

# Pre-Retirement 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



- **Applying for Your Retiree Health Insurance Benefits**
- **Eligibility**
- **Medicare**
- **Premiums and Contribution**
- **Health Plan Options**
- **Completing the EC-2 Enrollment Form**
- **Required Documents**
- **Making Changes to Your Plans**
- **Contact Information**



# New Retiree Enrollment

# Reference Guide



- Available at [eutf.hawaii.gov](http://eutf.hawaii.gov)
- Rates and contribution amounts
- Dependent eligibility criteria
- Health plan options
- EC-2 Enrollment form

## Hawaii Employer-Union Health Benefits Trust Fund

### RETIREE BENEFIT PLANS REFERENCE GUIDE (EUTF and HSTA VB)



*Effective January 1, 2016 – December 31, 2016*

**Retirees and their dependents who are or soon will be eligible for Medicare please note:** Hawaii law requires that you enroll in Medicare Part B when you become eligible in order to enroll in any EUTF or HSTA VB retiree medical and/or prescription drug plan. Please see page 46 for more information on this important topic.

**Disclaimer:** This Reference Guide offers general information on your health and other benefit plans which are exclusively governed by Hawaii Statutes, the EUTF Administrative Rules as they are amended from time to time and the carrier plan documents all of which are available at [eutf.hawaii.gov](http://eutf.hawaii.gov). Nothing in this Reference Guide is intended to amend, change, or contradict these documents. This Reference Guide is not a legal document or contract and the information in the Reference Guide is not intended as legal advice or to create any legal or contractual liabilities.



# New Retiree Enrollment

## Applying for Your Health Insurance Benefits

- File for retirement with **ERS**
- ERS Retirement Estimate Letter

Retirement - Estimate  
Hybrid Plan



**STATE OF HAWAII**  
EMPLOYEES' RETIREMENT SYSTEM

March 15, 2012

NEIL ABERCROMBIE  
GOVERNOR

JOHN A DOE  
201 MERCHANT STREET, SUITE 1520  
HONOLULU, HI 96813

Dear JOHN A DOE:

Thank you for contacting us about your retirement plans! Retirement is a significant event in each of our lives and it is important that you take the time to understand the application process and your retirement options.

Your estimate was determined using the following information:  
**\*\* Any part-time service worked has been converted to its full-time equivalence**

Projected Retirement Date:	May 1, 2012
Birth Date:	XX/XX/1946
Membership Date:	November 18, 2002

Membership Service for Eligibility:	9	Years	5	Months
Earned:	9	Years	5	Months
Acquired:	0	Years	0	Months
Hybrid Service for Estimate**:	5	Years	5	Months
Earned:	5	Years	5	Months
Acquired:	0	Years	0	Months
Noncontributory Service for Estimate**:	3	Years	7	Months
Earned:	3	Years	7	Months
Acquired:	0	Years	0	Months

RECEIVED  
DATE  
STATE OF HAWAII  
2012 APR 18 P 2:14

City Financial Tower • 201 Merchant Street, Suite 1400 • Honolulu, Hawaii 96813-2980  
Telephone (808) 586-1735 • Fax (808) 586-1977 • <http://www.ers.hawaii.gov/ers>

v1.03



**Eligibility**



# Retiree Eligibility

## Retired employee

- You do not need to be covered under an EUTF Active Employee Plan at the time of retirement to be eligible to enroll in the EUTF retiree plans

## The surviving spouse, domestic or civil union partner of a deceased retired employee

- Provided the spouse or partner does not remarry or enter into another domestic or civil union partnership

## The unmarried child of a deceased retired employee

- Provided the child is under age 19 with no surviving parent



# Dependent Eligibility

## Spouse or partner (domestic or civil union)

## Children by birth, adoption, legal guardianship or foster child

- Children are covered until age 19 for medical, prescription drug, dental and vision plans
- Covered until age 24 if unmarried and a full-time student
- Legal guardianship or foster children will terminate upon the age of 18, regardless of whether the child is a full-time student or not
- Coverage can be continued for an unmarried child incapable of self-support due to mental/physical incapacity that existed prior to age 19



# Dual Enrollment

- EUTF rules specify that if both you and your spouse/partner are employees and/or retirees of the State or counties, you can enroll in only one family or two-party plan, or two self plans.
- Children cannot be enrolled by more than one employee or retiree-beneficiary.



**Medicare**



# Mandatory Medicare Enrollment

## Retirees eligible for Medicare Part B

**MUST** enroll in Medicare Part B when they become eligible in order to be enrolled in the EUTF retiree medical and/or prescription drug plan.

MEDICARE		HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)			
NAME OF BENEFICIARY YOUR NAME HERE			
MEDICARE CLAIM NUMBER 000-00-0000-A		SEX FEMALE	
IS ENTITLED TO HOSPITAL (PART A)		EFFECTIVE DATE 07-01-1986	
MEDICAL (PART B)		07-01-1986	
SIGN HERE		<i>Jane Doe</i>	

## Covered dependents eligible for Medicare Part B

**MUST** also enroll in Medicare Part B when they become eligible, regardless of whether they are retired or actively employed, if enrolled in the EUTF retiree medical and/or prescription drug plan.

**YOU MUST PROVIDE THE EUTF WITH PROOF OF YOUR MEDICARE PART B ENROLLMENT WITHIN 60 DAYS OF BECOMING ELIGIBLE OR ENROLLING INTO AN EUTF RETIREE MEDICAL AND/OR DRUG PLAN. PLEASE SUBMIT A COPY OF YOUR AND/OR YOUR DEPENDENT'S MEDICARE CARD.**



# How do I enroll in Medicare Part B?

- Social Security will send you information about enrolling into Medicare three months prior to your 65<sup>th</sup> birthday.

