An Introduction to Your Health Benefits

Hawaii Employer-Union Health Benefits Trust Fund

Who We Are

The EUTF, our agency and our mission

Health Plan Selection

Knowing what to consider when selecting a health plan

Health Plan Options

Details on available health plan options for employees and eligible dependents

Enrollment Form

Completing and submitting forms for health plan enrollment

Premiums and Contributions

Health plan premium information and employer/employee contributions

Making Changes

Qualifying Events and form submission when making changes

Who We Are

Who We Are

The EUTF is a State agency administratively attached to the department of Budget and Finance. The EUTF was established on July 1, 2003 and provides medical, prescription drug, dental, vision, and life insurance benefits to nearly two hundred thousand eligible State and county employees, retirees and their dependents.

Our Mission

We care for the health and well being of our beneficiaries by striving to provide quality health benefit plans that are affordable, reliable, and meet their changing needs.
We provide informed service that is excellent, courteous and compassionate.

State of Hawaii

Employer-Union Health Benefits Trust Fund

Who We Are | Health Plan Options | Premiums and Contribution | Health Plan Selection | Enrollment Form | Making Changes

State of Hawaii

Employer-Union Hea

Fund

HOME | ABOUT EUTF | ACTIVE | FUTURE

Home » EUTF Plan Finder Results

EUTF PLAN FINDER RESULTS

Search Again

Employer	Plan Year	Benefit Ty
State of Hawaii	7/1/2018 – 6/30/2019	Medical/Dr
State of	7/1/2018 –	

Sign-up for our Pre-Retirement Healt
too early to start planning for your fut
us for a 45-minute presentation to lea
covered will include:

- Dependent eligibility
- Health plan options
- Medicare
- Differences between active em

2018 Schedule of E

Date	Island	
July 2	Oahu	
July 2	Hawaii - Kona	West H
July 13	Oahu	
July 16	Maui	
July 16	Maui (Hana)	UHMC H
July 16	Molokai	UH
July 16	Lanai	UHMC Lanai Education Center, Room 102

11:00 – 11:45 am , 12:30 – 1:15 pm

1

Applying For Your Health Insurance Benefits

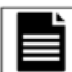
Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

NEW HIRE/NEWLY ELIGIBLE EMPLOYEE

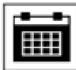
This guide is designed to provide step-by-step instructions on how to enroll in EUTF health and life insurance benefits.

Step #1: Review Health Plan Options
There are seven medical plan options to choose from. HMSA and Kaiser medical plans include prescription drug and chiropractic coverage. Employees may also enroll in dental and vision plans, as well as 100% employer-paid life insurance.

Step #2: Calculate Your Monthly Health Plan Cost
Review health plan premiums for the plans you've selected. Employee premium contributions are negotiated through collective bargaining and may vary depending on the bargaining unit you belong to.



Step #3: Complete an EC-1 Enrollment Form
Once you determine which health plans you wish to be enrolled in you will need to complete an EC-1 enrollment form.



Step #4: Submit the EC-1 Form and Supporting Proof Documents
Submit the EC-1 form and supporting proof documents to your departmental human resource office or enrollment designee within 45 days of your new hire date. All required proof documents must be submitted in order to process your health plan enrollment. Forms received after the deadline will be rejected and you will have to wait until the next open enrollment period or experience a mid-year qualifying event to enroll in plans. Once your enrollment is processed, you will receive a Confirmation Notice in the mail indicating the plans you are enrolled into.

IMPORTANT

If you have an urgent need to fill a prescription or go to the doctor prior to receiving your ID card (VSP does not provide an ID card) you should email EUTF at eutf@hawaii.gov. In the email subject line type "URGENT – Confirmation of coverage needed". EUTF checks the email daily and will contact the carrier to rush your enrollment, if you have an immediate need for services.

Contact the EUTF: Website: eutf.hawaii.gov | Phone: 586-7390 (Oahu) 1-800-295-0089 (Toll-free) | Email: eutf@hawaii.gov

Revised 10/2018

Health Plan Options

Health Plan Options

Medical

- Hawaii Medical Service Association (HMSA)
- Kaiser Permanente

Prescription Drug

- CVS Caremark - *For HMSA Subscribers*
- Kaiser Prescription Drug

Chiropractic Coverage

- American Specialty Health Group (ASH Group)

  - *For HMSA & Kaiser Subscribers*

Supplemental Plan

- Hawaii-Mainland Administrators (HMA)

Dental & Vision

- Hawaii Dental Service
- Vision Service Plan

Life Insurance

- Securian

Medical Plan Options

Preferred Provider Organization (PPO)

- Freedom of choice
- Offers in and out of network benefits
- Out-of-pocket cost based on coinsurance

EUTF PPO Medical Plan Options
90/10 Plan – HMSA Medical with ASH Group Chiropractic coverage and CVS Caremark Prescription Drug
80/20 Plan – HMSA Medical with ASH Group Chiropractic coverage and CVS Caremark Prescription Drug
75/25 Plan – HMSA Medical with ASH Group Chiropractic coverage and CVS Caremark Prescription Drug

Health Maintenance Organization (HMO)

- Select a PCP who will coordinate care
- Out-of-network services require a referral
- Out-of-pocket cost based on copayments

EUTF HMO Medical Plan Options
HMSA HMO with ASH Group Chiropractic coverage and CVS Caremark Prescription Drug
Kaiser Comprehensive Medical and Prescription Drug coverage with ASH Group Chiropractic coverage
Kaiser Standard Medical and Prescription Drug coverage with ASH Group Chiropractic coverage

Other Plans

A supplemental medical and prescription drug plan under HMA is offered to employees who have non-EUTF medical and prescription drug coverage. In order to be enrolled in the HMA supplemental plan, your primary insurance cannot be Medicare.

Dental and vision benefits are available for the employee, employee's spouse or partner and eligible dependents.

Life insurance is 100% employer paid and is available for the employee only.

