

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
EFFECTIVE JANUARY 1, 2018

| | Monthly Premium | Monthly Premium | Monthly Premium |
|-------------------------------------|-------------------------------------|-------------------------------------|--------------------|
| 1A MEDICAL/PRESCRIPTION DRUG | HMSA | Kaiser | |
| A. Non-Medicare - Self | <input type="checkbox"/> \$701.68 | <input type="checkbox"/> \$797.76 | |
| B. Non-Medicare - 2-Party | <input type="checkbox"/> \$1,367.12 | <input type="checkbox"/> \$1,611.44 | |
| C. Non-Medicare - Family | <input type="checkbox"/> \$2,026.80 | <input type="checkbox"/> \$2,377.30 | |
| D. Medicare - Self | <input type="checkbox"/> \$399.02 | <input type="checkbox"/> \$483.16 | |
| E. Medicare - 2-Party | <input type="checkbox"/> \$777.28 | <input type="checkbox"/> \$942.12 | |
| F. Medicare - Family | <input type="checkbox"/> \$1,152.36 | <input type="checkbox"/> \$1,396.24 | |

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

1A \$ _____

| 1B MEDICAL ONLY | HMSA |
|---------------------------|-------------------------------------|
| A. Non-Medicare - Self | <input type="checkbox"/> \$520.18 |
| B. Non-Medicare - 2-Party | <input type="checkbox"/> \$1,013.62 |
| C. Non-Medicare - Family | <input type="checkbox"/> \$1,502.68 |
| D. Medicare - Self | <input type="checkbox"/> \$234.22 |
| E. Medicare - 2-Party | <input type="checkbox"/> \$456.38 |
| F. Medicare - Family | <input type="checkbox"/> \$676.56 |

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

1B \$ _____

| 1C PRESCRIPTION DRUG ONLY | |
|----------------------------------|-----------------------------------|
| A. Non-Medicare - Self | <input type="checkbox"/> \$181.50 |
| B. Non-Medicare - 2-Party | <input type="checkbox"/> \$353.50 |
| C. Non-Medicare - Family | <input type="checkbox"/> \$524.12 |
| D. Medicare - Self | <input type="checkbox"/> \$164.80 |
| E. Medicare - 2-Party | <input type="checkbox"/> \$320.90 |
| F. Medicare - Family | <input type="checkbox"/> \$475.80 |

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

1C \$ _____

| 2 DENTAL | HDS |
|-----------------------|----------------------------------|
| Non Medicare/Medicare | |
| Self | <input type="checkbox"/> \$39.48 |
| 2-Party | <input type="checkbox"/> \$77.04 |
| Family | <input type="checkbox"/> \$94.38 |

Select one plan and enter premium amount

2 \$ _____

| 3 VISION | VSP |
|-----------------------|----------------------------------|
| Non Medicare/Medicare | |
| Self | <input type="checkbox"/> \$4.96 |
| 2-Party | <input type="checkbox"/> \$9.94 |
| Family | <input type="checkbox"/> \$13.34 |

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 | <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 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.