual Cost: Comprehensive \$7,963 Standard \$10,073**

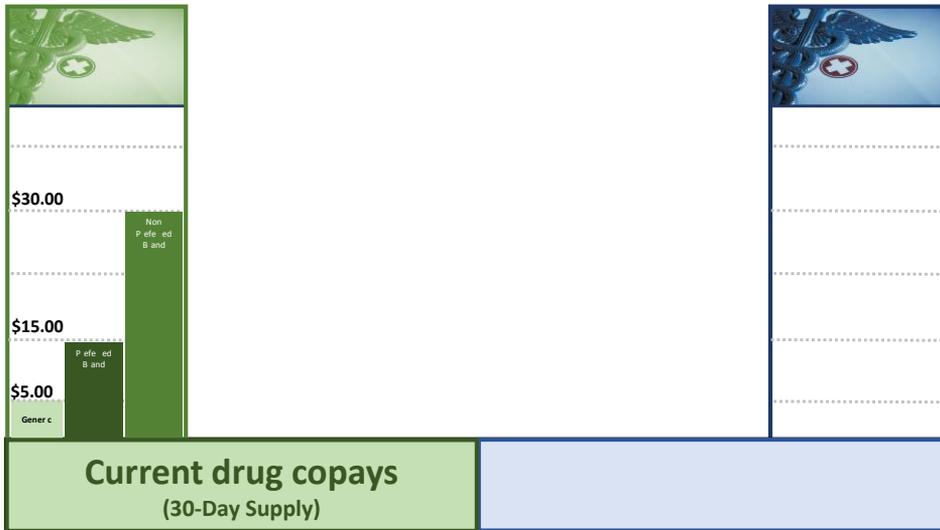
**Total annual estimated savings under the Kaiser Comprehensive: \$2,110**

The Kaiser Standard plan has a co-insurance of 15% for inpatient hospital services which comes out to \$15,000 (plus any tax). The MOOP limit for a family under the Kaiser Standard plan is \$7,500. Malia will only pay \$7,500 because the MOOP limit has been reached. Malia's total estimated cost under the Kaiser Standard plan is \$10,073. Please keep in mind that because the MOOP was reached under the Kaiser Standard plan, any addition services Malia receives will be covered at 100% for the remainder of the calendar year. If Malia were to enroll in the Kaiser Comprehensive plan she would save \$2,110.

