

2017 Open Enrollment Informational Session For Retirees

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.



Open Enrollment



Reference Guide

Mailed to all EUTF retirees

Available on our website at eutf.hawaii.gov

- 2017 Health plan premiums
- Dependent eligibility criteria
- Health plan options
- EC-2/EC-2H Enrollment forms
- Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement Form

Hawaii Employer-Union Health Benefits Trust Fund

RETIREE BENEFIT PLANS REFERENCE GUIDE (EUTF and HSTA VB)



Effective January 1, 2017 – December 31, 2017

Retirees and their dependents who are or soon will be eligible for Medicare and anyone considering retirement or who is covering a dependent 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 53 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 the Hawaii Revised 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. 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.

This guide can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990. Please contact the EUTF office at 808-586-7390 or toll free at 1-800-295-0089 for special needs.

Open Enrollment

October 10, 2016 through October 31, 2016

Plan and rate changes effective January 1, 2017

During open enrollment you can:

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

If you are making changes, enrollment forms must be postmarked by October 31, 2016



HSTA VB

Only available to those who are currently enrolled in the HSTA VB retiree plans (former VEBA members)

HSTA VB members must complete an EC-2H enrollment form if making changes

HSTA VB members can switch to EUTF plans, but cannot switch back to HSTA VB plans

HSTA VB members cannot enroll in both EUTF and HSTA VB plans simultaneously



Student Certification

For unmarried, full-time students ages 19 through 23

To maintain enrollment, student certification must be renewed annually

EUTF will mail out a courtesy reminder



HAWAII EMPLOYER-UNION
HEALTH BENEFITS TRUST FUND

P.O. Box 2121
Honolulu, HI 96805-2121
Oahu (808) 506-7300
Toll Free 1-800-296-0009
www.eutf.hawaii.gov

LEILANI KEALOHA
1234 MAHALO WAY
HONOLULU, HI 96813

Date of Notice: April 24, 2016
HB#: 9998887
Agency/Dept: State of Hawaii

Dear LEILANI KEALOHA,

Your dependent listed below will be attaining the age of 19:

Name: Kawika K Kealeha
Birth date: 07/13/97
HB#: 9998890

The Affordable Care Act (federal health care reform legislation) extends adult child eligibility for active plan participants. As a result of this legislation, your child may maintain health benefit coverage under your medical and prescription drug plans up to age 26. Coverage will automatically be terminated at the end of the pay period in which the dependent child turns 26. At that time, your child will be offered COBRA continuation coverage for up to 36 months.

Under the EUTF administrative rule 3.01(b)(2) for active plan participants, your child may continue enrollment in the dental and/or vision plan up to age 24 provided that he/she is a full-time student at an accredited school, college, or university. You must notify the EUTF if your child meets this criteria by submitting a letter from the registrar or National Student Clearinghouse with the dependent's name, the semester they are enrolled, number of enrolled units, and a school phone number. If no longer a full-time student, your child will be offered COBRA for up to 36 months.

Please submit a letter from the school's registrar or National Student Clearinghouse by 06/28/2016 to EUTF, at P.O. Box 2121, Honolulu, HI 96805-2121.

Please keep a copy for your records.



Benefit Additions



2017 Benefit Additions

EUTF Kaiser Medicare Senior Advantage Plan
Residential hospice room and board: 100%

EUTF HMSA Medical Plan
Physical Examinations

- In-network provider: 100%
- Out-of-network provider: 70% (subject to plan deductible)



For Retirees with Medicare

Wellness Exam Visits under Medicare Part B* include:

“Welcome to Medicare” available during the first 12 months

Visit includes:

- Review of medical and social history
- Education and counseling about preventive services
- Benefit available at no cost**

Yearly “Wellness” available after the first 12 months

Visit includes:

- Completing a Health Risk Assessment
- Assessment used to develop or update a personalized plan to prevent disease or disability
- Benefit available at no cost**

