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
- Rates and contribution amounts
- Dependent eligibility criteria
- Health plan options
- EC-2 Enrollment form
New Retiree Enrollment

Applying for Your Health Insurance Benefits

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

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 65th birthday.

- 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 2017

<table>
<thead>
<tr>
<th>If your yearly income in 2015 was...</th>
<th>Amount you pay per month in 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>File individual tax return</td>
<td>File joint tax return</td>
</tr>
<tr>
<td>$85,000 or less</td>
<td>$170,000 or less</td>
</tr>
<tr>
<td>above $85,000 up to $107,000</td>
<td>above $170,000 up to $214,000</td>
</tr>
<tr>
<td>above $107,000 up to $160,000</td>
<td>above $214,000 up to $320,000</td>
</tr>
<tr>
<td>above $160,000 up to $214,000</td>
<td>above $320,000 up to $428,000</td>
</tr>
<tr>
<td>above $214,000</td>
<td>above $428,000</td>
</tr>
</tbody>
</table>
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

Your Social Security benefits will increase by 3.9 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: $1,576.70
- Your 2012 monthly deduction for the Medicare Part B Premium is: $259.70
- $90.00 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

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
  - 1st 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) Direct Deposit Agreement Form]

- 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 30, SLH 2006) 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/our 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:**
- **Routing:**
- **Account:**
- **Checking:**
- **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 VOIRED check and return this form to the EUTF*
• 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

<table>
<thead>
<tr>
<th>Active Plan</th>
<th>Retiree Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>As active employees, the portion of health coverage costs paid by the employer is negotiated within the collective bargaining process.</td>
<td>As a retired employee-beneficiary, the portion of health coverage costs paid by the employer is <strong>determined by law</strong>.</td>
</tr>
</tbody>
</table>
## Contribution

### 2017 Base Monthly Contribution (BMC)

<table>
<thead>
<tr>
<th>Maximum Allowable</th>
<th>Single</th>
<th>Two-Party</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medicare</td>
<td>$940.70</td>
<td>$1,896.14</td>
<td>$2,775.20</td>
</tr>
<tr>
<td>Medicare</td>
<td>$670.12</td>
<td>$1,343.12</td>
<td>$1,956.24</td>
</tr>
</tbody>
</table>

### Base Monthly Contribution

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

Date of Hire \[ \rightarrow \] ? \[ \rightarrow \] % \[ \rightarrow \] Base Monthly Contribution set by law

Length of Service
## Contribution

### Employer Contribution Table

<table>
<thead>
<tr>
<th>Years of Credited Service (excluding sick leave)</th>
<th>State’s Base Monthly Contribution If You Were Hired:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>On or Before 6/30/1996</td>
</tr>
<tr>
<td>Less than 10 years</td>
<td>50%</td>
</tr>
<tr>
<td>10 yrs less than 15</td>
<td>100%</td>
</tr>
<tr>
<td>15 yrs less than 25</td>
<td>100%</td>
</tr>
<tr>
<td>25 yrs or more</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Maximum Allowable</th>
<th>Single</th>
<th>Two-Party</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Medicare</td>
<td>$940.70</td>
<td>$1,896.14</td>
<td>$2,775.20</td>
</tr>
<tr>
<td>Medicare</td>
<td>$670.12</td>
<td>$1,343.12</td>
<td>$1,956.24</td>
</tr>
</tbody>
</table>

**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
# Premium

## Health Plan Premium example

**Malia** will be retiring October 1, 2017 and does not qualify for Medicare yet.

<table>
<thead>
<tr>
<th>Malia’s ERS Retirement Estimate Letter shows:</th>
<th>Non-Medicare total BMC amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Membership Date: July 1, 1999</td>
<td>$940.70</td>
</tr>
<tr>
<td>• Total Earned Years of Service: 18 years</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hire Date:</th>
<th>Earned Years of SVC:</th>
<th>Total cost for plans selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/01/99</td>
<td>18 yrs</td>
<td>$762.78</td>
</tr>
<tr>
<td>$940.70 X .75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$705.52</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- HMSA 90/10 $497.24
- CVS Caremark Drug Coverage $222.80
- HDS Dental $37.40
- VSP Vision $5.34
- Life Insurance $0.00

\[
\text{Total cost for plans selected} = 762.78 \\
\text{Non-Medicare total BMC amount} = 940.70 \\
\text{Malia’s total monthly premium is} = 57.26
\]
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
## PPO – HMSA 90/10 Plan

