

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
HSTA VB RETIREES
EFFECTIVE JANUARY 1, 2017

		Monthly Premium	Monthly Premium
1 MEDICAL/PRESCRIPTION DRUG/CHIRO/VISION		HMSA	Kaiser
A.	Non-Medicare - Self	<input type="checkbox"/> \$683.42	<input type="checkbox"/> \$713.20
B.	Non-Medicare - 2-Party	<input type="checkbox"/> \$1,331.74	<input type="checkbox"/> \$1,439.70
C.	Non-Medicare - Family	<input type="checkbox"/> \$1,971.66	<input type="checkbox"/> \$2,120.96
D.	Medicare - Self	<input type="checkbox"/> \$445.96	<input type="checkbox"/> \$450.16
E.	Medicare - 2-Party	<input type="checkbox"/> \$869.16	<input type="checkbox"/> \$878.14
F.	Medicare - Family	<input type="checkbox"/> \$1,285.82	<input type="checkbox"/> \$1,298.70

Select one plan and enter premium amount

1 \$ _____

2 DENTAL		HDS
Non Medicare/Medicare		
	Self	<input type="checkbox"/> \$44.42
	2-Party	<input type="checkbox"/> \$86.54
	Family	<input type="checkbox"/> \$105.94

Select one plan and enter premium amount

2 \$ _____

3 Add lines 1 and 2

3 \$ _____

4 EMPLOYER CONTRIBUTION		0%	50%	75%	100%
A.	Non Medicare - Self	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$470.34	<input type="checkbox"/> \$705.52	<input type="checkbox"/> \$940.70
B.	Non Medicare - 2-Party	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$948.06	<input type="checkbox"/> \$1,422.10	<input type="checkbox"/> \$1,896.14
C.	Non Medicare - Family	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$1,387.60	<input type="checkbox"/> \$2,081.40	<input type="checkbox"/> \$2,775.20
D.	Medicare - Self	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$335.06	<input type="checkbox"/> \$502.58	<input type="checkbox"/> \$670.12
E.	Medicare - 2-Party	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$671.56	<input type="checkbox"/> \$1,007.34	<input type="checkbox"/> \$1,343.12
F.	Medicare - Family	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$978.12	<input type="checkbox"/> \$1,467.18	<input type="checkbox"/> \$1,956.24

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

4 \$ _____

5 Line 3 minus line 4, enter the AMOUNT YOU OWE monthly

5 \$ _____

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