EUTF and HSTA VB Medicare Retirees and Dependents
with HMSA Medical and SilverScript Prescription Drug Plans
Medicare Part D Vaccinations

Certain vaccinations are covered first under the EUTF and HSTA VB Medicare prescription drug plans (administered by SilverScript) as required by Medicare Part D, including vaccinations for hepatitis A, measles, mumps, and rubella (MMR), and shingles. For these vaccinations, the EUTF and HSTA VB prescription drug plans pay first and the EUTF and HSTA VB HMSA medical plans pay second. **As a result, if you are required to pay a copayment (generally $30 for EUTF members and $9 for HSTA VB members), you are entitled to a reimbursement from the HMSA medical plan.**

Received at a Pharmacy

If you receive a Part D vaccination at a pharmacy, inform the pharmacist that you are also covered under an HMSA plan and request that the pharmacy submit a claim for your copayment to HMSA. If the pharmacist submits the claim to HMSA, you should not have to pay anything. If the pharmacist does not, you will be charged a copayment and will need to submit a reimbursement request to HMSA as follows:

I. Documentation required for copayment reimbursement:

a. **Pharmacy prescription tag** – The tag must show:
- Vaccine name
- Amount you paid
- Examples below: Shingrix, $30.00

b. AND **Pharmacy Cash Register receipt** – The receipt must show:
- Amount you paid
- Examples: Pharmacy #RX M/M, $30.00; RX #7340000, $30.00

SAFEWAY

STORE MGR CLAYTON ETO 808-535-1780
THANK YOU FOR SHOPPING WITH US!

PHARMACY

#RX M/M NON-TAX IT 30.00 Q

TAX 0.00
**** BALANCE 30.00

SAFEWAY STORE #2944
1234 SOUTH BERETANIA
HONOLULU HI 96814

Credit Purchase 03/12/18 14:00
CARD # **********[redacted]
REF: 50001394420 AUTH: [redacted]

PAYMENT AMOUNT 30.00

AL [redacted]
AID A0000000031010
TVR 0000008000
TSI E800

Visa 30.00

CHANGE 0.00
TOTAL NUMBER OF ITEMS SOLD = 1
03/12/18 14:00 2944 29 26 8686

Longs Drugs

377 KEAHOLE ST
HONOLULU, HI 96825
808.395.9491

REG#15 TRN#0150 CSHR#1379793 STR#9185

Helped by: GREGORY

[redacted]

F 1 RX #: ****7340000 30.00N

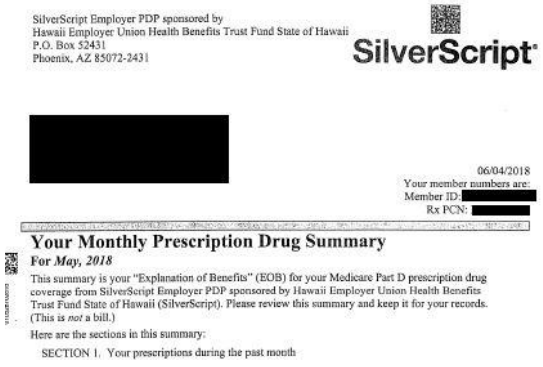
TOTAL 30.00
CHARGE 30.00
*** [redacted] CH

CHASE VISA **********[redacted]
APPROVED# 07040C
REF# 151501
TRAN TYPE: SALE
AID: A0000000031010
TC: 7305FEBA6A3885E8
TERMINAL# 84259296
NO SIGNATURE REQUIRED
CVM: 5E0000
TVR(95): 0000008000
TSI(9B): E800

CHANGE .00

[redacted]

c. OR, if missing either or both a and b above, an **Explanation of Benefits (EOB)** which shows:
   - First page showing name, member ID, Rx PCN
   - Continued page(s) showing complete Chart 1



SilverScript Employer PDP sponsored by
Hawaii Employer Union Health Benefits Trust Fund State of Hawaii
P.O. Box 52431
Phoenix, AZ 85072-2431

SilverScript

[redacted]

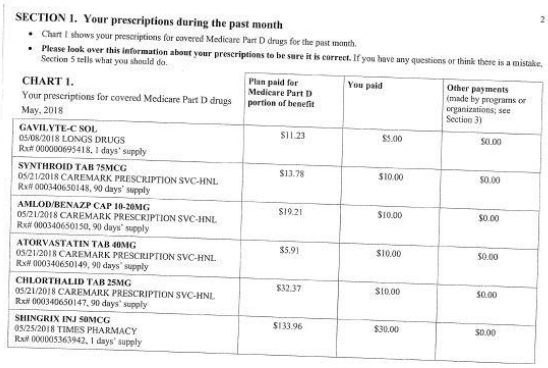
06/04/2018
Your member numbers are:
Member ID: [redacted]
Rx PCN: [redacted]

Your Monthly Prescription Drug Summary
For *May, 2018*

This summary is your "Explanation of Benefits" (EOB) for your Medicare Part D prescription drug coverage from SilverScript Employer PDP sponsored by Hawaii Employer Union Health Benefits Trust Fund State of Hawaii (SilverScript). Please review this summary and keep it for your records. (This is *not* a bill.)