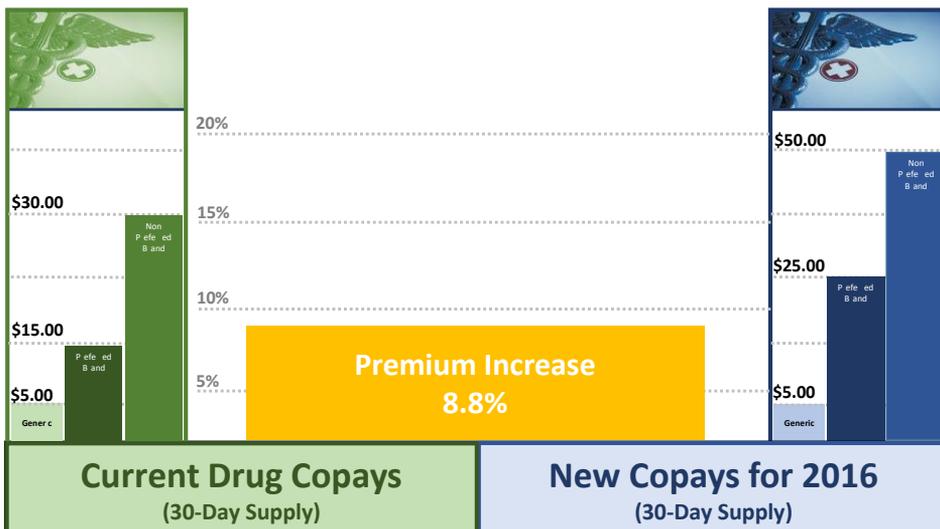


## Understanding Your Benefits

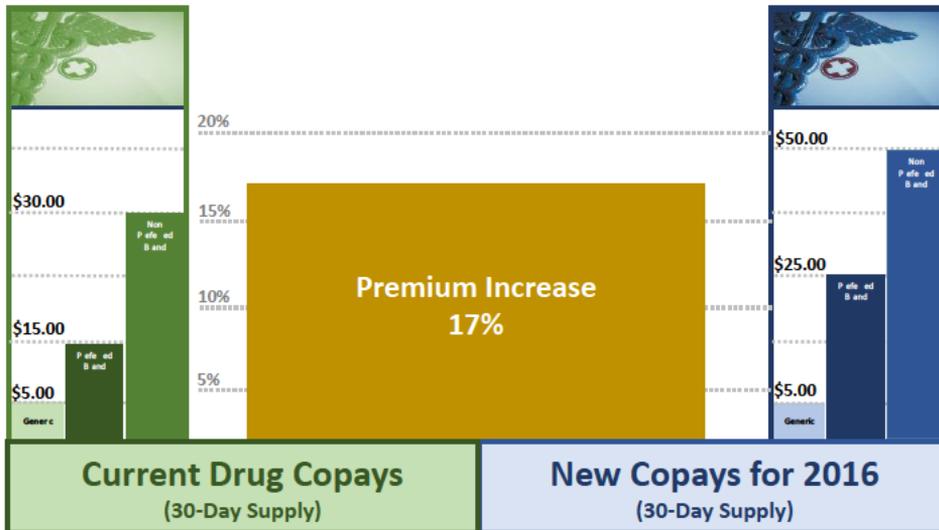
- Selecting the right plan for you
- Prescription drug copayment increases
- How premiums are determined



Current prescription drug copayments for a 30-day supply have remained the same since 2003 despite drug costs increasing annually. The decision was made by the EUTF Board of Trustees to offset this year's premium increases by making changes to the prescription drug plan design.



Generic drug copayments will remain at \$5.00, preferred brands will increase to \$25.00 and non-preferred brands will increase to \$50.00. Changes to the prescription drug plan design and implementation of Retail 90 network will result in a premium increase of 8.8%.

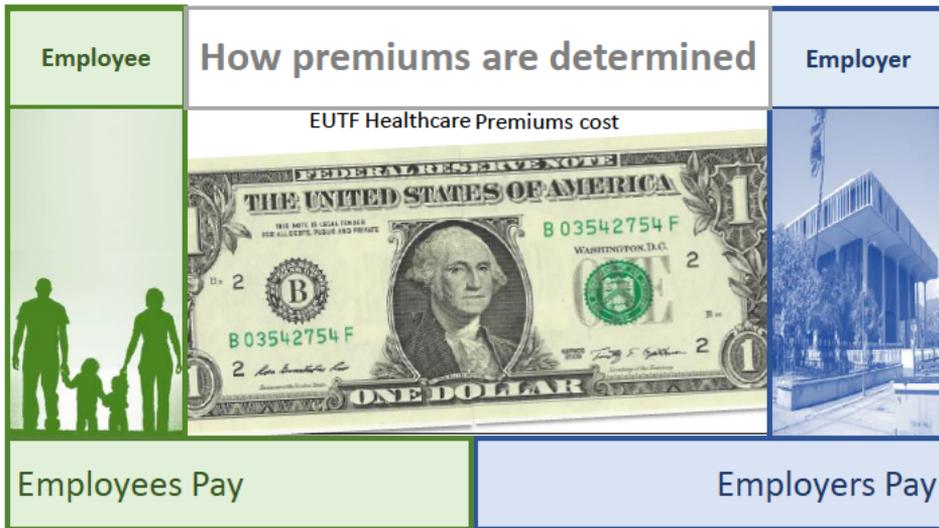


If the current drug plan design remained the same premiums would have increased by 17%. The new drug copayment design plays a significant roll in minimizing premium increases and transfers the cost to those who utilize the plan instead of passing it on to all EUTF members.