Supplemental Medical Plan
HMA

Dental Plan
HDS Dental

Vision Plan
VSP Vision

Life Insurance
USAble Life Insurance

Premiums and Contribution

Premiums and Contribution

- Listed by employer and bargaining unit
- Benefit plan option
- Type of enrollment
- Monthly employee contribution

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
BU's 00, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 13, 14

EFFECTIVE JULY 1, 2018

BU's 00, 01, 02, 03, 04, 06, 07, 08, 09, 10, 11, 13, 14: ALL EMPLOYERS

BU 05: FOR HAWAII PUBLIC CHARTER SCHOOLS, STATE OF HAWAII HSTA VEBA EMPLOYEES WHO OPTED TO TRANSFER TO EUTF PLANS or BU 05 EMPLOYEES HIRED ON OR AFTER JANUARY 1, 2011

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
MEDICAL PLANS						
PPO - 90/10 Plan - HMSA Medical and Chiropractic, and CVS Caremark Prescription Drug	Self	$168.41	$336.82	$368.50	52.2%	$705.32
	Two-Party	$409.01	$818.02	$893.72	52.2%	$1,711.74
	Family	$522.78	$1,045.56	$1,136.36	52.1%	$2,181.92
PPO - 80/20 Plan - HMSA Medical and Chiropractic, and CVS Caremark Prescription Drug	Self	$110.12	$220.24	$368.50	62.6%	$588.74
	Two-Party	$267.50	$535.00	$893.72	62.6%	$1,428.72
	Family	$342.36	$684.72	$1,136.36	62.4%	$1,821.08
PPO - 75/25 Plan - HMSA Medical and Chiropractic, and CVS Caremark Prescription Drug	Self	$29.43	$58.86	$316.06	84.3%	$374.92
	Two-Party	$71.41	$142.82	$766.80	84.3%	$909.62
	Family	$91.01	$182.02	$977.26	84.3%	$1,159.28
HMSA HMO Medical and Chiropractic, and CVS Caremark Prescription Drug	Self	$218.95	$437.90	$368.50	45.7%	$806.40
	Two-Party	$531.78	$1,063.56	$893.72	45.7%	$1,957.28
	Family	$679.37	$1,358.74	$1,136.36	45.5%	$2,495.10
HMO - Kaiser Comprehensive Medical, Chiropractic, and Prescription Drug	Self	$130.33	$260.66	$368.50	58.6%	$629.16
	Two-Party	$317.57	$635.14	$893.72	58.5%	$1,528.86
	Family	$407.03	$814.06	$1,136.36	58.3%	$1,950.42
HMO - Kaiser Standard Medical, Chiropractic, and Prescription Drug	Self	$32.01	$64.02	$343.74	84.3%	$407.[illegible]
	Two-Party	$77.78	$155.56	$835.20	84.3%	$990.[illegible]
	Family	$99.22	$198.44	$1,065.54	84.3%	$1,263.[illegible]
Supplemental - HMA Medical and	Self	$6.41	$12.82	$19.20	60.0%	$32.[illegible]

Premium Calculator

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EUTF Active

HSTA VB Active

EUTF/HSTA ACTIVE

Plan Benefits

- Medical/Prescription Drug
- Dental
- Vision
- Life
- Premium Conversion Plan
- Chiropractic

Enrollment & Rates

- Eligibility
- Enrollment Overview
- Rates & Contributions
- Summary of Benefits and Coverage
- EUTF Premium Calculator

Popular Forms & Doc

- Reference Guide
- EC-1

View All Forms

Experienced a Life Change?

View All

EUTF HAS MOVED TO THE

Read More

NEWS

- New – Important Not... Benefits
- New – Important Notice to HSTA VB Retirees – Benefit Plan Changes
- New—Expression of Interest for Banking Services and RFP No. 16-001, Benefit Plan Audit Services

- ...Protected Health Information
- Creditable Coverage Notice
- HIPAA Notice: Notice of HIPAA Privacy Rules

Read All Notices

EUTF Board

Request For Proposals (RFPs)

Premium Calculator

State of Hawaii
Employer-Union Health Benefits Trust Fund

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HOME | ABOUT EUTF | ACTIVE | FUTURE RETIREES | RETIREES | HEALTH AND WELLNESS | LEARNING CENTER | MEDICARE

Home » EUTF Premium Calculator

EUTF PREMIUM CALCULATOR

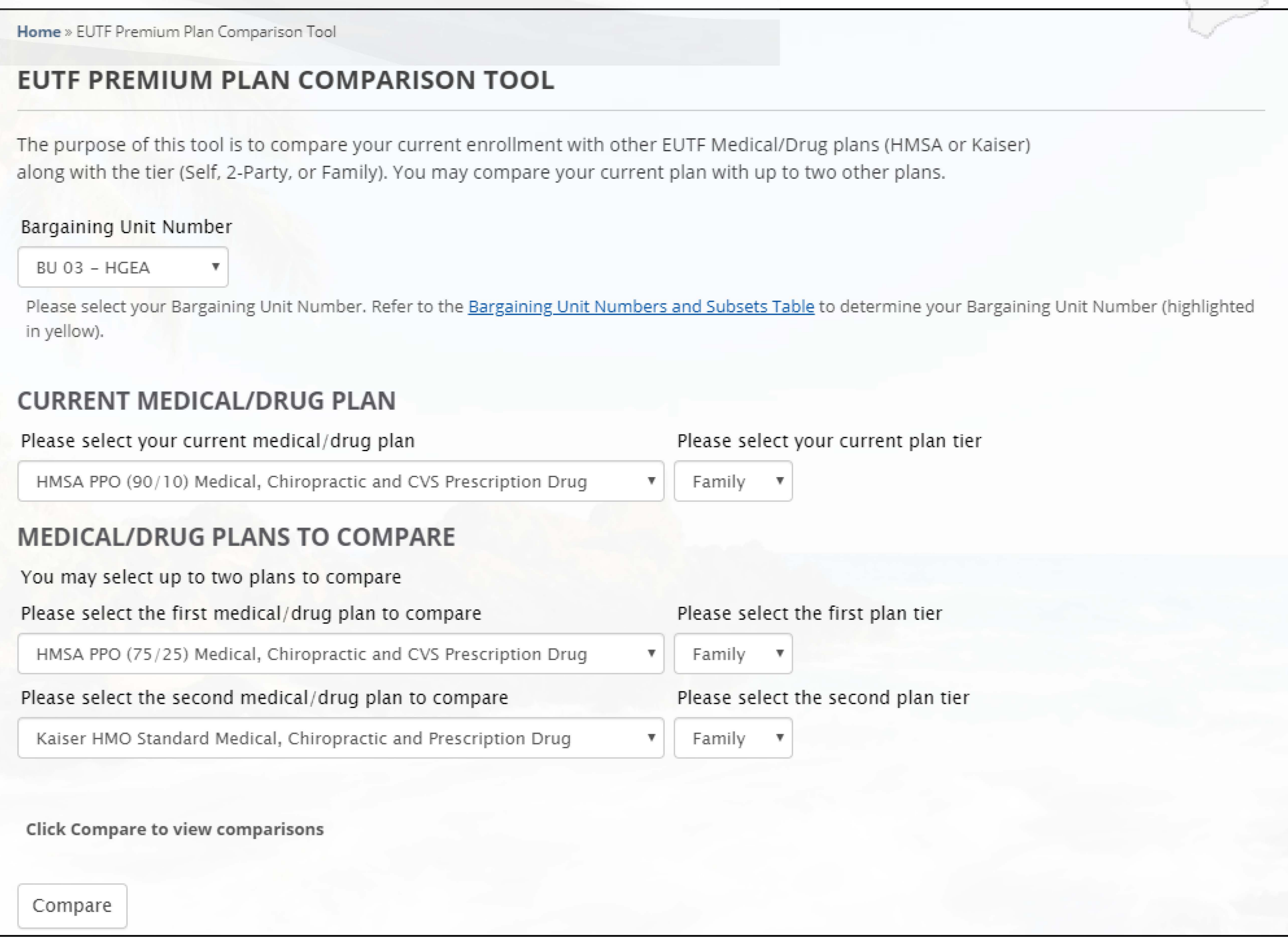
This rate calculator currently does not support Internet Explorer. For best results, please use this calculator in Google Chrome.