Here are the sections in this summary:

SECTION 1. Your prescriptions during the past month



SECTION 1. Your prescriptions during the past month 2

- Chart 1 shows your prescriptions for covered Medicare Part D drugs for the past month.
- **Please look over this information about your prescriptions to be sure it is correct.** If you have any questions or think there is a mistake, Section 5 tells what you should do.

CHART 1.
Your prescriptions for covered Medicare Part D drugs
May, 2018

	Plan paid for Medicare Part D portion of benefit	You paid	Other payments (made by programs or organizations; see Section 3)
GAVILYTE-C SOL 05/08/2018 LONGS DRUGS Rx# 0000000695418, 1 days' supply	$11.23	$5.00	$0.00
SYNTHROID TAB 75MCG 05/21/2018 CAREMARK PRESCRIPTION SVC-HNL Rx# 000340650148, 90 days' supply	$13.78	$10.00	$0.00
AMLOD/BENAZP CAP 10-20MG 05/21/2018 CAREMARK PRESCRIPTION SVC-HNL Rx# 000340650150, 90 days' supply	$19.21	$10.00	$0.00
ATORVASTATIN TAB 40MG 05/21/2018 CAREMARK PRESCRIPTION SVC-HNL Rx# 000340650149, 90 days' supply	$5.91	$10.00	$0.00
CHLORTHALID TAB 25MG 05/21/2018 CAREMARK PRESCRIPTION SVC-HNL Rx# 000340650147, 90 days' supply	$32.37	$10.00	$0.00
SHINGRIX INJ 50MCG 05/25/2018 TIMES PHARMACY Rx# 000005363942, 1 days' supply	$133.96	$30.00	$0.00

You will receive an EOB, which is a monthly listing of your prescription drug claims, if you have prescription drug claims for that month. If you need a copy of your EOB, please call SilverScript (toll free at 1-877-878-5715) or log onto Caremark.com.

II. Send proof of payment along with your member information within one (1) year from date of service/vaccination. Your member information must include:

a. Name
b. HMSA Membership Number
c. Date of Birth

III. Mail to:

HMSA
P.O. Box 860
ATTN: 7 CR
Honolulu, HI 96808-0860

Or scan & email to:
customer-service@hmsa.com

**Please allow two (2) weeks for HMSA to send your reimbursement.*

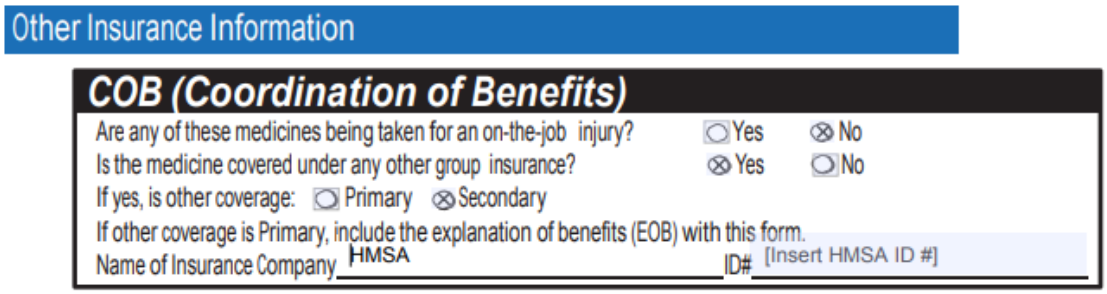
Received from your Physician

If you receive a Part D vaccination from your physician, you will be charged the full cost of the vaccination plus an administration fee.

I. SilverScript Reimbursement

To receive reimbursement from SilverScript for the cost of the vaccination and the administration fee less your copayment, you must complete and submit a claim form (which you can download from eutf.silverscript.com/Documents.aspx) along with your invoice to SilverScript within 12 months from the date of service.

Complete the Prescription Claim Form as shown below and mail to the address indicated on the form:


Other Insurance Information

COB (Coordination of Benefits)

Are any of these medicines being taken for an on-the-job injury? ○ Yes ⊗ No
Is the medicine covered under any other group insurance? ⊗ Yes ○ No
If yes, is other coverage: ○ Primary ⊗ Secondary
If other coverage is Primary, include the explanation of benefits (EOB) with this form.
Name of Insurance Company HMSA ID# [Insert HMSA ID #]

II. HMSA Reimbursement

To receive reimbursement from HMSA for your copayment, you must submit the invoice from SilverScript, showing your copayment, within one year from the date of service. Follow steps II and III above.

If you have any questions regarding coverage of Part D vaccinations, please contact HMSA (948-6499 on Oahu or toll free at 1-800-776-4672) or SilverScript (toll free 1-877-878-5715).