*See your “Medicare & You” Medicare handbook for more information

**You pay nothing if the doctor or qualified health care provider accepts assignment



2016 Benefit Additions

EUTF Non-Medicare Prescription Drug Plan

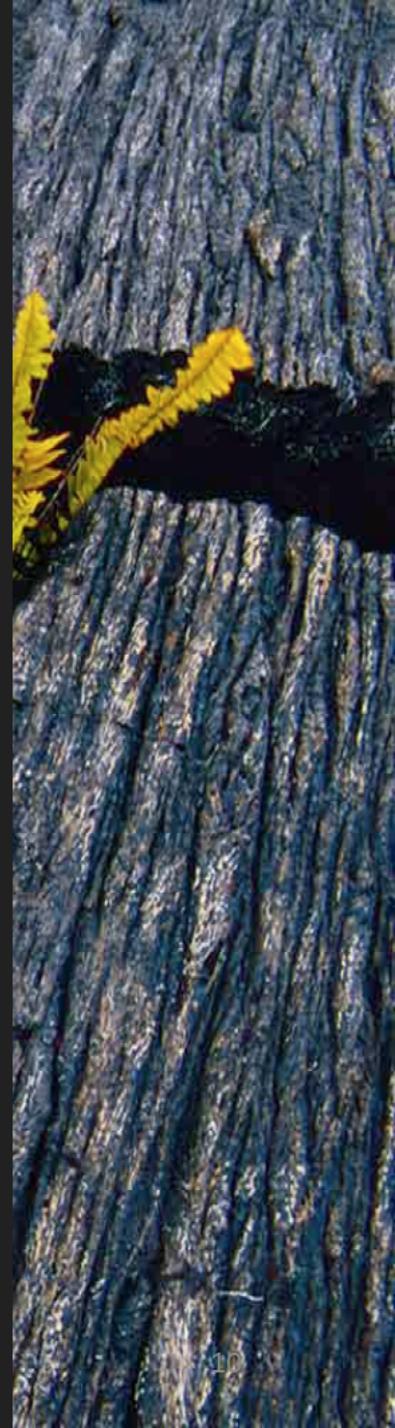
- CVS Caremark Retail 90 network
 - 90-day supply filled for a 60-day supply copayment when prescriptions are filled at a retail 90 pharmacy

EUTF and HSTA VB HMSA and Kaiser Medical Plans

- Autism benefit for individuals under 14 years of age, up to \$25,000 per year
- Orthodontic services for children born with orofacial anomalies up to \$5,500 per treatment phase

EUTF HMSA Medical Plan

- Advanced care planning office visits

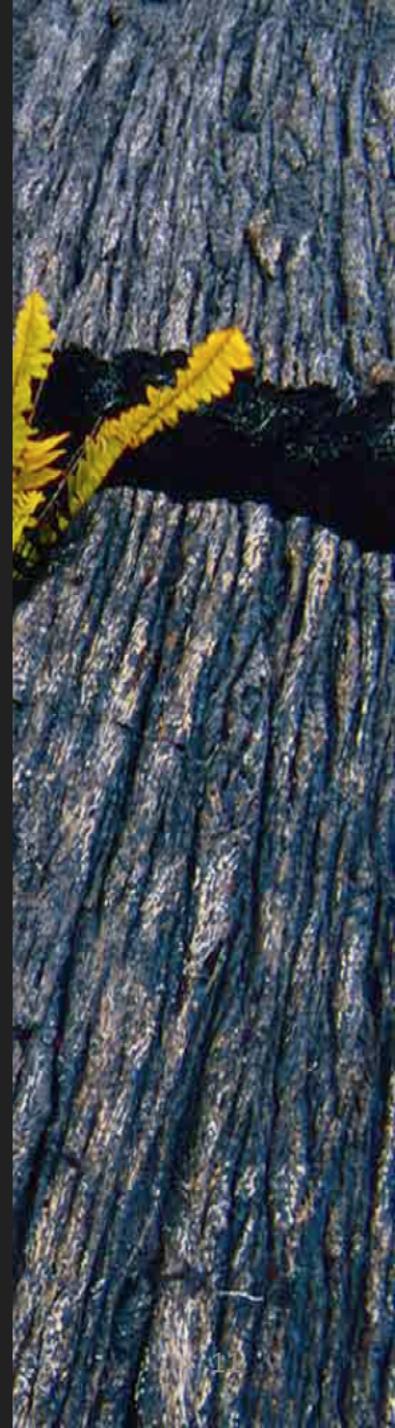


2016 Benefit Additions

HSTA VB HDS Dental Plans

- Annual plan maximum benefit: \$2,000 per member*
- Two fluoride treatments through the age of 19
- Implant benefit reimbursement increase and removal of requirement that implant only apply when tooth is missing between two natural teeth

