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

1A MEDICAL/PRESCRIPTION DRUG

		Monthly Premium HMSA	Monthly Premium Kaiser	Monthly Premium UHC
A.	Non-Medicare - Self	☐ $720.04	☐ $720.16	
B.	Non-Medicare - 2-Party	☐ $1,402.86	☐ $1,453.96	
C.	Non-Medicare - Family	☐ $2,079.78	☐ $2,144.72	
D.	Medicare - Self	☐ $442.02	☐ $436.40	☐ $275.46
E.	Medicare - 2-Party	☐ $861.00	☐ $850.96	☐ $539.40
F.	Medicare - Family	☐ $1,276.48	☐ $1,261.16	

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

1B MEDICAL ONLY

		HMSA	UHC
A.	Non-Medicare - Self	☐ $497.24	
B.	Non-Medicare - 2-Party	☐ $968.92	
C.	Non-Medicare - Family	☐ $1,436.40	
D.	Medicare - Self	☐ $223.86	☐ $57.30
E.	Medicare - 2-Party	☐ $436.20	☐ $114.60
F.	Medicare - Family	☐ $646.64	

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

1C PRESCRIPTION DRUG ONLY

A.	Non-Medicare - Self	☐ $222.80
B.	Non-Medicare - 2-Party	☐ $433.94
C.	Non-Medicare - Family	☐ $643.38
D.	Medicare - Self	☐ $218.16
E.	Medicare - 2-Party	☐ $424.80
F.	Medicare - Family	☐ $629.84

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

2 DENTAL HDS

Non Medicare/Medicare

Self	☐ $37.40
2-Party	☐ $72.88
Family	☐ $89.26

Select one plan and enter premium amount **2** $ _____

3 VISION VSP

Non Medicare/Medicare

Self	☐ $5.34
2-Party	☐ $10.68
Family	☐ $14.34

Select one plan and enter premium amount **3** $ _____

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

5 EMPLOYER CONTRIBUTION

		0%	50%	75%	100%
A.	Non Medicare - Self	☐ $0.00	☐ $470.34	☐ $705.52	☐ $940.70
B.	Non Medicare - 2-Party	☐ $0.00	☐ $948.06	☐ $1,422.10	☐ $1,896.14
C.	Non Medicare - Family	☐ $0.00	☐ $1,387.60	☐ $2,081.40	☐ $2,775.20
D.	Medicare - Self	☐ $0.00	☐ $335.06	☐ $502.58	☐ $670.12
E.	Medicare - 2-Party	☐ $0.00	☐ $671.56	☐ $1,007.34	☐ $1,343.12
F.	Medicare - Family	☐ $0.00	☐ $978.12	☐ $1,467.18	☐ $1,956.24

Check your medical selection on line 1A or 1B. (For example, if you selected 1AA, your employer contribution will be non medicare self.) Enter your employer contribution amount (0% or 50% or 75%). **5** $ _____

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

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