Back | Next | Start over

SELECT YOUR EMPLOYER

◉ All Employers

Premium Calculator



Home » EUTF Premium Plan Comparison Tool Results

EUTF PREMIUM PLAN COMPARISON TOOL RESULTS

Compare Plans Again

	Date	Plan	Tier	Semi-Monthly (Pay Period)	Monthly	Annually
Current Plan	Thru 6/30/2019	HMSA PPO (90/10) Medical, Chiropractic and CVS Prescription Drug	Family	$522.78	$1,045.56	$12,546.72
	As of 7/1/2019	HMSA PPO (90/10) Medical, Chiropractic and CVS Prescription Drug	Family	$599.60	$1,199.20	$14,390.40
First Plan	As of 7/1/2019	HMSA PPO (75/25) Medical, Chiropractic and CVS Prescription Drug	Family	$96.80	$193.60	$2,323.20
Second Plan	As of 7/1/2019	Kaiser HMO Standard Medical, Chiropractic and Prescription Drug	Family	$98.35	$196.70	$2,360.40

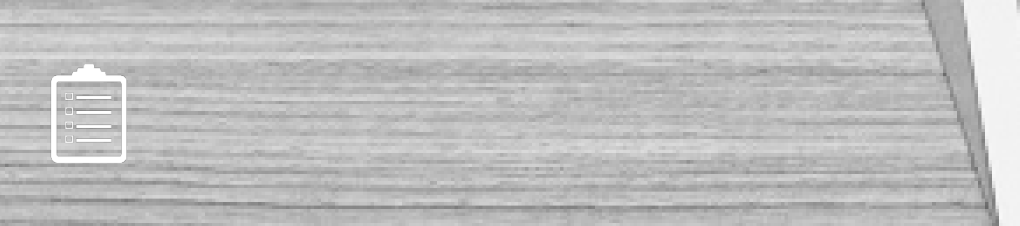
DISCLAIMER

By using this premium plan comparison tool, I acknowledge and agree that:

1. This comparison tool provides an unofficial estimate of health insurance premiums;
2. The EUTF retains no record of estimates produced by this comparison tool;
3. The EUTF has no liability or obligation to offer health insurance plans at any premium amount produced as a result of using this comparison tool; and
4. This comparison tool is not to be construed in any way as a promise or contract with the EUTF for the EUTF to offer health insurance plans at the premium amount calculated, or any other amount.

All final health insurance benefits shall be determined by the EUTF in accordance with the laws in effect at the time such health insurance benefits are offered.

Health Plan Selection



Things to Consider

PREMIUMS	The monthly amount paid for your health insurance shared between the employer and employee.
DEDUCTIBLE	Deductibles do not apply to all plans or all services. They cannot be paid in advance and are renewed annually. Deductibles must be paid each calendar year on a claim-by-claim basis before benefits subject to the deductible become available.
CALENDAR YEAR PLAN YEAR	**Calendar Year** - January 1st to December 31st Includes medical and prescription drug benefits. **Plan Year** – July 1st to June 30th Includes dental and vision benefits.
IN-NETWORK OUT-OF-NETWORK	**In-network** - Physicians, hospitals, pharmacies, and other providers contracted with your health insurance. **Out-of-network -** Providers are not contracted with your health insurance carrier.
COINSURANCE COPAYYMENT	Your out-of-pocket cost for covered services. • Coinsurance is based on a percentage. • Copayment is based on a fixed dollar amount.
MAXIMUM OUT-OF-POCKET	The maximum amount in coinsurance and copayments you will pay for covered medical and prescription drug cost within a calendar year.

Maximum Out-of-Pocket (MOOP)

- Financial protection
- All covered coinsurance, copayments and deductibles apply towards MOOP
- Insurance company keeps track of out-of-pocket
- When MOOP is reached – 100% coverage
- Resets every calendar year

EUTF 90/10 PPO Plan
HMSA
$2,000/$4,000 (medical)
$4,350/$8,700
(CVS prescription drug)

EUTF 80/20 PPO Plan
HMSA
$2,500/$5,000 (medical)
$4,350/$8,700
(CVS prescription drug)

EUTF 75/25 PPO Plan
HMSA
$5,000/$10,000 (medical)
$2,350/$4,700
(CVS prescription drug)

EUTF HMO
HMSA
$1,500/$3,000 (medical)
$4,350/$8,700
(CVS prescription drug)

EUTF HMO Comprehensive
Kaiser
$2,000/$6,000
(medical and prescription drug)

EUTF HMO Standard
Kaiser
$2,500/$7,500
(medical and prescription drug)

Rick is considering enrolling in either the 90/10, 80/20 or 75/25 Self-only plan (Low dollar example)

HMSA PPO Plan Comparison for Self-only	HMSA 90/10	HMSA 80/20	HMSA 75/25
Annual Employee Premium Contribution	$4,042	$2,643	$706
Rick anticipates 4 doctor visits during the calendar year. His doctors charge $100 per visit before insurance pays. Total $400	Coinsurance 10% $40	Coinsurance 20% $80	Coinsurance 25% $100
Calendar Year Plan Deductible	~~$0~~	~~$0~~	~~$300~~
Calendar Year Maximum Out-Of-Pocket (MOOP)	Coinsurance less than $2,000 MOOP	Coinsurance less than $2,500 MOOP	Coinsurance less than $5,000 MOOP
Total Estimated Annual Cost:	$4,082	$2,723	$806

The HMSA 75/25 PPO Plan for Self-only offers Rick the most savings in this scenario

Rick is considering enrolling in either the 90/10, 80/20 or 75/25 Self-only plan (High dollar example)

HMSA PPO Plan Comparison for Self-only	HMSA 90/10	HMSA 80/20	HMSA 75/25
Annual Employee Premium Contribution	$4,042	$2,643	$706
Rick anticipates $19,100 in covered in-network medical expenses (with $300 subject to the 75/25 deductible) from January 2019 - April 2019	Coinsurance 10% $1,910	~~Coinsurance 20%~~ $2,500	Coinsurance 25% $4,700
Calendar Year Plan Deductible	~~$0~~	~~$0~~	$300
Calendar Year Maximum Out-Of-Pocket (MOOP)	Coinsurance less than $2,000 MOOP	Coinsurance exceeds $2,500 MOOP	Coinsurance + deductible reaches $5,000 MOOP
Total Estimated Annual Cost:	$5,952	$5,143	$5,706