MEDICARE		HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)			
NAME OF BENEFICIARY YOUR NAME HERE			
MEDICARE CLAIM NUMBER 000-00-0000-A		SEX FEMALE	
IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B)		EFFECTIVE DATE 07-01-1986 07-01-1986	
SIGN HERE <i>Jane Doe</i>			

- EUTF will send a courtesy letter to retirees and their dependents to enroll into Medicare Part B.

**FAILURE TO PROVIDE PROOF OF MEDICARE PART B ENROLLMENT WILL RESULT IN YOU AND/OR YOUR DEPENDENT'S DISENROLLMENT FROM THE EUTF MEDICAL AND/OR PRESCRIPTION DRUG PLAN**



# Medicare

## Federal Medicare Part B Premium Rates as of January 2016

### If your yearly income in 2014 was...

File individual tax return	File joint tax return	Amount you pay per month in 2016
\$85,000 or less	\$170,000 or less	<b>\$104.90/\$121.80</b>
above \$85,000 up to \$107,000	above \$170,000 up to \$214,000	<b>\$170.50</b>
above \$107,000 up to \$160,000	above \$214,000 up to \$320,000	<b>\$243.60</b>
above \$160,000 up to \$214,000	above \$320,000 up to \$428,000	<b>\$316.70</b>
above \$214,000	above \$428,000	<b>\$389.80</b>



# Medicare

## Medicare Part B Premium Social Security Administration Letter

Submit a copy of the Social Security Administration letter indicating your Medicare Part B premium amount.

Social Security Administration

RECEIVED  
EUIF  
STATE OF HAWAII  
2012 APR 18 P 2:38

007835 1 AT 0.365 0047 LTR RM1 507 1117  
JOHN A DOE  
201 MERCHANT STREET, SUITE 1520  
HONOLULU, HI 96813

Date: November 23, 2011  
Claim Number: 123-45-6789-A

Your Social Security benefits will increase by 3.6 percent in 2012 because of a rise in the cost of living. The Social Security Act requires some people to pay higher premiums for their Medicare Part B (Medical Insurance) and their prescription drug coverage based on their income. Because of your income, your premiums will be increased. The information in this notice about your premium is for 2012 only.

If you currently do not have Medicare Part B or prescription drug coverage and enroll in 2012, those premiums will also be increased based on your income.

**How Much Social Security Will I Get?**

• Your new 2012 monthly benefit amount before deductions is:	\$1,575.70
• Your 2012 monthly deduction for the Medicare Part B Premium is:	\$259.70
- \$99.90 for the standard Medicare premium, plus	
- \$159.80 for the income-related monthly adjustment amount based on your 2010 income tax return	
• Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January 25, 2012 is:	\$1,316.00

C See Next Page



# Medicare

## Medicare Part B Reimbursement

- Premium reimbursement **quarterly**
- Direct deposited into retiree's account
- Reimbursement will begin the **later of**:
  - Effective date of Medicare Part B coverage
  - 1<sup>st</sup> day of the month EUTF receives a copy of your Medicare Part B card
- Complete Direct Deposit Agreement form
  - Checking account – Submit voided check
  - Savings account – Form must be signed by your bank

**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND ("EUTF")**  
**Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement**

✓ I request reimbursement for my Medicare Part B Premium. A copy of my Medicare card and a copy of the letter from the Social Security Administration or Centers for Medicare & Medicaid Services showing the Medicare Part B Premium I pay are attached (for initial requests only). I understand that reimbursement of Medicare Part B Premiums will not begin until the EUTF receives a copy of the letter from the Social Security Administration or Centers for Medicare & Medicaid Services showing the Medicare Part B Premium I pay.

✓ I certify that my Medicare Part B premiums are not paid by any other entity, e.g. the Medicare Savings Program or Medicaid. Should my Part B premiums be paid by another entity in the future, I will notify the EUTF within 30 days of being notified by the other entity.

✓ If my enrollment in Medicare Part B stops I will notify the EUTF within 30 days. I understand that disenrollment from Medicare Part B means I will no longer be eligible for Part B premium reimbursement, as well as medical and prescription drug coverage.

Retiree Name:		SSN or EUTF ID Number:	
Retiree Mailing Address:		Phone:	

**SECTION A – Deposit Authorization**  
 Hawaii law (Act 039, SLH2006) requires all individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to designate a financial institution account into which the State of Hawaii EUTF shall be authorized to deposit their quarterly Medicare Part B reimbursements.

By signing in Section D, I/We hereby authorize the State of Hawaii EUTF to automatically and directly deposit my Medicare Part B premium reimbursements to my/our account at the financial institution named below:

**SECTION B – Account Information** (see your financial institution for help in completing this section)

Name of Account Holder(s):			
Name of Financial Institution:			
Routing Number:	Account Number:	<input type="checkbox"/> Checking*	<input type="checkbox"/> Savings
Financial Institution Certification (Required for Savings; Optional for Checking):			
Name of Agent:	Signature	Date:	

**SECTION C – Agreements of All Account Holders**  
 By signing in Section D, the Account Holder(s):

- Certify all information is accurate and authorize the EUTF to make withdrawals from my/our account in the event that the EUTF benefits have been deposited to the account in error, e.g., overpayments.
- Consent to the disclosure by the Financial Institution to the EUTF of any information that the EUTF requests to effectuate, administer, or enforce the transactions authorized in Sections A and C.
- Agree not to hold the EUTF responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me/us or by Financial Institution or due to an error on the part of Financial Institution in depositing funds to the account.

**SECTION D – Signatures of All Account Holders**

Authorized Signature (Primary):	Date:
Authorized Signature:	Date:

\*Please attach a VOIDED check and return this form to the EUTF

Rev. 12/2013



# Medicare Part D

- Upon enrolling in Medicare Part B you will be enrolled in the EUTF's Medicare Part D prescription drug plan, if you are enrolled in the non-Kaiser prescription drug plan.
- If in the future you enroll in another Medicare Part D plan, you will be disenrolled from EUTF's Medicare Part D plans including the Kaiser and UHC medical plans.