<table>
<thead>
<tr>
<th></th>
<th>Non-Medicare</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$100 per person</td>
<td>$300 per family</td>
</tr>
<tr>
<td><strong>Primary Care Office Visit</strong></td>
<td>10%*</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>10%*</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic lab, X-ray</strong></td>
<td>20%*</td>
<td></td>
</tr>
<tr>
<td><strong>Maximum Out-of-Pocket</strong></td>
<td>$2,500/$7,500</td>
<td></td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Service</th>
<th>Non-Medicare</th>
<th>Senior Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$15</td>
<td></td>
</tr>
<tr>
<td>In-Patient Hospital Services</td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Diagnostic lab, X-ray</td>
<td>$15</td>
<td>No Charge</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket</td>
<td>$2,000/$6,000</td>
<td></td>
</tr>
</tbody>
</table>
# UnitedHealthcare

## PPO – UnitedHealthcare Medicare Advantage

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

<table>
<thead>
<tr>
<th>Deductible</th>
<th>$100 per person</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Office Visit</strong></td>
<td>10%*</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>10%*</td>
</tr>
<tr>
<td><strong>Diagnostic lab, X-ray</strong></td>
<td>20%*</td>
</tr>
<tr>
<td><strong>Maximum Out-of-Pocket</strong></td>
<td>$2,500</td>
</tr>
</tbody>
</table>

* Deductible does not apply
# Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Prescription Drug Coverage</th>
<th>Non-Medicare</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network or Retail 90 Pharmacy</td>
<td>In-Network Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$5/$10 copayment</td>
<td>$15/$30 mail only</td>
</tr>
<tr>
<td>Preferred Brand Name</td>
<td>$15/$30 copayment</td>
<td>$15/$30 mail only</td>
</tr>
<tr>
<td>Other Brand Name</td>
<td>$30/$60 copayment</td>
<td>$15/$30 mail only</td>
</tr>
<tr>
<td>Specialty Drug</td>
<td>20% coinsurance, $250 max per fill, $2,000 annual max</td>
<td>$15/$30 mail-order for eligible drugs</td>
</tr>
</tbody>
</table>
# Other Plans

<table>
<thead>
<tr>
<th>Dental</th>
<th>Vision</th>
<th>Life Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Diagnostic/Preventive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Services</td>
<td>Eye Exam</td>
<td></td>
</tr>
<tr>
<td>Plan Year Maximum</td>
<td>Prescription Glasses</td>
<td>$10 copay</td>
</tr>
<tr>
<td>(per person)</td>
<td></td>
<td>Lenses every year $25 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frames every other year $120 allowance</td>
</tr>
<tr>
<td></td>
<td>Contacts</td>
<td>$120 Allowance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$2,235</td>
</tr>
</tbody>
</table>

* 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.

- 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.
Enrollment Procedures
Enrollment Procedures

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

### Section 1: Retiree Data

Complete applicable fields.

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**EC-2: Enrollment Form for Retirees**

**SECTION 1: RETIREE DATA**

- **Name**: Kealoha, Maile K.
- **Home Phone**: (808) 396-9999
- **Work Phone**: (808) 222-1234
- **Mobile Phone**: (808) 222-1234
- **Email**: mailekealoha@email.com
- **Mailing Address**: 123 Aloha Lane
- **City**: Kailua, State: HI, Zip Code: 96825
- **Marital Status**: Married
- **Birth Date**: 10/15/1953
- **Gender**: Female
- **Social Security Number**: 575-12-3456
- **Event Date**: 10/01/2017
- **Newly Retired Date of Retirement**: 10/01/2017
- **Qualifying Event (describe)**: 
- **Civil Union Partner (Civil Union Status)**: 
- **IRS Qualified**: 
- **Civil Union Date (MM/DD/YYYY)**: 
- **Domestic Partner (DP Status)**: 
- **DP Date (MM/DD/YYYY)**: 
- **Marital Status**: Married
- **Single Marriage Date (MM/DD/YYYY)**: 
- **Special Note**: If your Spouse/Civil Union or Domestic Partner is a State or County Employee or Retiree, please provide the following:
  - **NAME**: Richard Kealoha
  - **SSN**: 576-55-8888
  - **DOB**: 3/22/1953
**Enrollment Procedures**

**SECTION 2: COVERAGE AND CONTRIBUTION SELECTION**

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.

**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 following event
- Coverage and premium contributions start 1st day of the second pay period following event

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.

**SECTION 3: PLAN SELECTION**

<table>
<thead>
<tr>
<th>Type</th>
<th>Carrier Selection</th>
<th>Cancel/Waive</th>
<th>Self</th>
<th>2-Party</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>PPO-90/10 HNSA Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Prescription Drug Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPO</td>
<td>UnitedHealthcare Medicare Advantage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grp. 13840-Medicare A&amp;B required</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Prescription Drug Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>CVS Caremark Prescription Drug</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Not a valid selection with Kaiser)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO</td>
<td>HMO-Kaiser Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Includes Kaiser Prescription Drug)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>Hawaii Dental Service</td>
<td></td>
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<tr>
<td>Vision</td>
<td>Vision Service Plan</td>
<td></td>
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</tr>
<tr>
<td>Life</td>
<td>USAble Life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EC-2 Rev. 10/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Not available to dependents
Enrollment Procedures

Section 4: Dependent Information and Plan Selection

Enter dependent information.

### SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

<table>
<thead>
<tr>
<th>Continue Coverage</th>
<th>Add</th>
<th>Delete</th>
<th>Relationship</th>
<th>Gender</th>
<th>Medical</th>
<th>Drug</th>
<th>Dental</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kealoha, Richard</td>
<td></td>
<td></td>
<td>SP</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Social Security Number: 576-55-8888


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. **MKK** (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
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 United-Healthcare Medicare Advantage Plan, YOU MUST COMPLETE THE INFORMATION BELOW (the information is on your red, white and blue Medicare card):

Retiree – Name of Beneficiary: Maile K. Kealoha  
Medicare Claim #: 575-12-3456-B  
Do you have End Stage Renal Disease (ESRD) □ Yes □ No

Spouse/Partner – Name of Beneficiary: Richard Kealoha  
Medicare Claim #: 576-55-8888-B  
Do you have End Stage Renal Disease (ESRD) □ Yes □ No

If the above information is not completed, your enrollment into the United-Healthcare 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: ________ Maile K. Kealoha ________ Date Signed: 10/15/2017

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

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite 1700, Honolulu, HI 96813

EC-2 Rev. 10/16

Customer Service Call Center
Oahu (808) 586-7390
Toll Free 1(800) 295-0089

Page 4 of 4
Confirmation Notice

- Confirmation Notice
- 10 calendar days to respond in writing

HAWAII EMPLOYER-UNION
HEALTH BENEFITS TRUST FUND

Confirmation Notice
Date: May 04, 2015

SARAH ALOHA
123 MAHALO STREET
HONOLULU, HI 96805

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:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Benefit Plan</th>
<th>Coverage Type</th>
<th>Effective Date</th>
<th>Pay Period Deduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>Enroll</td>
<td>N/A</td>
<td>01/01/2015</td>
<td>$0.00</td>
</tr>
<tr>
<td>Medical</td>
<td>PPO Medical (90/10) w/ Chore</td>
<td>Self</td>
<td>01/01/2015</td>
<td>$101.52</td>
</tr>
<tr>
<td>Dental</td>
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<td>Self</td>
<td>01/01/2015</td>
<td>$6.42</td>
</tr>
<tr>
<td>Vision</td>
<td>Vision</td>
<td>Self</td>
<td>01/01/2015</td>
<td>$1.28</td>
</tr>
<tr>
<td>Prescription Drug</td>
<td>PPO Prescription Drug</td>
<td>Self</td>
<td>01/01/2015</td>
<td>$17.68</td>
</tr>
<tr>
<td>Life</td>
<td>Life Insurance</td>
<td>Self</td>
<td>01/01/2015</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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 access to the information. It is available online at 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 service that is dedicated, courteous, competent, and informative.

City Financial Tower, 201 Merchant Street, Suite 1210, Honolulu, Hawaii 96813
Required Documents
Required Documents

- **ERS Retirement Estimate Letter**

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**STATE OF HAWAII**

**EMPLOYEES RETIREMENT SYSTEM**

March 15, 2012

JOHN A DOE

201 MERCHANT STREET, SUITE 1320

HONOLULU, HI 96813

Dear JOHN A DOE:

Thank you for contacting us about your retirement plan! 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:**
  - Earned: 9 Years 5 Months
  - Acquired: 0 Years 0 Months
- **Hybrid Service for Eligibility:**
  - Earned: 5 Years 5 Months
  - Acquired: 0 Years 0 Months
- **Noncontributory Service for Estimate:**
  - Earned: 3 Years 7 Months
  - Acquired: 0 Years 0 Months
Required Documents

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

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

- ERS Retirement Estimate Letter
- EC-2 Enrollment form
  - Must be received within 60 days of your retirement
- Copy of Medicare card
- Direct Deposit Agreement form
Required Documents

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

Social Security Administration

RECEIVED
STATE OF HAWAII
1407 APR 10 12 38

DEPARTMENT OF LABOR
JOHN A BOR
201 KIRKLAND STREET, SUITE 1520
HONOLULU, HI 96813

Date: November 23, 2011
Claim Number: 123-42-0189-6

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
  - $99.00 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
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 ateutf.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, 17th 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

- **Mailing Address**
  P.O. Box 2121
  Honolulu, HI 96805-2121

- **Website**
  eutf.hawaii.gov
Mahalo