The HMSA 80/20 PPO Plan for Self-only offers Rick the most savings in this scenario

Malia is a State employee under BU 13 and enrolled in Kaiser Comprehensive Self only coverage

Malia is considering enrolling in the Kaiser Comprehensive or Standard plan

Kaiser HMO Plans	Comprehensive Plan	Standard Plan
Annual Employee Premium Contribution	$3,128	$768
Malia will undergo surgery and was told the cost before insurance could be $50,000 at an in-network Kaiser facility this year.	No Charge	~~Coinsurance 15%~~ $7,500 / $2,500
Calendar Year Maximum Out-Of-Pocket (MOOP)	$2,000 Not met	$2,500 Met
Total Estimated Annual Cost:	$3,128 / $0	$3,268 / $768

Difference: $2,360

Total estimated annual savings under the Kaiser Comprehensive plan: $140

Enrollment

EUTF Enrollment

EC-1 Enrollment Form

- Available at: eutf.hawaii.gov
- Complete all sections of the EC-1
- Attach any proof documents
- Submit forms within 45 days of your hire date to:
  - Human Resource Officer
  - Personnel Office

Hawaii Employer-Union Health Benefits Trust Fund

ACTIVE EMPLOYEE
EC-1 HEALTH BENEFITS ENROLLMENT FORM
All Bargaining Units Except BU12

Submit this form to your personnel office

DOE employees submit to:
DOE-EBU
PO Box 2360
Honolulu HI, 96804

EMPLOYEE DATA

Complete each section thoroughly, please print clearly

Enrollment Type (*You must check one box*): ❑ New Hire ❑ Qualifying Event ❑ Open Enrollment

New Hire or Qualifying Event Date: ______ **Qualifying Event Description:** ______

Full Legal Name: Last ______ First ______ M.I. ______ Social Security No. or EUTF ID No.: ______

Mailing Address: ______ City ______ State ______ Zip Code ______
Residence Address: ______ City ______ State ______ Zip Code ______

Marital Status: ❑ Single ❑ Married ❑ Domestic Partner Marriage Date: __/__/__
Gender: ❑ Male ❑ Female Birthdate: __/__/__

Home Phone: ( ) ______ Cell Phone: ( ) ______ Email: ______

Spouse/Partner Name: ______ SSN: ______ Birthdate: __/__/__

COVERAGE START DATE

Complete this section if filing for new hire/newly eligible employee, adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled).

❑ Coverage starts day of the event & premium contr butions 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 contr butions start 1st day of the first pay period following event date (1st or the 16th of the month)
❑ Coverage and premium contr butions start 1st day of the second pay period following event date (1st or the 16th of the month)

PLAN SELECTION & CONTRIBUTIONS EFFECTIVE 7/1/18 THROUGH 6/30/19

Medical, Chiro and Prescription Drug Select one:

Plan				
HMSA PPO-90/10 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $336.82	❑ Two-Party $818.02	❑ Family $1,045.56
HMSA PPO-80/20 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $220.24	❑ Two-Party $535.00	❑ Family $684.72
HMSA PPO-75/25 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $58.86	❑ Two-Party $142.82	❑ Family $182.02
HMSA HMO Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $437.90	❑ Two-Party $1,063.56	❑ Family $1,358.74
Kaiser HMO Comprehensive Medical, Chiro and Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $260.66	❑ Two-Party $635.14	❑ Family $814.06
Kaiser HMO Standard Medical, Chiro and Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $64.02	❑ Two-Party $155.56	❑ Family $198.44
HMA Supplemental Medical and Prescription Drug Monthly Employee Premium (Must have coverage under a non-EUTF health plan to be eligible for Supplemental)	❑ Cancel/Waive	❑ Self $12.82	❑ Two-Party $26.62	❑ Family $29.22

Dental Select one:

Plan				
Hawaii Dental Service Monthly Employee Premium	❑ Cancel/Waive	❑ Self $13.48	❑ Two-Party $26.98	❑ Family $44.36

Vision Select one:

Plan				
Vision Service Plan Monthly Employee Premium	❑ Cancel/Waive	❑ Self $2.44	❑ Two-Party $4.50	❑ Family $5.90

Life Select one:

Plan		
USAble Life Monthly Employee Premium	❑ Cancel/Waive	❑ Self $0
Premium Conversion Plan For State Employees only	❑ Cancel/Waive	❑ Enroll

Additional resources available on our website at: eutf.hawaii.gov

Employee Data

Complete all applicable fields. Check the box labeled “New Hire” and indicate your date of hire. Your 9-digit Social Security Number and date of birth are required to process your enrollment form.

If you are married or in a civil union or domestic partnership, please provide your spouse/partner’s information.

Hawaii Employer-Union Health Benefits Trust Fund

ACTIVE EMPLOYEE
EC-1 HEALTH BENEFITS ENROLLMENT FORM

All Bargaining Units Except BU12

Submit this form to your personnel office

DOE employees submit to:
DOE-EBU
PO Box 2360
Honolulu HI, 96804

EMPLOYEE DATA

Complete each section thoroughly, please print clearly

Enrollment Type (*You must check one box*): ☐ **New Hire** ☐ **Qualifying Event** ☐ **Open Enrollment**

New Hire or Qualifying Event Date: ____________ **Qualifying Event Description:** ____________

Full Legal Name: ____________ *Last* *First* *M.I.* Social Security No. or EUTF ID No.: ____________

Mailing Address: ____________ *City* *State* *Zip Code* Residence Address: ____________ *City* *State* *Zip Code*

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner Marriage Date: __/__/__ Gender: ☐ Male ☐ Female Birthdate: __/__/__

Home Phone: ( ) ____ Cell Phone: ( ) ____ Email: ____

Spouse/Partner Name: ____________ SSN: ____________ Birthdate: __/__/__

COVERAGE START DATE

Complete this section if filing for new hire/newly eligible employee, adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled).

- ☐ Coverage starts day of the event & premium contr butions 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 contr butions start 1st day of the first pay period following event date (1st or the 16th of the month)
- ☐ Coverage and premium contr butions start 1st day of the second pay period following event date (1st or the 16th of the month)

PLAN SELECTION & CONTRIBUTIONS EFFECTIVE 7/1/18 THROUGH 6/30/19

Medical, Chiro and Prescription Drug Select one:				
HMSA PPO-90/10 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $336.82	☐ Two-Party $818.02	☐ Family $1,045.56
HMSA PPO-80/20 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $220.24	☐ Two-Party $535.00	☐ Family $684.72
HMSA PPO-75/25 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $58.86	☐ Two-Party $142.82	☐ Family $182.02
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Dental Select one:				
Hawaii Dental Service Monthly Employee Premium	☐ Cancel/Waive	☐ Self $13.48	☐ Two-Party $26.98	☐ Family $44.36
Vision Select one:				
Vision Service Plan Monthly Employee Premium	☐ Cancel/Waive	☐ Self $2.44	☐ Two-Party $4.50	☐ Family $5.90
Life Select one:				
USAble Life Monthly Employee Premium	☐ Cancel/Waive	☐ Self $0		
Premium Conversion Plan For State Employees only	☐ Cancel/Waive	☐ Enroll		

Additional resources available on our website at: eutf.hawaii.gov

DUAL ENROLLMENT

Dual Enrollment is not allowed

- 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.