# Premiums and Contribution



# Contribution

## Employer Contribution

Active Plan	Retiree Plan
<p>As active employees, the portion of health coverage costs paid by the employer is negotiated within the collective bargaining process.</p>	<p>As a retired employee-beneficiary, the portion of health coverage costs paid by the employer is <u>determined by law</u>.</p>



# Contribution

## 2016 Base Monthly Contribution (BMC)

Maximum Allowable	Single	Two-Party	Family
Non-Medicare	\$855.18	\$1,723.76	\$2,522.92
Medicare	\$609.20	\$1,221.02	\$1,778.40

## Base Monthly Contribution

- May be adjusted every January 1
- Based on Medicare Part B premium increase or decrease

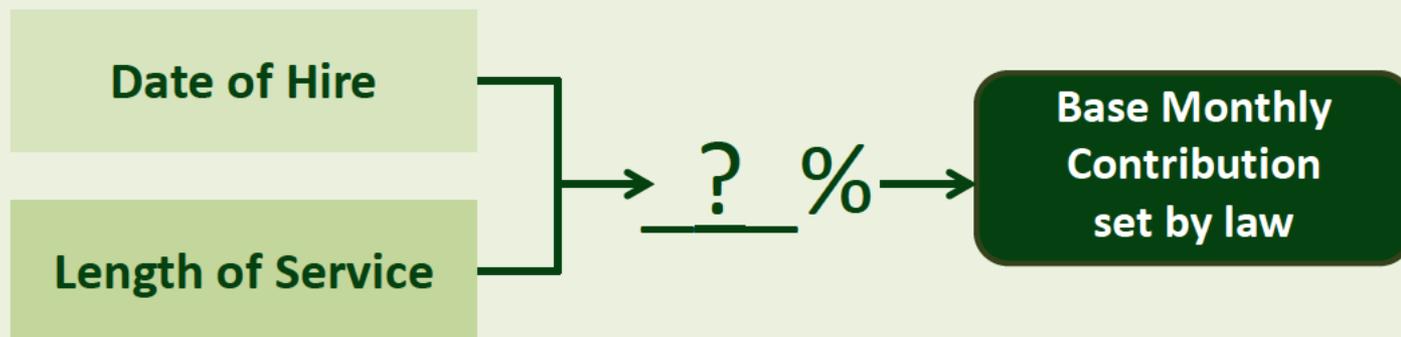


# Contribution

## Employer Contribution

The employer premium contribution is determined by statute and is based on three factors:

- Date the employee was hired
- Length of service - taking into account breaks in service
- Base Monthly Contribution (BMC)





# Contribution

## Employer Contribution Table

Years of Credited Service (excluding sick leave)	State's Base Monthly Contribution If You Were Hired:		
	On or Before 6/30/1996	On or Between 7/1/96 – 6/30/01	**On or After 7/1/2001 (self only)
Less than 10 years	50%	0%	0%
10 yrs less than 15	100%	50%	50%
15 yrs less than 25	100%	75%	75%
25 yrs or more	100%	100%	100%

The employer's contribution is equal to the lesser of the Base Monthly Contribution percentage and the actual premium.

***\*\*If you were hired on or after 07/01/2001, the monthly employer-sponsored contribution will be calculated on the Base Monthly Contribution for a self rate ONLY. You may obtain coverage for eligible dependents but you will be responsible for the difference in premium cost.***



# Contribution

Maximum Allowable	Single	Two-Party	Family
Non-Medicare	\$855.18	\$1,723.76	\$2,522.92
Medicare	\$609.20	\$1,221.02	\$1,778.40

## Employer Contribution – 100%

- You will probably pay nothing

## Employer Contribution – 50% or 75%

- Complete EUTF Retiree Worksheet

## Employer Contribution – 0%

- You will pay the full premium amount

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND  
P.O. BOX 2121  
HONOLULU, HI 96805

Monthly Premium (Medicare)      Monthly Premium (Medicare)      Monthly Premium (Medicare)

**1) MEDICAL/PHARMACEUTICAL DRUGS**      HMOA      Kaiser      UHC

A. Non-Medicare - Self       \$776.16       \$943.00       \$943.00

B. Non-Medicare - 2Party       \$1,221.02       \$1,221.02       \$1,221.02

C. Non-Medicare - Family       \$1,854.36       \$1,854.36       \$1,854.36

D. Medicare - Self       \$292.14       \$292.14       \$292.14

E. Medicare - 2Party       \$718.12       \$718.12       \$718.12

F. Medicare - Family       \$7,395.32       \$7,395.32       \$7,395.32

If you select Medicare and prescription drug, check the plan and enter premium amount. See the 100% section.  
If you select Medicare, but do not select drug, check the 100% section. If you select drug, but do not select Medicare, check the 100% section.

**2) MEDICAL ONLY**      HMOA      Kaiser      UHC

A. Non-Medicare - Self       \$204.24       \$204.24       \$204.24

B. Non-Medicare - 2Party       \$204.24       \$204.24       \$204.24

C. Non-Medicare - Family       \$1,221.02       \$1,221.02       \$1,221.02

D. Medicare - Self       \$193.48       \$193.48       \$193.48

E. Medicare - 2Party       \$271.00       \$271.00       \$271.00

F. Medicare - Family       \$353.00       \$353.00       \$353.00

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

**3) MEDICAL/PHARMACEUTICAL DRUGS**      HMOA      Kaiser      UHC

A. Non-Medicare - Self       \$776.16       \$943.00       \$943.00

B. Non-Medicare - 2Party       \$1,221.02       \$1,221.02       \$1,221.02

C. Non-Medicare - Family       \$1,854.36       \$1,854.36       \$1,854.36

D. Medicare - Self       \$292.14       \$292.14       \$292.14

E. Medicare - 2Party       \$718.12       \$718.12       \$718.12

F. Medicare - Family       \$7,395.32       \$7,395.32       \$7,395.32

Select one plan and enter premium amount.  
If you select a plan in 3A, do not complete this section.