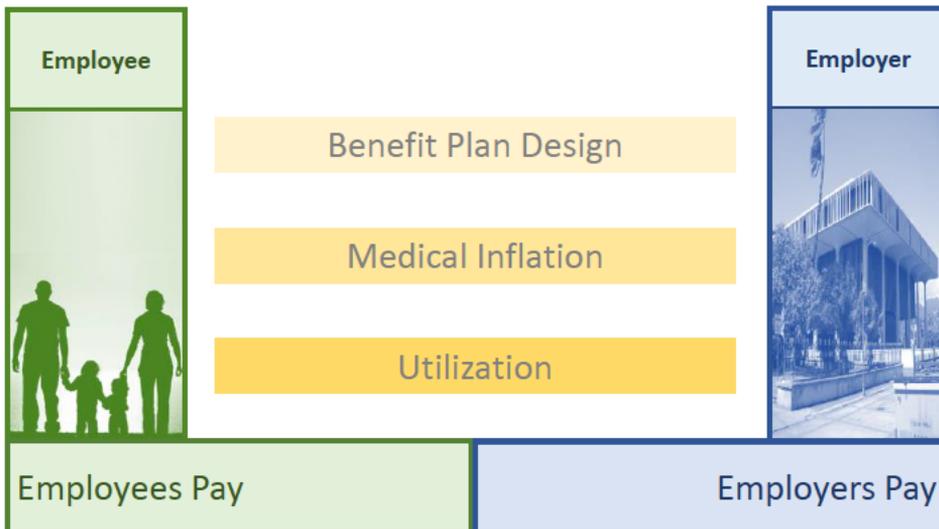


## Understanding Your Benefits

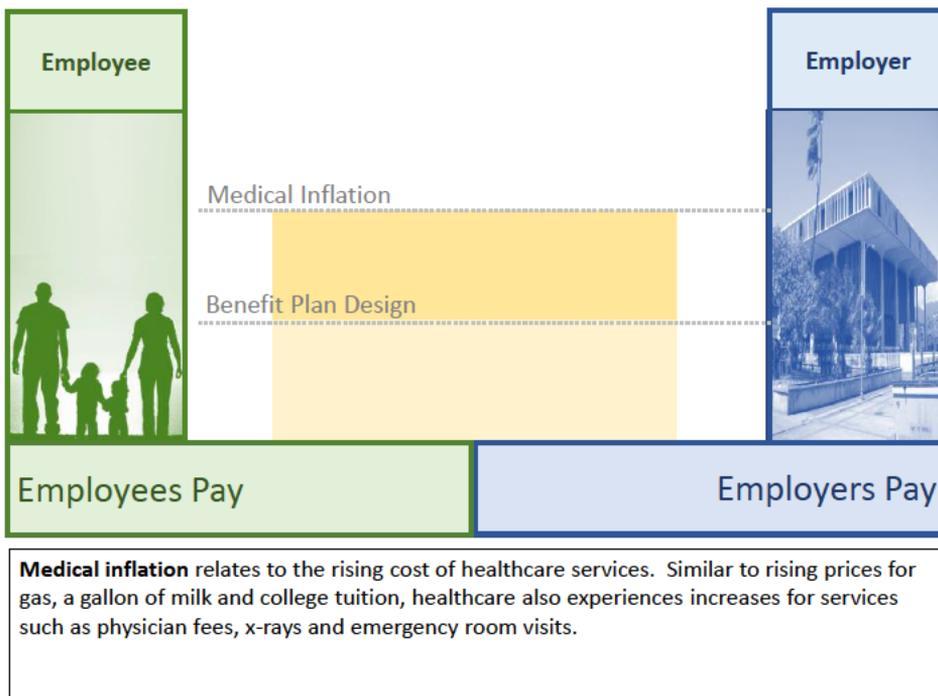
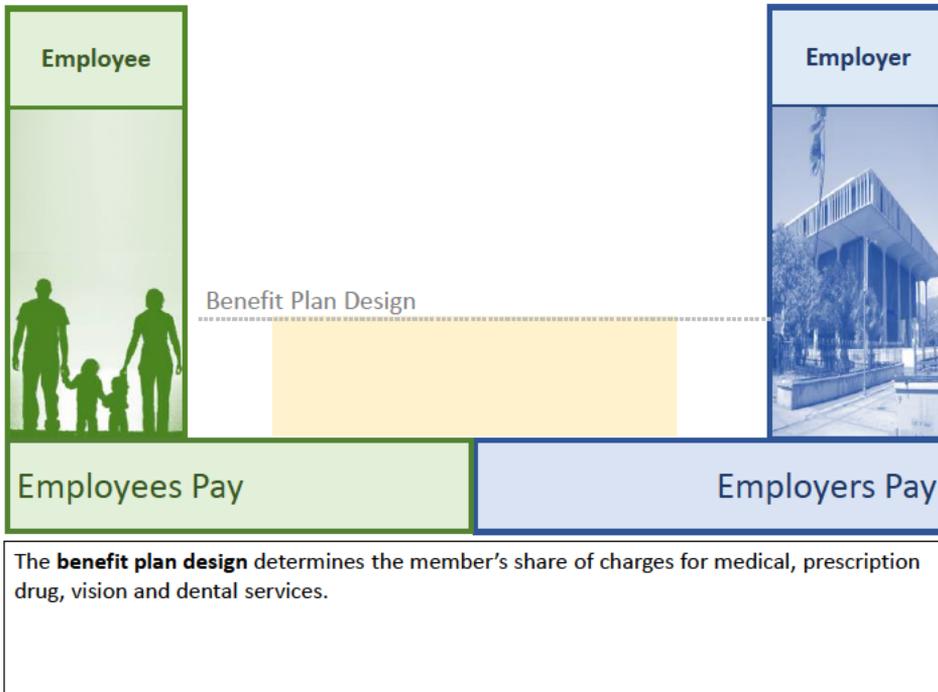
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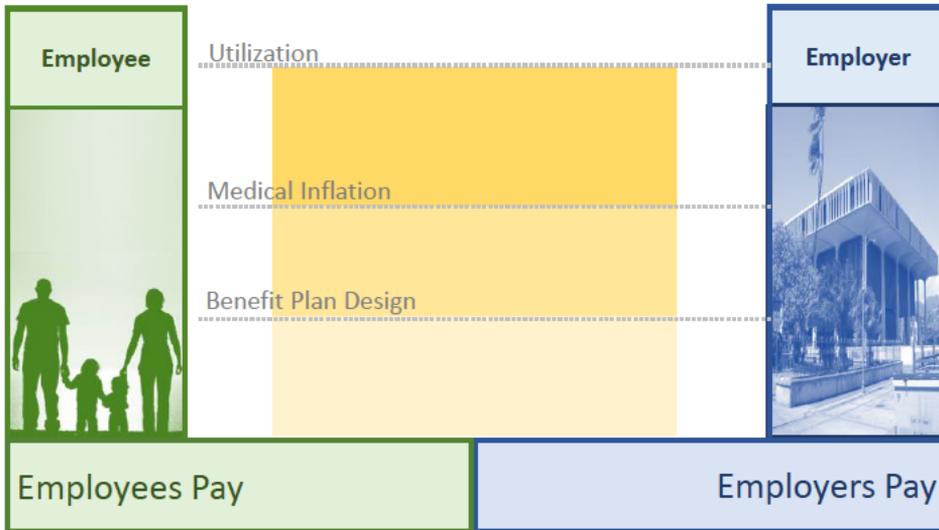


As you know healthcare premiums generally have been increasing every year. As State and county employees a portion of your healthcare premium costs are paid by the employer. The remaining balance becomes the employee's share.