Coverage Start Date

Carefully consider when you would like your health plans and premium deductions to begin and check the appropriate box. You can select one of the following:

(Option #1) Coverage starts on the date of hire.
Premium contributions start 1st day of the pay period in which the date of hire occurs. *(If no selection is made, this option will be used)*

(Option #2) Coverage and Contributions start 1st day of the first pay period following the date of hire.

(Option #3) Coverage and Contributions start 1st day of the 2nd pay period following the date of hire.

Hawaii Employer-Union Health Benefits Trust Fund

Submit this form to your personnel office

DOE employees submit to:
DOE-EBU
PO Box 2360
Honolulu HI, 96804

ACTIVE EMPLOYEE
EC-1 HEALTH BENEFITS ENROLLMENT FORM
All Bargaining Units Except BU12

EMPLOYEE DATA

Complete each section thoroughly, please print clearly

Enrollment Type (*You must check one box*): ❑ New Hire ❑ Qualifying Event ❑ Open Enrollment

New Hire or Qualifying Event Date: ______ **Qualifying Event Description:** ______

Full Legal Name: Last ______ First ______ M.I. ______ Social Security No. or EUTF ID No.: ______

Mailing Address: ______ City ______ State ______ Zip Code ______ Residence Address: ______ City ______ State ______ Zip Code ______

Marital Status: ❑ Single ❑ Married ❑ Domestic Partner Gender: ❑ Male ❑ Female Birthdate: __/__/__

Marriage Date: __/__/__

Home Phone: ( ) ______ Cell Phone: ( ) ______ Email: ______

Spouse/Partner Name: ______ SSN: ______ Birthdate: __/__/__

COVERAGE START DATE

Complete this section if filing for new hire/newly eligible employee, adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled).

❑ Coverage starts day of the event & premium contr butions 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 contr butions start 1st day of the first pay period following event date (1st or the 16th of the month)
❑ Coverage and premium contr butions start 1st day of the second pay period following event date (1st or the 16th of the month)

PLAN SELECTION & CONTRIBUTIONS EFFECTIVE 7/1/18 THROUGH 6/30/19

Medical, Chiro and Prescription Drug Select one:

Plan	Cancel/Waive	Self	Two-Party	Family
HMSA PPO-90/10 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $336.82	❑ Two-Party $818.02	❑ Family $1,045.56
HMSA PPO-80/20 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $220.24	❑ Two-Party $535.00	❑ Family $684.72
HMSA PPO-75/25 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $58.86	❑ Two-Party $142.82	❑ Family $182.02
HMSA HMO Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $437.90	❑ Two-Party $1,063.56	❑ Family $1,358.74
Kaiser HMO Comprehensive Medical, Chiro and Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $260.66	❑ Two-Party $635.14	❑ Family $814.06
Kaiser HMO Standard Medical, Chiro and Prescription Drug Monthly Employee Premium	❑ Cancel/Waive	❑ Self $64.02	❑ Two-Party $155.56	❑ Family $198.44
HMA Supplemental Medical and Prescription Drug Monthly Employee Premium (Must have coverage under a non-EUTF health plan to be eligible for Supplemental)	❑ Cancel/Waive	❑ Self $12.82	❑ Two-Party $26.62	❑ Family $29.22

Dental Select one:

Plan	Cancel/Waive	Self	Two-Party	Family
Hawaii Dental Service Monthly Employee Premium	❑ Cancel/Waive	❑ Self $13.48	❑ Two-Party $26.98	❑ Family $44.36

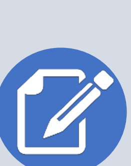
Vision Select one:

Plan	Cancel/Waive	Self	Two-Party	Family
Vision Service Plan Monthly Employee Premium	❑ Cancel/Waive	❑ Self $2.44	❑ Two-Party $4.50	❑ Family $5.90

Life Select one:

Plan	Cancel/Waive	Self
USAble Life Monthly Employee Premium	❑ Cancel/Waive	❑ Self $0
Premium Conversion Plan For State Employees only	❑ Cancel/Waive	❑ Enroll

Additional resources available on our website at: eutf.hawaii.gov



Plan Selection & Contribution

Check the box of each plan you wish to enroll in. You may enroll in only one medical/prescription drug plan.

A spouse/partner and/or dependent child may enroll in the same plans as the employee, but may not enroll in health plans on their own.

Life insurance is 100% employer-paid and is available for the employee only.

Hawaii Employer-Union Health Benefits Trust Fund

Submit this form to your personnel office

DOE employees submit to:
DOE-EBU
PO Box 2360
Honolulu HI, 96804

ACTIVE EMPLOYEE
EC-1 HEALTH BENEFITS ENROLLMENT FORM

All Bargaining Units Except BU12

EMPLOYEE DATA

Complete each section thoroughly, please print clearly

Enrollment Type (*You must check one box*): **New Hire** ☐ **Qualifying Event** ☐ **Open Enrollment** ☐

New Hire or Qualifying Event Date: ______ **Qualifying Event Description:** ______

Full Legal Name: ______ *Last* *First* *M.I.* Social Security No. or EUTF ID No.: ______

Mailing Address: ______ *City* *State* *Zip Code* Residence Address: ______ *City* *State* *Zip Code*

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner Gender: ☐ Male ☐ Female Birthdate: __/__/__

Marriage Date: __/__/__

Home Phone: ( ) ______ Cell Phone: ( ) ______ Email: ______

Spouse/Partner Name: ______ SSN: ______ Birthdate: __/__/__

COVERAGE START DATE

Complete this section if filing for new hire/newly eligible employee, adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled).