**4) MEDICAL ONLY**      HMOA      Kaiser      UHC

A. Non-Medicare - Self       \$204.24       \$204.24       \$204.24

B. Non-Medicare - 2Party       \$204.24       \$204.24       \$204.24

C. Non-Medicare - Family       \$1,221.02       \$1,221.02       \$1,221.02

D. Medicare - Self       \$193.48       \$193.48       \$193.48

E. Medicare - 2Party       \$271.00       \$271.00       \$271.00

F. Medicare - Family       \$353.00       \$353.00       \$353.00

Select one plan and enter premium amount.  
If you select a plan in 4A, do not complete this section.

**5) ADDITIONAL 1A OR 1B OR 1C, 2, 3, 4 (Check, Prescription Drug, Dental, Vision)**                       

All 50% Employer Contribution Amounts Not Available at These Times  
See the 50% section for more information.

**6) EMPLOYER CONTRIBUTION**      0%      50%      75%      100%

A. Non-Medicare - Self       \$0.00       \$0.00       \$0.00       \$0.00

B. Non-Medicare - 2Party       \$0.00       \$0.00       \$0.00       \$0.00

C. Non-Medicare - Family       \$0.00       \$0.00       \$0.00       \$0.00

D. Medicare - Self       \$0.00       \$0.00       \$0.00       \$0.00

E. Medicare - 2Party       \$0.00       \$0.00       \$0.00       \$0.00

F. Medicare - Family       \$0.00       \$0.00       \$0.00       \$0.00

Check your medical section on the 1A or 1B. (For example, if you select 100% for employer contribution, it is not possible to select your employer contribution amount. 0%, 50% or 75%.)

**7) I have a plan, but I want the amount you give me.**           

Check here. This field is for your records. We do not send monthly notices or statements. Your monthly amounts will be on your contribution card. Payments are due by the end 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 2121, Honolulu, HI 96805.



# Premium

## Health Plan Premium example

**Malia** will be retiring October 1, 2016 and does not qualify for Medicare yet.

Non-Medicare total BMC amount  
**\$855.18**

**Malia's** ERS Retirement Estimate Letter shows:

- Membership Date July 1, 1997
- Total Earned Years of Service: 18 years

Hire Date: 7/01/97  
Earned Years of SVC: 18 yrs  
\$855.18  
X .75  
**\$641.38**

**Malia** selected the following coverages for herself:

HMSA 90/10	\$469.86
CVS Caremark Drug Coverage	\$198.10
HDS Dental	\$36.06
VSP Vision	\$5.48
Life Insurance	\$0.00

Total cost for plans selected  
**\$709.50**

Malia's total monthly premium is

\$709.50  
- \$641.38  
\$68.12



# Health Plan Options



# Retiree Health Plan Options

## Medical

HMSA 90/10 PPO Plan

Kaiser HMO Medical Plan/ Senior Advantage Plan

UnitedHealthcare PPO Medicare Advantage Plan

## Prescription Drug

CVS Caremark & SilverScript

Kaiser Prescription Drug

## Dental & Vision

Hawaii Dental Service

Vision Service Plan

## Life Insurance

USABLE Life



# HMSA

## PPO – HMSA 90/10 Plan

	Non-Medicare	Medicare
<b>Deductible</b>	<b>\$100 per person \$300 per family</b>	
<b>Primary Care Office Visit</b>	<b>10%*</b>	
<b>Hospital</b>	<b>10%*</b>	
<b>Diagnostic lab, X-ray</b>	<b>20%*</b>	
<b>Maximum Out-of-Pocket</b>	<b>\$2,000/\$6,000</b>	<b>\$2,500/\$7,500</b>

\*Deductible does not apply

If a retiree is enrolled in Medicare Parts A & B, he/she will likely pay no copayment since Medicare is primary and EUTF's HMSA plan is secondary and will cover the member's copayment.



# Kaiser Permanente

## HMO – Kaiser Medical Plan

	Non-Medicare	Senior Advantage
<b>Deductible</b>	<b>None</b>	
<b>Primary Care Office Visit</b>	<b>\$15</b>	
<b>In-Patient Hospital Services</b>	<b>No Charge</b>	
<b>Diagnostic lab, X-ray</b>	<b>\$15</b>	<b>No Charge</b>
<b>Maximum Out-of-Pocket</b>	<b>\$2,000/\$6,000</b>	



# UnitedHealthcare

## PPO – UnitedHealthcare Medicare Advantage

Available only to those enrolled in **Medicare Part A & B**

<b>Deductible</b>	<b>\$100 per person</b>
<b>Primary Care Office Visit</b>	<b>10%*</b>
<b>Hospital</b>	<b>10%*</b>
<b>Diagnostic lab, X-ray</b>	<b>20%*</b>
<b>Maximum Out-of-Pocket</b>	<b>\$2,500</b>

\* Deductible does not apply



# Prescription Drug Coverage

	Non-Medicare		Medicare	
Prescription Drug Coverage	CVS Caremark PPO Prescription Drug Plan (Participating Pharmacy)	Kaiser HMO Prescription Drug Plan	SilverScript Prescription Drug Plan (Participating Pharmacy)	Kaiser HMO Prescription Drug Plan
Retail & Mail Prescription Program (30/90 day supply)	In-Network or Retail 90 Pharmacy		In-Network Pharmacy	
Generic	\$5/\$10 copayment	\$15/\$30 mail only	\$5/\$10 copayment	\$15/\$30 mail only
Preferred Brand Name	\$15/\$30 copayment	\$15/\$30 mail only	\$15/\$30 copayment	\$15/\$30 mail only
Other Brand Name	\$30/\$60 copayment	\$15/\$30 mail only	\$30/\$60 copayment	\$15/\$30 mail only
Specialty Drug	20% coinsurance \$250 max per fill \$2,000 annual max	\$15/\$30 mail-order for eligible drugs	20% coinsurance \$250 max per fill \$2,000 annual max	\$15/\$30 mail only