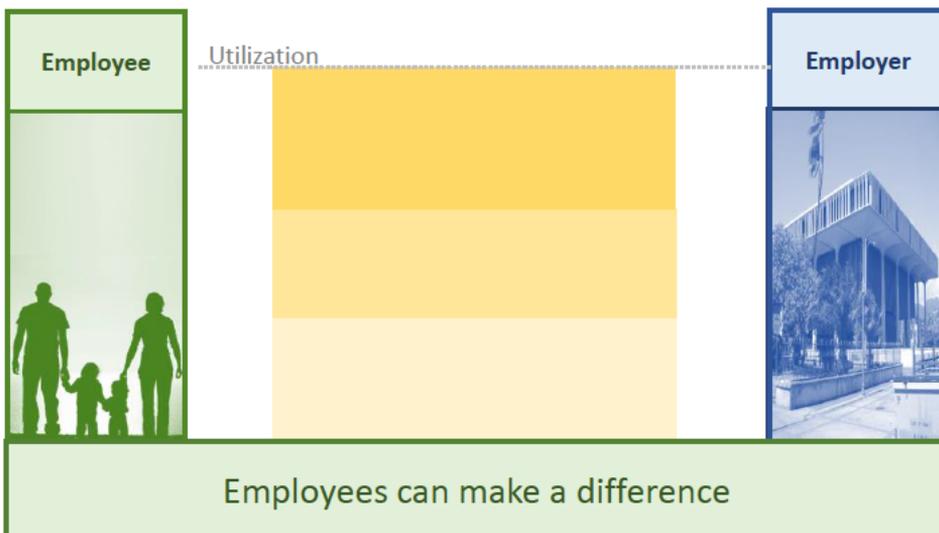


Premiums are generally made up of three factors.





**Utilization** reflects how much the insurance is used. While health plans are there if you need them, the more you use your health insurance the more we all pay in premium increases in following years.



Utilization is the factor where employees can make the biggest difference. Here are some examples of choices we can all make to help keep our healthcare costs down.

## Generic vs Brand Names



Choosing generic drugs when possible can represent significant savings in out-of-pocket costs and health plan cost share. For example, the cholesterol medication, Lipitor costs approximately seven times the generic equivalent. Generic drugs are FDA approved and contain the same active ingredients found in their brand equivalent. Check with your doctor if generic alternatives are available to you.

## Mail Order vs Retail



Using mail order for prescriptions can save you time and money if you are on maintenance medication or medication you take on a long-term basis. Our prescription drug plans provide significant cost savings for most maintenance medication dispensed in a 90-day supply. Mail order can save up to 25% compared to retail.

## Emergency Room use for non-emergent care



Emergency Room services come with substantially higher costs compared to a regular doctor's visit. We encourage you to use the emergency room only for emergencies in order to keep healthcare cost down. Members have alternatives such as urgent care facilities or telephonic doctor visits.

### Health and Wellness Benefits



## Reminders

- Deadline for employees to submit EC-1/EC-1H forms is **April 29, 2016**
- Deadline for employers to submit forms to EUTF is **May 6, 2016**
- Submit all required proof documents

## Contact Information

- **Phone**  
Oahu: 586-7390  
Toll-Free: 1-800-295-0089
- **Office Hours**  
Monday – Friday  
7:45 am - 4:30 pm  
*(except State holidays)*
- **E-mail**  
[eutf@hawaii.gov](mailto:eutf@hawaii.gov)
- **Mailing Address**  
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Honolulu, HI 96805-2121
- **Walk-In**  
Oahu: City Financial Tower  
201 Merchant Street, 17<sup>th</sup> Floor  
Honolulu, HI 96813  
*(No Validated Parking)*
- **Website**  
[eutf.hawaii.gov](http://eutf.hawaii.gov)