☐ Coverage starts day of the event & premium contr butions 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 contr butions start 1st day of the first pay period following event date (1st or the 16th of the month)
☐ Coverage and premium contr butions start 1st day of the second pay period following event date (1st or the 16th of the month)

PLAN SELECTION & CONTRIBUTIONS EFFECTIVE 7/1/18 THROUGH 6/30/19

Medical, Chiro and Prescription Drug Select one:				
HMSA PPO-90/10 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $336.82	☐ Two-Party $818.02	☐ Family $1,045.56
HMSA PPO-80/20 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $220.24	☐ Two-Party $535.00	☐ Family $684.72
HMSA PPO-75/25 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $58.86	☐ Two-Party $142.82	☐ Family $182.02
HMSA HMO Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $437.90	☐ Two-Party $1,063.56	☐ Family $1,358.74
Kaiser HMO Comprehensive Medical, Chiro and Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $260.66	☐ Two-Party $635.14	☐ Family $814.06
Kaiser HMO Standard Medical, Chiro and Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $64.02	☐ Two-Party $155.56	☐ Family $198.44
HMA Supplemental Medical and Prescription Drug Monthly Employee Premium (Must have coverage under a non-EUTF health plan to be eligible for Supplemental)	☐ Cancel/Waive	☐ Self $12.82	☐ Two-Party $26.62	☐ Family $29.22
Dental Select one:				
Hawaii Dental Service Monthly Employee Premium	☐ Cancel/Waive	☐ Self $13.48	☐ Two-Party $26.98	☐ Family $44.36
Vision Select one:				
Vision Service Plan Monthly Employee Premium	☐ Cancel/Waive	☐ Self $2.44	☐ Two-Party $4.50	☐ Family $5.90
Life Select one:				
USAble Life Monthly Employee Premium	☐ Cancel/Waive	☐ Self $0		
Premium Conversion Plan For State Employees only	☐ Cancel/Waive	☐ Enroll		

Additional resources available on our website at: eutf.hawaii.gov

Dependent Information

List all eligible dependents you wish to enroll in plans. Complete all line items associated with each dependent.

Employee's Name: ______________________

State and County Contributions: No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled on more than one retiree/active employee plan (dual enrollment). In addition, if you and your spouse/partner are both retirees/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. You and your spouse/partner are able to select EUTF self-only plans but by selecting Self-only and 2-Party plans or Self-only and Family plans, you will exceed the employer's monthly contribution for a family plan.

DEPENDENT INFORMATION

Complete dependent information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First, Middle Initial	Birth date	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐

If dependents are age 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov

OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide data below.

Type of Plan: (e.g. medical, dental)	Name of the Plan: (e.g. HMSA, Quest)	Subscribers Name(s):

EMPLOYEE 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 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 elected.

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. I agree to immediately notify the Fund in writing of any changes that would result in the loss or change of elig bility of my or any of my dependent-beneficiary's benefits. I understand that the Fund reserves the right to terminate benefits and to seek recovery of any overpayment of benefits resulting from my failure to provide written notice within thirty (30) days of the event that caused the change or inelig bility. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions 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 penalties for perjury.

_______________________ *Employee Signature* _______________ *Date*

Official Use Only

Department ID#	Department	Division/School	Bargaining Unit
Date Received in Office / /	DPO Phone Number	DPO Fax Number	
DPO (or employer designee) Printed Name		Date of DPO (or employer designee) Signature / /	
DPO (or employer designee) Signature			

By signing this EC-1 form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.

Comments:

Rev. 01/2018

Additional resources available on our website at: eutf.hawaii.gov

DEPENDENT ELIGIBILITY

- Legal spouse or partner (domestic or civil union)
- Children by birth, marriage, adoption or placement for adoption
    - Children are covered until age 26 for medical and prescription drug plans
    - For dental and vision coverage, children are covered until age 19, or until age 24 if unmarried and a full-time student
    - Coverage can be continued for an unmarried child, regardless of age, who is incapable of self-support due to mental/physical incapacity that existed prior the child reaching age 19

Dependent Information

List all eligible dependents you wish to enroll in plans. Complete all line items associated with each dependent.

If this is your first time enrolling dependents in EUTF plans, please submit the following proof documents.

Employee's Name: ____________________

State and County Contributions: No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled on more than one retiree/active employee plan (dual enrollment). In addition, if you and your spouse/partner are both retirees/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. You and your spouse/partner are able to select EUTF self-only plans but by selecting Self-only and 2-Party plans or Self-only and Family plans, you will exceed the employer's monthly contribution for a family plan.

DEPENDENT INFORMATION

Complete dependent information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First, Middle Initial	Birth date	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
❑	❑	❑						❑	❑	❑
❑	❑	❑						❑	❑	❑
❑	❑	❑						❑	❑	❑
❑	❑	❑						❑	❑	❑
❑	❑	❑						❑	❑	❑

If dependents are age 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov

OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide data below.

Type of Plan: (e.g. medical, dental)	Name of the Plan: (e.g. HMSA, Quest)	Subscribers Name(s):

EMPLOYEE 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 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 elected.

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. I agree to immediately notify the Fund in writing of any changes that would result in the loss or change of elig bility of my or any of my dependent-beneficiary's benefits. I understand that the Fund reserves the right to terminate benefits and to seek recovery of any overpayment of benefits resulting from my failure to provide written notice within thirty (30) days of the event that caused the change or inelig bility. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions 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 penalties for perjury.

Employee Signature ____________________ *Date* ____________________

Official Use Only

Department ID#	Department	Division/School	Bargaining Unit
Date Received in Office / /	DPO Phone Number	DPO Fax Number	
DPO (or employer designee) Printed Name	Date of DPO (or employer designee) Signature / /		
DPO (or employer designee) Signature By signing this EC-1 form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.			
Comments:			

Rev. 01/2018

Additional resources available on our website at: eutf.hawaii.gov

Proof Documents

Enrollment Type	Required Proof Documents
SELF PLANS	No proof documents required
ADDING A SPOUSE/PARTNER	☐ Marriage certificate ☐ Domestic partnership documents with verification documents* (available at eutf.hawaii.gov)
ADDING A DEPENDENT CHILD	☐ Birth Certificate* ☐ Guardianship Decree (if legal guardian) ☐ Adoption Decree (if child is placed for adoption or adopted) (Social Security numbers required for all newly added dependents)*
DEPENDENT CHILDREN AGE 19 – 23 WHO ARE FULL-TIME STUDENTS AND ENROLLING IN DENTAL & VISION PLANS	☐ Student Certification Letter (A letter from school's registrar or verification certificate from the National Clearinghouse. Transcripts are not accepted)

*Effective July 1, 2019

Other Insurance Information

If you or any of your dependents are covered under a non-EUTF health plan, provide the type of plan, name of the plan, subscriber's name, and name of the dependents enrolled. This helps to ensure that you receive the full benefit of your EUTF and non-EUTF plans by reducing your share of the costs.

Employee's Signature

Read the statement and if you agree, sign and date the form.

Employee's Name: ______________________

State and County Contributions: No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled on more than one retiree/active employee plan (dual enrollment). In addition, if you and your spouse/partner are both retirees/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. You and your spouse/partner are able to select EUTF self-only plans but by selecting Self-only and 2-Party plans or Self-only and Family plans, you will exceed the employer's monthly contribution for a family plan.

DEPENDENT INFORMATION

Complete dependent information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First, Middle Initial	Birth date	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
❑	❑	❑						❑	❑	❑
❑	❑	❑						❑	❑	❑
❑	❑	❑						❑	❑	❑
❑	❑	❑						❑	❑	❑
❑	❑	❑						❑	❑	❑

If dependents are age 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov

OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide data below.