# Other Plans

<b>Chiropractic</b>		<b>None</b>
<b>Dental</b>	Diagnostic/Preventive	<b>100%*</b>
	Other Services	<b>60%</b>
	Plan Year Maximum (per person)	<b>\$2,000</b>
<b>Vision</b>	Eye Exam	<b>\$10 copay</b>
	Prescription Glasses	<b>Lenses every year \$25 copay</b>
		<b>Frames every other year \$120 allowance</b>
	Contacts	<b>\$120 Allowance</b>
<b>Life Insurance</b>		<b>\$2,235</b>

\* Excluding periodontal maintenance

# Differences Between the EUTF Active and Retiree Benefits



- Limiting age
  - ✓ Active plan – dependents covered up to age 26 for medical and prescription drug regardless of student, marriage and working status. Dependents covered up to age 24 for dental and vision if unmarried and a full-time student
  - ✓ Retiree plan – dependents covered up to age 24 for medical, prescription drug, dental and vision if unmarried and a full-time student
- Prescription drug benefit – lower copayments under the CVS Caremark retiree prescription drug plans. Generic copayments equal to or lower under the Kaiser active plans but lower for brand and specialty prescription drugs under the Kaiser retiree plans. Please see the Active and Retiree Reference Guides at [eutf.hawaii.gov](http://eutf.hawaii.gov).
- Chiropractic benefit – not offered under the retiree plans

# Differences Between the EUTF Active and Retiree Benefits



- Dental benefit
  - ✓ Active plan –restorative (except crowns and gold restorations 60%), endodontics, periodontal (including maintenance), oral surgery and adjunctive general services are covered at 80%. Limited orthodontic benefit at 50%.
  - ✓ Retiree plan – restorative (except crowns and gold restorations 60%), endodontics, periodontal (including maintenance), oral surgery and adjunctive general services are covered at 60%. No orthodontic benefit.
- Medicare Part B
  - ✓ Active plan – eligible employees and dependents are not required to enroll in Medicare Part B.
  - ✓ Retiree plan – eligible retirees and dependents (including disabled children) are required to enroll in Medicare Part B for coverage under the retiree medical and prescription drug plans. Retirees and spouses will be reimbursed for the Medicare Part B premiums. Non-spouse dependents are not reimbursed for the Medicare Part B premiums.

A photograph of a taro field with large, vibrant green leaves growing in shallow water. The leaves are heart-shaped with prominent veins. The background is a dark green gradient.

# Enrollment Procedures



# Enrollment Procedures

EC-2 enrollment forms are available on our website at eutf.hawaii.gov

The screenshot shows the website for the State of Hawaii Employer-Union Health Benefits Trust Fund. The browser address bar shows 'http://eutf.hawaii.gov/'. The website header includes the 'hawaii.gov' logo, text size options, and a 'Stay Connected' link. A search bar is located in the top right corner.

The main navigation menu includes: HOME, ABOUT THE EUTF, ACTIVE, RETIREES, TRAINING/RESOURCES, MEDICARE, COBRA, CARRIERS, and NEWS.

The 'RETIREES' dropdown menu is open, showing 'EUTF Retiree' and 'HSTA VB Retiree'. The 'EUTF RETIREE' sub-menu is expanded, displaying the following categories:

- Plan Benefits**
  - Medical (Medicare)
  - Medical (Non Medicare)
  - Prescription Drug (Medicare)
  - Prescription Drug (Non Medicare)
  - Dental
  - Life
  - Vision
- Enrollment & Rates**
  - Eligibility
  - Enrollment Overview
  - Rates & Contributions
- Popular Documents**
  - Reference Guide
  - EC-2 (PDF) **Click**
  - [View All](#)

Below the navigation menu, there is a featured article titled 'RETIREES OPEN ENROLLMENT 2016' with a 'Read More' link. A 'NEWS' section is also visible at the bottom left.



# Enrollment Procedures

## Section 1: Retiree Data

Complete applicable fields.

<b>EC-2</b> Rev. Oct 2015	Hawaii Employer-Union Health Benefits Trust Fund <b>EC-2: Enrollment Form for Retirees</b>	PLEASE SUBMIT THIS FORM EC-2 TO THE EUTF
<b>SECTION 1: RETIREE DATA</b>		Please complete all applicable fields below. Social Security numbers are required to process new retirees and dependent enrollments. **

Name (Last, First, Middle Initial) Smith, Eric L.

Home Phone (808) 263-5555

Work Phone (\_\_\_\_) \_\_\_\_\_

Mobile Phone (808) 555-1234

Email ericsmith@email.com

Residence Address  Check this box if your address has changed

Street 123 Aloha Lane

Line 2 \_\_\_\_\_

City Kailua State HI Zip Code 96734

Mailing Address (if different from above)

Street \_\_\_\_\_

Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Open Enrollment (effective 01/01/2016)

Retiree's Social Security Number (SSN) or EUTF ID Number 575-12-3456

Gender  Male  Female

Birth Date: (MM/DD/YYYY) 10 / 15 / 1953

Marital Status  Married  Single

Marriage Date: (MM/DD/YYYY) 02 / 14 / 1980

Check this box if status change

Mid-Year Qualifying Event (describe) Retirement

Event Date: 11 / 01 / 16

Civil Union Partner (Civil Union Status)

IRS Qualified  Not Qualified

Civil Union Date: (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Check this box if status change

Domestic Partner (DP Status)

IRS Qualified  Not Qualified

DP Date: (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Check this box if status change

If you are including your Spouse/Civil Union/ Domestic Partner and/or dependents in your health benefit plans, please complete Section 4

Special Note: If your Spouse/Civil Union or Domestic Partner is a State or County Employee or Retiree, please provide the following:  
NAME: Kayla Smith SSN: 576-55-5555 DOB: 03/22/1953



# Enrollment Procedures

## SECTION 2: COVERAGE AND DEDUCTION START SELECTION

Skip this section if RETIREE does NOT pay towards health plan benefits.