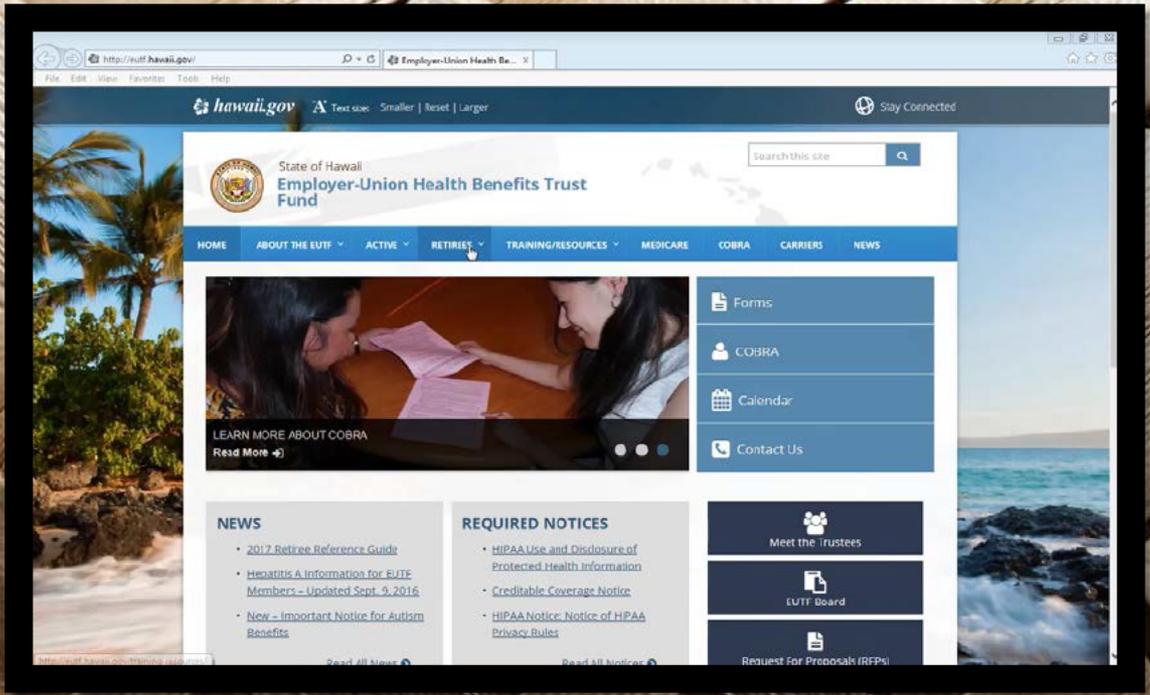
*Note, this benefit was already implemented for EUTF retirees





Plan Selection & Enrollment





EC-2 Hawaii Employer-Union Health Benefits Trust Fund
EC-2: Enrollment Form for Retirees

SECTION 1: RETIREE DATA

Name (Last, First, Middle Initial) _____ Open Enrollment Mid-Year Qualifying Event (see above)

Home Phone (____) _____ Retiree's Social Security Number (SSN) or EUTF ID Number _____ Event Date: ____/____/____

Work Phone (____) _____ IRS Qualified Not Qualified Civil Union Partner (Civil Union Status) Civil Union Date (MM/DD/YYYY) Check this box if not a change

Mobile Phone (____) _____ Gender Male Female Birth Date (MM/DD/YYYY) _____ Check this box if not a change

Email: _____

Residence Address Check the box if your address has changed

Street _____ Married Single Domestic Partner (DP Status) IRS Qualified Not Qualified Civil Union Date (MM/DD/YYYY) Check this box if not a change

Line 2 _____ Marriage Date (MM/DD/YYYY) _____ Check this box if not a change

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

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

Line 2 _____

City _____ State _____ Zip Code _____

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: _____

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

Qualifying Events for this Section: Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

SECTION 3: PLAN SELECTION

Type	Carrier Selection	Choose only one box in each plan selection			
		Cancel/Waive	Self	2-Party	Family
Medical	PPO-9070 HNSA Medical No Prescription Drug Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PPO	UnitedHealthcare Medicare Advantage Op. 13860-Medicare AAB required No Prescription Drug Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	CVS Carmark 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	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 type="checkbox"/>	<input type="checkbox"/>
Vision	Vision Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life	USAB Life	<input type="checkbox"/>	<input type="checkbox"/>	Not available to spouse/partner or dependent(s)	

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EC-2/EC-2H Available:

- Online at eutf.hawaii.gov
- In the 2017 EUTF Retiree Reference Guide

EC-2

Rev. Oct 2016

Hawaii Employer-Union Health Benefits Trust Fund

EC-2: Enrollment Form for RetireesPLEASE SUBMIT THIS
FORM EC-2 TO THE
EUTF**SECTION 1: RETIREE DATA**

Please complete all applicable fields below. Social Security numbers are required to process new retirees and dependent enrollments. **

Name (Last, First, Middle Initial)

John J Kealoha Newly Retired

Date of Retirement (MM/DD/YYYY)

____/____/____

 Qualifying Event (describe)

Event Date: ____/____/____

Home Phone (808) 555-6666

Work Phone (____) _____

Mobile Phone (808) 323-0000Email johnjkealoha808@gmail.com Open Enrollment (effective 01/01/2017)Retiree's Social Security Number
(SSN) or EUTF ID Number555-66-7777

Civil Union Partner (Civil Union Status)

 IRS Qualified Not Qualified

Civil Union Date: (MM/DD/YYYY)

 Check this box if status change

____/____/____

Mailing Address (Check this box if your address has changed)Street 888 Retirement Lane

Line 2 _____

City Pau Hana State HI Zip Code 96888Gender Male Female

Birth Date: (MM/DD/YYYY)

07/01/1950

Domestic Partner (DP Status)

 IRS Qualified Not Qualified

DP Date: (MM/DD/YYYY)

 Check this box if status change

____/____/____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Marital Status Married Single

Marriage Date: (MM/DD/YYYY)

 Check this box if status change07/01/1992

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:

Complete Section 1: Retiree Data

Residence Address (if different from above)

Check this box if status change

Street _____

07/01/1992

Line 2 _____

City _____ State _____ Zip Code _____

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:

SECTION 2: COVERAGE AND CONTRIBUTION 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 selection of the Coverage and Premium Contribution Start Dates. If your event is listed below, please select one of the three options to determine when you wish to skip the event.

Leave Blank

Qualifying Events for the following coverage start dates: Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

- Coverage and premium contributions start 1st day of the first pay period⁴ following event
- Coverage and premium contributions start 1st day of the **second** pay period⁴ following event
- (1st or 16th 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.

Choose only one box in each plan selection

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
Medical	PPO-90/10 HMSA Medical No Prescription Drug Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	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 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"/>

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

Leave Section 2 blank

Residence Address (if different from above)

Check this box if status change

Street _____

07/01/1992

Line 2 _____

City _____ State _____ Zip Code _____

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:

SECTION 2: COVERAGE AND CONTRIBUTION 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^v following event
- Coverage and premium contributions start 1st day of the second pay period^v following event
√ (1st or 16th 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.

Choose only one box in each plan selection

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
Medical	PPO-90/10 HMSA Medical No Prescription Drug Coverage	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	UnitedHealthcare Medicare Advantage Grp. 13840-Medicare A&B required No Prescription Drug Coverage	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drug	CVS Caremark Prescription Drug (Not a valid selection with Kaiser)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO-Kaiser Medical (Includes Kaiser Prescription Drug)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 dependents	

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

Complete Section 3: Plan Selection

Retiree's Name John J Kealoha

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: Last Name (if different), First Name, Middle Initial	Birth Date (MMDDYYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jane J Kealoha	10 / 1 / 1951	555-44-3333	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 plans. JJK (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-2". _____ (initials)

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

Complete Section 4: Dependent Information And Plan Selection

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-2". _____ (initials)

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.

Complete Section 6 only if you are enrolling into
UnitedHealthcare Medicare Advantage Plan

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: John J Kealoha Date Signed: 10/28/2016

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

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

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite1700, Honolulu, HI 96813

EC-2 Rev. 10/16

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Deadline to submit EC-2/EC-2H form is
October 31, 2016 (Postmark)



Medicare Enrollment



FAILURE TO ENROLL IN MEDICARE PART B WILL RESULT IN YOU & YOUR DEPENDENT'S DISENROLLMENT FROM THE EUTF MEDICAL AND/OR PRESCRIPTION DRUG PLAN

Mandatory Medicare Part B Enrollment

Submit Medicare card to EUTF within 60 days:

- From the day you turn 65
- From the day you become eligible for Medicare

Medicare Part B premium reimbursement is only available for retirees and eligible spouse/partner who pay Medicare Part B premiums

No reimbursement for beneficiaries who do not pay a Part B premium(e.g. Enrolled in MSP or Medicaid)

EUTF does not reimburse penalties or Medicare Part D premiums



Medicare Part B Reimbursement

Premium reimbursement is **quarterly**

Complete the Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement form

- *Checking account – Submit voided check*
- *Savings account – Form must be signed by your bank*

Reimbursement will begin the **later of:**

- *Effective date of Medicare Part B coverage*
- *1st day of the month EUTF receives a copy of your Medicare Part B card*



ENROLLMENT IN A NON-EUTF MEDICARE ADVANTAGE OR NON-EUTF MEDICARE PART D PLAN WILL RESULT IN YOU AND/OR YOUR DEPENDENT'S DISENROLLMENT FROM EUTF MEDICARE PLANS.