If events are filed within 30 days of the qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. If your event is listed below, please select one of the three options, otherwise skip this section.

### Qualifying Events for this Section

Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

### Available Options for this Section

- Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used)
- Coverage and premium contributions start 1st day of the **first** pay period<sup>v</sup> following event
- Coverage and premium contributions start 1st day of the **second** pay period<sup>v</sup> following event<sup>v</sup> (1<sup>st</sup> or 16<sup>th</sup> of the month)

## SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below.

Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If no selection is made, EUTF will assume no changes are being made.

Type	Carrier Selection	Choose only one box in each plan selection			
		Cancel/Waive	Self	2-Party	Family
Medical	PPO-90/10 HMSA Medical No Prescription Drug Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	PPO UnitedHealthcare Medicare Advantage Grp. 13840-Medicare A&B required No Prescription Drug Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drug	CVS Caremark Prescription Drug (Not a valid selection with Kaiser)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
HMO	HMO-Kaiser Medical (Includes Kaiser Prescription Drug)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	Hawaii Dental Service	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Vision	Vision Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Life	USABLE Life	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Not available to spouse/partner or dependents	

(All enrollees must be enrolled in Medicare Parts A&B)



# Enrollment Procedures

## Section 4: Dependent Information and Plan Selection

Enter dependent information.

Retiree's Name Eric L. Smith

### SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add/delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship\* Key: SP=Spouse, CU=Civil Union Partner, DP=Domestic Partner, CH=your Child or your Spouse's Child, CUCH=Civil Union Partner's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step 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-2 for new birth. Please be sure to submit an EC-2 to update our records for your newborn once the information is received/issued by SSA.

Continue Coverage	Add	Delete	Dependent:		Birth Date (MMDDYYYY)	Social Security Number**	Relationship *	Gender		Medical	Drug	Dental	Vision
			Last Name (if different), First Name, Middle Initial					M / F					
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Smith, Kayla		03/22/1953	576-55-5555	SP	F		<input checked="" type="checkbox"/>	<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"/>

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 regarding Dependent and Student Certification on "Instructions for Completing Form EC-2" for more information.

I certify that my spouse/partner and/or dependent children meet eligibility requirements for enrollment in the EUTF/HSTA VB plans.  
(initials)

ELS

### Proof Documents

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



# Enrollment Procedures

## Section 5: Medicare

- Mandatory Medicare Part B enrollment

## Section 6: United Healthcare Medicare Advantage Plan (UHC)

- Enrollment into United Healthcare

### SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires all Medicare eligible retirees and their dependents to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF retiree benefit plans. If you or your dependent(s) are Medicare eligible and are not enrolled in Medicare Part B, you must enroll immediately and provide EUTF with a copy of your Medicare card. If you are already enrolled, be sure EUTF has a copy of your Medicare card.

### SECTION 6: UNITEDHEALTHCARE MEDICARE ADVANTAGE PLAN (UHC)

If you or any of your dependents are enrolling in the UnitedHealthcare Medicare Advantage Plan, YOU MUST COMPLETE THE INFORMATION BELOW (the information is on your red, white and blue Medicare card):

**Retiree – Name of Beneficiary:** \_\_\_\_\_ **Medicare Claim #** \_\_\_\_\_

Do you have End Stage Renal Disease (ESRD)  Yes  No

**Spouse/Partner – Name of Beneficiary:** \_\_\_\_\_ **Medicare Claim #** \_\_\_\_\_

Do you have End Stage Renal Disease (ESRD)  Yes  No

If the above information is not completed, your enrollment into the UnitedHealthcare Medicare Advantage Plan may be rejected resulting in no medical coverage.



# Enrollment Procedures

## Section 7: Retiree & Spouse/Partner Signature

- Read, sign and date form
- Spouse/Partner signature required only for UHC enrollees
- Form must be received by EUTF within 60 days of retirement

### SECTION 7: RETIREE & SPOUSE/PARTNER 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

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.

Retiree Signature: Eric L. Smith Date Signed: 10/15/2016

Retiree Spouse/Partner Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_ (Signature & date required if enrolling in UHC)

Please submit your signed EC-2 form by mail to:

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

Customer Service Call Center

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite 1520, Honolulu, HI 96813

Oahu (808) 586-7390  
Toll Free 1(800) 295-0089



# Confirmation Notice

- Confirmation Notice
- 10 calendar days to respond in writing



## HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

P.O. Box 2121  
Honolulu, HI 96805-2121  
Oahu (808) 556-7390  
Toll Free 1(800) 295-0089  
www.eutf.hawaii.gov

Confirmation Notice

Date: May 04, 2016

SARAH ALOHA  
123 MAHALO STREET  
HONOLULU, HI 96805

MB #: 9999999  
Agency/Department: Budget and Finance  
Bargaining Unit: 13

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 change(s) 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:

Plan Type	Benefit Plan	Coverage Type	Effective Date	Pay Period Deduction
PCP	Enroll	N/A	01/31/2015	\$0.00
Medical	PPO Medical (90/10) w/ Chiro	Self	01/31/2015	\$101.52
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	\$0.00

NOTE: Kaiser and HMSA HMO includes prescription drug coverage.

Your Total Pay Period Deduction:

\$126.90

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 [eutf.hawaii.gov](http://eutf.hawaii.gov). Please review it carefully.

EUTF's Mission: We care for the health and well-being of our beneficiaries by striving to provide quality benefit plans that are affordable, reliable, and meet their changing needs. We provide services that are excellent, courteous, compassionate, and informative.