Enrollment in Non-EUTF Medicare Plans

Medicare requires that you are enrolled in only one Medicare Part D or Medicare Advantage Plan

EUTF Medicare plan options include:

- Medicare Part D prescription drug plan administered by SilverScript (CVS)
- UnitedHealthcare Medicare Advantage PPO Plan
- EUTF Kaiser Permanente Senior Advantage Plan





Base Monthly Contribution



Employer 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

May be adjusted every January 1

Based on Medicare Part B premium increase or decrease

BMC for 2017 will be available later this year after CMS publishes Medicare

Part B premiums effective 1/1/2017

Employer Contribution

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 Base Monthly Contribution multiplied by the applicable percentage not to exceed 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 single rate ONLY. You may obtain coverage for your spouse, domestic partner, or civil union partner but you will be responsible for the premium cost.*

Employer 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

Employer

Contribution 100%

You will pay nothing. 2017 BMC will exceed premiums for medical, prescription drug, dental and vision plans.

Employer Contribution 50% to 75%

Complete EUTF Retiree Worksheet. Will be available on EUTF website in December.

Employer

Contribution 0%

You will pay premiums listed in reference guide.

Premium Example (2016 BMC Self Example)

Malia will be retiring March 1, 2017 and does not qualify for Medicare.

Non-Medicare total
BMC amount for self
\$855.18

Malia's ERS Retirement Estimate Letter shows:

- Membership Date July 1, 1997
- Total Earned Years of Service 19 years

75% of BMC
\$855.18
X .75
\$641.38

Malia selected the following coverages for herself:

- HMSA 90/10 (self).....\$497.24
- CVS Caremark Prescription Drug Coverage (self).....\$222.80
- HDS Dental (self).....\$37.40
- VSP Vision (self).....\$5.34
- Life Insurance\$0.00

Total cost for plans
selected
\$762.78

\$762.78
- \$641.38
\$121.40

Malia's total monthly premium is

Coming Soon!!!

Electronic Premium Payment

Allows retiree to make premium payments to the EUTF via
Credit/Debit Card*



*Fees will apply



Health & Wellness





Annual Wellness Examination



Preventive and Screening Services



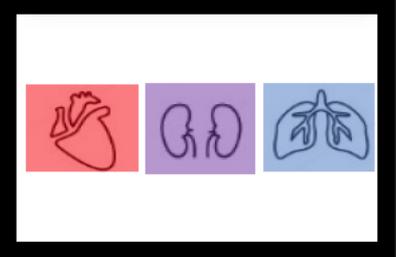
Tobacco Cessation Products & Programs



Diabetic Meter Program



Health Coaching



Disease Management Programs



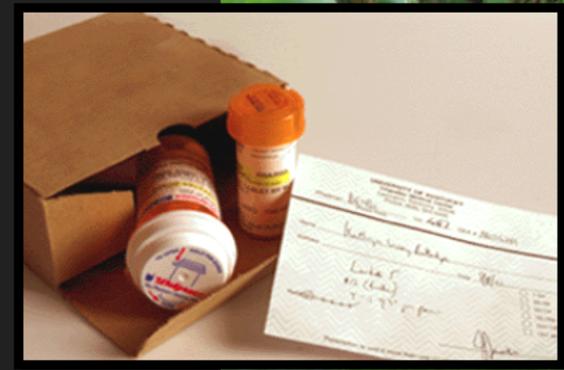
Generic vs Brand Name

- Generic drugs can represent significant savings.
- Generic drugs have the same quality and performance as brand name drugs and can help you save up to 80 percent in cost.
- Check with your doctor if a generic option is available for you.



Mail Order vs Retail

- Mail order can save you time and money if you are on maintenance medication.
- Mail order allows you to receive a 90-day supply for a 60-day supply copayment.
- For more information call CVS at 1-855-801-8263 or Kaiser at 1-808-643-7979.



EUTF Contact Information

- **Call**

Phone: 808-586-7390

Toll-Free: 1-800-295-0089

- **Email**

eutf@hawaii.gov

- **Website**

eutf.hawaii.gov



- **Mailing Address**

P.O. Box 2121

Honolulu, HI 96805-2121

- **Walk-In**

Oahu: City Financial
Tower

201 Merchant Street,
Suite 1700

Honolulu, HI 96813
(No validated parking)

- **Office Hours:**

Monday – Friday

7:45am - 4:30pm

(except State holidays)