City Financial Tower, 201 Merchant Street, Suite 1200, Honolulu, Hawaii 96813



# Required Documents



# Required Documents

- ERS Retirement Estimate Letter

Retirement- Estimate  
Hybrid Plan



**STATE OF HAWAII**  
EMPLOYEES' RETIREMENT SYSTEM

March 15, 2012

NEIL LABERCROMBIE  
GOVERNOR

JOHN A DOE  
201 MERCHANT STREET, SUITE 1520  
HONOLULU, HI 96813

Dear JOHN A DOE:

Thank you for contacting us about your retirement plans! Retirement is a significant event in each of our lives and it is important that you take the time to understand the application process and your retirement options.

Your estimate was determined using the following information:  
 \*\* Any part-time service worked has been converted to its full-time equivalence

Projected Retirement Date:	May 1, 2012
Birth Date:	XX/XX/1946
Membership Date:	November 18, 2002
Membership Service for Eligibility:	9 Years 5 Months
Earned:	9 Years 5 Months
Acquired:	0 Years 0 Months
Hybrid Service for Estimate**:	5 Years 5 Months
Earned:	5 Years 5 Months
Acquired:	0 Years 0 Months
Noncontributory Service for Estimate**:	3 Years 7 Months
Earned:	3 Years 7 Months
Acquired:	0 Years 0 Months

RECEIVED  
 ERS  
 STATE OF HAWAII  
 10:17 APR 18 P 2:14

City Financial Tower • 201 Merchant Street, Suite 1400 • Honolulu, Hawaii 96813-2980  
 Telephone (808) 586-1735 • Fax (808) 586-1677 • <http://www4.hawaii.gov/ers>

v1.03



# Required Documents

- ERS Retirement Estimate Letter
- EC-2 Enrollment form
  - Must be received within **60 days** of your retirement

<b>EC-2</b> Rev. 03/2015	Hawaii Employer-Union Health Benefits Trust Fund <b>EC-2: Enrollment Form for Retirees</b>	PLEASE PRINT THIS FORM IN FULL 6/17/15			
<b>SECTION 1: RETIREE DATA</b> <small>Please complete all applicable fields below. Social Security numbers are required to process new enrollments and dependent enrollments.</small>					
Name (Last, First, Middle Initial) _____	<input type="checkbox"/> Open Enrollment (effective 01/01/2016)	<input type="checkbox"/> Mid-Year Qualifying Event (describe) Event Date: ____/____/____			
Home Phone (____) _____	Retiree's Social Security Number (SSN) or EUTF ID Number _____	Civil Union Partner (Civil Union Status) <input type="checkbox"/> IRS Qualified <input type="checkbox"/> Not Qualified Civil Union Date: (MM/DD/YYYY) <input type="checkbox"/> Check this box if status change			
Work Phone (____) _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Birth Date: (MM/DD/YYYY) ____/____/____	Domestic Partner (DP Status) <input type="checkbox"/> IRS Qualified <input type="checkbox"/> Not Qualified DP Date: (MM/DD/YYYY) <input type="checkbox"/> Check this box if status change			
Mobile Phone (____) _____	Residence Address <input type="checkbox"/> Check this box if your address has changed Street _____ Line 2 _____ City _____ State _____ Zip Code _____	Martial Status <input type="checkbox"/> Married <input type="checkbox"/> Single Marriage Date: (MM/DD/YYYY) <input type="checkbox"/> Check this box if status change			
Email _____	Mailing Address (if different from above) Street _____ Line 2 _____ City _____ State _____ Zip Code _____	<b>If you are including your Spouse/Civil Union/Domestic Partner and/or dependents in your health benefit plans, please complete Section 4.</b>			
Special Note: If your Spouse/Civil Union or Domestic Partner is a State or County Employee or Retiree, please provide the following: NAME: _____ SSN: _____ DOB: _____					
<b>SECTION 2: COVERAGE AND DEDUCTION START SELECTION</b> <small>Skip this section if RETIREE does NOT pay towards health plan benefits. If events are filed within 30 days of the qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. If your event is listed below, please select one of the three options, otherwise skip this section.</small>					
Qualifying Events for this Section Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student					
Available Options for this Section <input type="checkbox"/> Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used). <input type="checkbox"/> Coverage and premium contributions start 1st day of the first pay period following event. <input type="checkbox"/> Coverage and premium contributions start 1st day of the second pay period following event (14 or 15th of the month).					
<b>SECTION 3: PLAN SELECTION</b> <small>Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If no selection is made, EUTF will assume no changes are being made.</small>					
Choose only one box in each plan selection					
Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
Medical	PPO-90/10 HMOA Medical No Prescription Drug Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	UnitedHealthcare Medicare Advantage Gp. 13840-Medicare A&B required No Prescription Drug Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO	CVS Caremark Prescription Drug (Not a valid selection with Kaiser)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drug	HMO-Kaiser Medical (Includes Kaiser Prescription Drug)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	Hawaii Dental Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	Vision Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	Life	<input type="checkbox"/>	<input type="checkbox"/>	Not available to spouse/partner or dependents	
Life	US Able Life	<input type="checkbox"/>	<input type="checkbox"/>	Not available to spouse/partner or dependents	



# Required Documents

- ERS Retirement Estimate Letter
- EC-2 Enrollment form
  - Must be received within **60 days** of your retirement
- Copy of Medicare card

MEDICARE			HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)			
NAME OF BENEFICIARY <b>YOUR NAME HERE</b>			
MEDICARE CLAIM NUMBER <b>000-00-0000-A</b>		SEX <b>FEMALE</b>	
IS ENTITLED TO <b>HOSPITAL (PART A)</b>		EFFECTIVE DATE <b>07-01-1986</b>	
<b>MEDICAL (PART B)</b>		<b>07-01-1986</b>	
SIGN HERE <i>Jane Doe</i>			



# Required Documents

- ERS Retirement Estimate Letter
- EC-2 Enrollment form
  - Must be received within **60 days** of your retirement
- Copy of Medicare card
- Medicare Part B Premium Request and Direct Deposit Agreement form

## HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND ("EUTF")

### Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement

- ✓ I request reimbursement for my Medicare Part B Premium. A copy of my Medicare card is attached (for initial requests only).
- ✓ I certify that my Medicare Part B premiums are not paid by any other entity, e.g. the Medicare Savings Program or Medicaid. Should my Part B premiums be paid by another entity in the future, I will notify the EUTF within 30 days of being notified by the other entity.
- ✓ If my enrollment in Medicare Part B stops I will notify the EUTF within 30 days. I understand that disenrollment from Medicare Part B means I will no longer be eligible for Part B premium reimbursement, as well as medical and prescription drug coverage.

Retiree's Name:		SSN or EUTF ID Number:	
Retiree's Mailing Address:		Phone:	

#### SECTION A – Deposit Authorization

Hawaii law (Act 039, SLH2006) requires all individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to designate a financial institution account into which the State of Hawaii EUTFs shall be authorized to deposit their quarterly Medicare Part B reimbursements.

By signing in Section D, I/We hereby authorize the State of Hawaii EUTF to automatically and directly deposit my Medicare Part B premium reimbursements to my/our account at the financial institution named below:

#### SECTION B – Account Information (see your financial institution for help in completing this section)

Name of Account Holder(s):	
Name of Financial Institution:	
Routing Number:	
Account Number:	<input type="checkbox"/> Checking* <input type="checkbox"/> Savings
Financial Institution Certification (Required for Savings; Optional for Checking):	
Name of Agent: _____	Phone: _____
Signature: _____	Date: _____

#### SECTION C – Agreements of All Account Holders

By signing in Section D, the Account Holder(s):

- Certify all information is accurate and authorize the EUTF to make withdrawals from my/our account in the event that the EUTF benefits have been deposited to the account in error, e.g., overpayments.
- Consent to the disclosure by the Financial Institution to the EUTF of any information that the EUTF requests to effectuate, administer, or enforce the transactions authorized in Sections A and C.
- Agree not to hold the EUTF responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me/us or by Financial Institution or due to an error on the part of Financial Institution in depositing funds to the account.

#### SECTION D – Signatures of All Account Holders

Authorized Signature (Primary):	Date:
Authorized Signature:	Date:

\*Please attach a VOIDED check and return this form to the EUTF



# Required Documents

- ERS Retirement Estimate Letter
- EC-2 Enrollment form
  - Must be received within **60 days** of your retirement
- Copy of Medicare card
- Medicare Part B Premium Request and Direct Deposit Agreement form
- Social Security Administration letter indicating Medicare Part B premium

## Social Security Administration

RECEIVED  
EUIF  
STATE OF HAWAII

2012 APR 18 P 2:38

007835 1 AT 0.385 0047 LTR IM1 507 1117  
JOHN A DOE  
201 MERCHANT STREET, SUITE 1520  
HONOLULU, HI 96813



Date: November 23, 2011  
Claim Number: 123-45-6789-A

Your Social Security benefits will increase by 3.6 percent in 2012 because of a rise in the cost of living. The Social Security Act requires some people to pay higher premiums for their Medicare Part B (Medical Insurance) and their prescription drug coverage based on their income. Because of your income, your premiums will be increased. The information in this notice about your premium is for 2012 only.

If you currently do not have Medicare Part B or prescription drug coverage and enroll in 2012, those premiums will also be increased based on your income.

### How Much Social Security Will I Get?

- |  |            |
|--|------------|
| • Your new 2012 monthly benefit amount before deductions is:   | \$1,575.70 |
| • Your 2012 monthly deduction for the Medicare Part B Premium is:  | \$259.70   |
| - \$99.90 for the standard Medicare premium, plus  |            |
| - \$159.80 for the income-related monthly adjustment amount based on your 2010 income tax return                                   |            |
| • Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January 25, 2012 is: | \$1,316.00 |



C

See Next Page



**Making Changes to your Plans**



# Qualifying Life Events

## Common Qualifying Life Events

- Marriage
- Divorce
- Death
- Loss of Coverage
- Acquisition of Coverage
- Move out of the service area (Kaiser members)
- Adding or Dropping Dependents
  - Birth
  - Adoption or placement for adoption
  - Legal Guardianship, Foster Child\*
  - No longer a full-time student

Please include all necessary proof documents.

*Dependents are covered until age 19 if unmarried. Coverage may continue until age 24 if dependent is unmarried and a full-time student. \*Legal Guardianship and Foster Children are covered until the age of majority, 18.*



# Qualifying Life Events

- **Complete EC-2 Enrollment form**
  - Forms are available online at [eutf.hawaii.gov](http://eutf.hawaii.gov)
- **Notify EUTF within 30 days of Qualifying Life Event**
  - Retirement – 60 days
  - Birth – 180 days
- **Submit Proof Documents within 60 days**
  - Do not wait for proof documents to submit EC-2 form
  - Contact EUTF if proof documents will take longer than 60 days



# Open Enrollment

## Plan Changes that can be made during Open Enrollment

- Add, remove, or change plans
- Add or remove dependents

**New coverage and rates are effective January 1**

**Plan year is from January to December**



# EUTF Contact Information

- **Walk-In**  
Oahu: City Financial Tower  
201 Merchant Street, 17<sup>th</sup> floor  
Honolulu, HI 96813  
(No Validated Parking)
- **Office Hours**  
Monday – Friday (except State holidays)  
7:45am - 4:30pm
- **Call**  
Phone: 808-586-7390  
Toll-Free: 1-800-295-0089
- **E-mail**  
[eutf@hawaii.gov](mailto:eutf@hawaii.gov)
- **Mailing Address**  
P.O. Box 2121  
Honolulu, HI 96805-2121
- **Website**  
[eutf.hawaii.gov](http://eutf.hawaii.gov)



**Mahalo**