Type of Plan: (e.g. medical, dental)	Name of the Plan: (e.g. HMSA, Quest)	Subscribers Name(s):

EMPLOYEE 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 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 elected.

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. I agree to immediately notify the Fund in writing of any changes that would result in the loss or change of elig bility of my or any of my dependent-beneficiary's benefits. I understand that the Fund reserves the right to terminate benefits and to seek recovery of any overpayment of benefits resulting from my failure to provide written notice within thirty (30) days of the event that caused the change or inelig bility. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions 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 penalties for perjury.

Please submit completed EC-1 forms and all required proof documents within 45 days of your hire date to:

Human Resource Officer or Personnel Office

DPO (or employer designee) Signature

By signing this EC-1 form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.

Comments:

Rev. 01/2018

Additional resources available on our website at: eutf.hawaii.gov

Confirmation Notice

Once your enrollment is processed, a confirmation notice will be mailed to the address indicated on the EC-1 form.

Use the corrective action form provided with the confirmation notice to notify the EUTF of any errors.

Please keep this notice for your records if everything is accurate.

**HAWAII EMPLOYER-UNION
HEALTH BENEFITS TRUST FUND**

P.O. Box 2121
Honolulu, HI 96805-2121
Oahu (808) 586-7390
Toll Free 1(800) 295-0089
www.eutf.hawaii.gov

Confirmation Notice

Date: XX XX, XXXX

SARAH ALOHA
123 MAHALO STREET
HONOLULU, HI 96805

HB #: 9999999
Agency/Department: Budget and Finance
Bargaining Unit: 13

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 15 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 15 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: as of 01/31/2015

Plan Type	Benefit Plan	Coverage Type	Effective Date	Pay Period Deduction
PCP	Enroll	N/A	01/31/2015	$.00
Medical	PPO Medical (90/10) w/ Chiro	Self	01/31/2015	$101.52
Dental	Dental	Self	01/31/2015	$6.42
Vision	Vision	Self	01/31/2015	$1.28
Prescription Drug	PPO Prescription Drug	Self	01/31/2015	$17.68
Life	Life Insurance	Self	01/31/2015	$.00

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 get access to the information. It is available online at eutf.hawaii.gov. Please review it carefully.

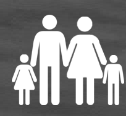
EUTF's Mission: We care for the health and well being of our beneficiaries by striving to provide quality benefit plans that are affordable, reliable, and meet their changing needs. We provide service that is excellent, courteous, compassionate, and informative.

Pay Lag

If you are a newly hired employee or enrolling in benefits for the first time, your pay period deduction amounts may be doubled for at least one (1) to two (2) pay periods to accommodate for processing time and the payroll lag.

If applicable, you will receive a separate notice, EUTF Health Insurance Premium Deduction Notice, to inform you of the additional premiums to be collected and the pay periods that will be adjusted.

Making Changes



Common Qualifying Life Events

- **Marriage**
- **Divorce**
- **Death**
- **Loss of Coverage**
- **Acquisition of Coverage**
- **Adding or Removing Dependents**
  - Birth
  - Adoption or placement for adoption
  - Legal guardianship, foster child*
  - Newly eligible/ineligible student

*Legal guardianship and foster children are covered until the age of majority, 18.

Making Changes to Your Enrollment

Complete EC-1 Enrollment form

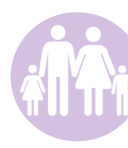
- Forms are available online at eutf.hawaii.gov

Submit EC-1 form within 45 days of Qualifying Life Event

- Birth - 180 days

Submit Proof Documents within 45 days

- All required proof documents must be submitted in order to process enrollment change requests
- Contact EUTF if proof documents will take longer than 45 days



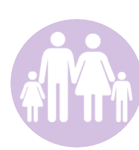
Open Enrollment

Changes that can be made during Open Enrollment:

- Add, remove, or change plans
- Add or remove dependents

New coverage and rates are effective July 1

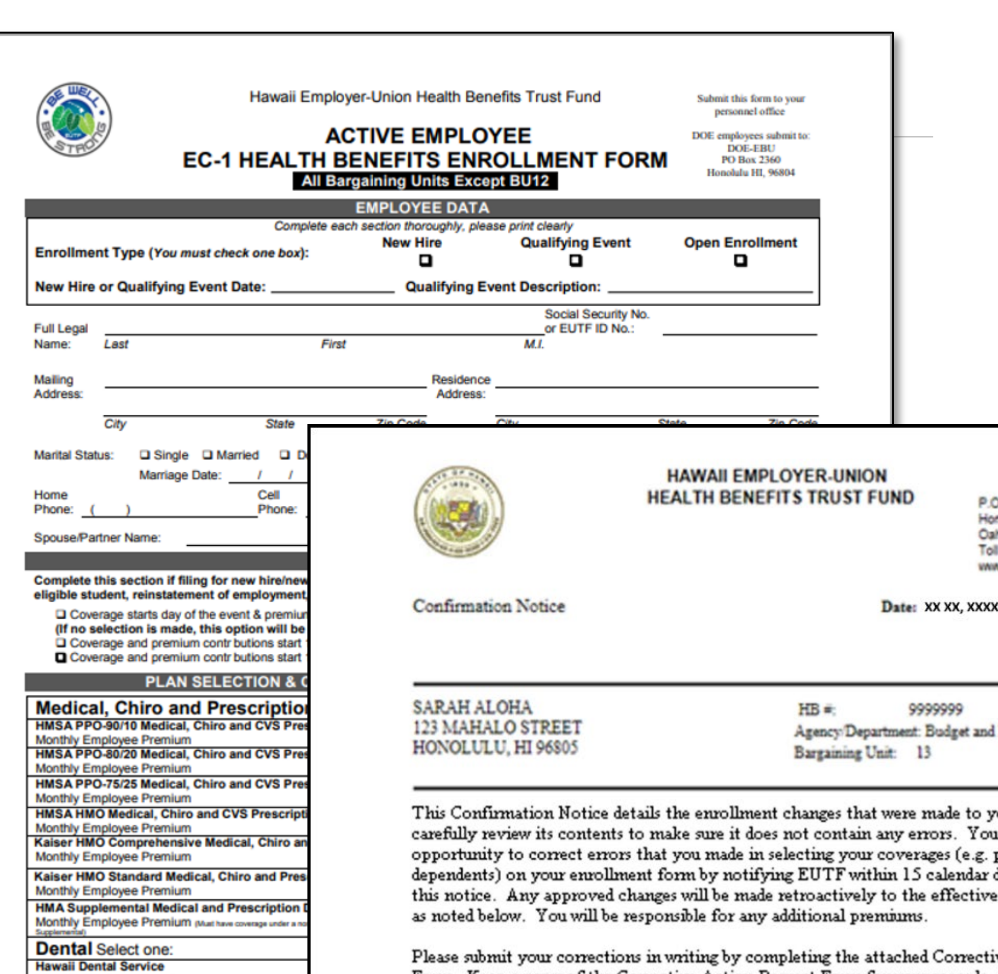
Plan year is from July 1 to June 30



New Hire Recap

EC-1 Enrollment Form

- Complete all sections of the EC-1
- Attach any proof documents
- Submit forms within 45 days of your hire date to:



Hawaii Employer-Union Health Benefits Trust Fund

Submit this form to your personnel office

DOE employees submit to: DOE-EBU PO Box 2360 Honolulu HI, 96804

ACTIVE EMPLOYEE
EC-1 HEALTH BENEFITS ENROLLMENT FORM
All Bargaining Units Except BU12

EMPLOYEE DATA

Complete each section thoroughly, please print clearly

Enrollment Type (*You must check one box*): New Hire ❑ Qualifying Event ❑ Open Enrollment ❑

New Hire or Qualifying Event Date: ______ **Qualifying Event Description:** ______

Full Legal Name: Last ______ First ______ M.I. ______ Social Security No. or EUTF ID No.: ______

Mailing Address: ______ City ______ State ______ Zip Code ______ Residence Address: ______ City ______ State ______ Zip Code ______

Marital Status: ❑ Single ❑ Married ❑ D

Marriage Date: / /

Home Phone: ( ) ______ Cell Phone: ______

Spouse/Partner Name: ______

Complete this section if filing for new hire/new
eligible student, reinstatement of employment

❑ Coverage starts day of the event & premium
(If no selection is made, this option will be
❑ Coverage and premium contributions start
❑ Coverage and premium contributions start

PLAN SELECTION & C

Medical, Chiro and Prescription
HMSA PPO-90/10 Medical, Chiro and CVS Pres
Monthly Employee Premium
HMSA PPO-80/20 Medical, Chiro and CVS Pres
Monthly Employee Premium
HMSA PPO-75/25 Medical, Chiro and CVS Pres
Monthly Employee Premium
HMSA HMO Medical, Chiro and CVS Prescripti
Monthly Employee Premium
Kaiser HMO Comprehensive Medical, Chiro an
Monthly Employee Premium
Kaiser HMO Standard Medical, Chiro and Pres
Monthly Employee Premium
HMA Supplemental Medical and Prescription
Monthly Employee Premium

Dental Select one:
Hawaii Dental Service
Monthly Employee Premium

Vision Select one:
Vision Service Plan
Monthly Employee Premium

Life Select one:
USAble Life

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

Confirmation Notice

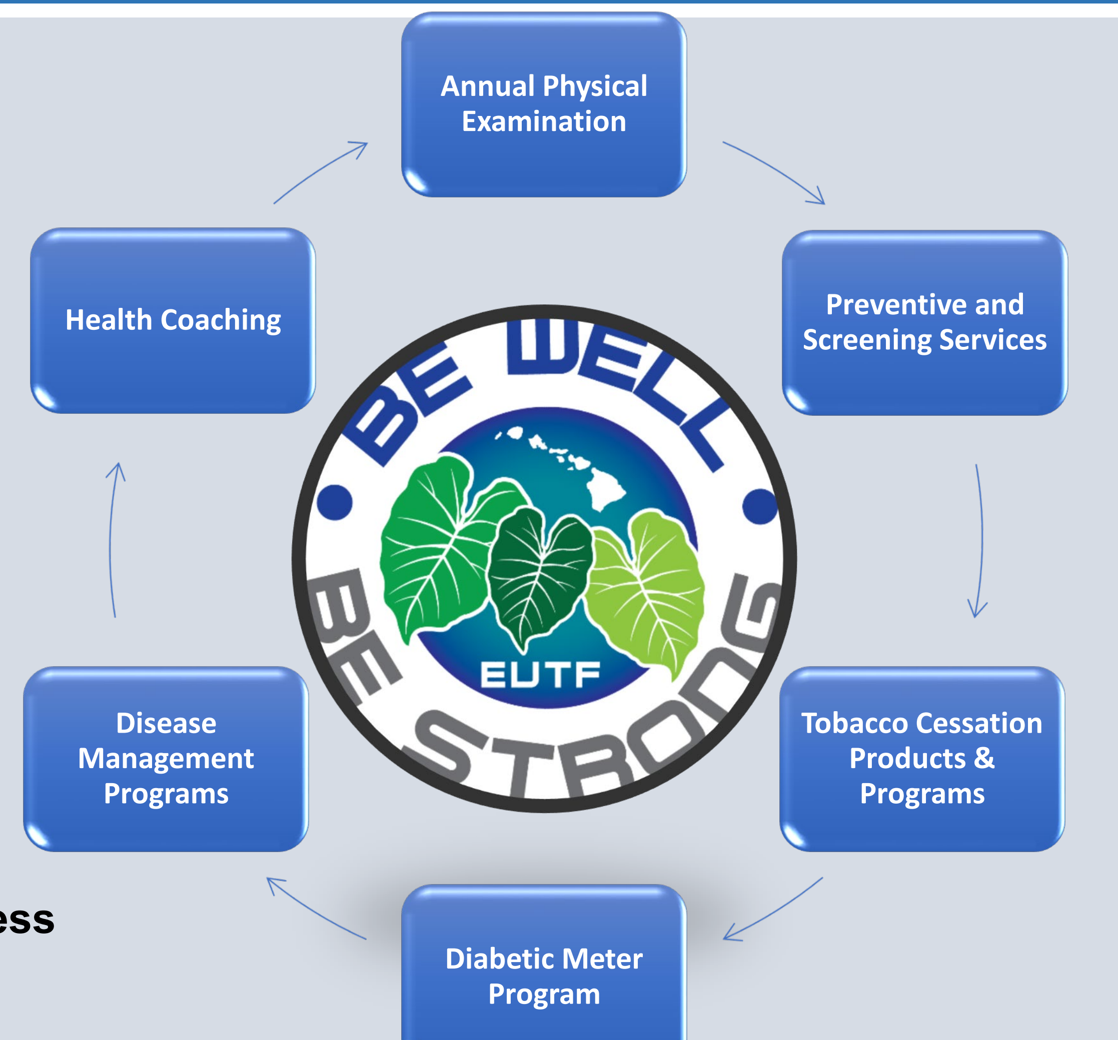
Date: XX XX, XXXX

SARAH ALOHA
123 MAHALO STREET
HONOLULU, HI 96805

HB #: 9999999
Agency/Department: Budget and F
Bargaining Unit: 13

This Confirmation Notice details the enrollment changes that were made to you
carefully review its contents to make sure it does not contain any errors. You h
opportunity to correct errors that you made in selecting your coverages (e.g. pl
dependents) on your enrollment form by notifying EUTF within 15 calendar da
this notice. Any approved changes will be made retroactively to the effective d
as noted below. You will be responsible for any additional premiums.

Please submit your corrections in writing by completing the attached Corrective
Form. Keep a copy of the Corrective Action Request Form for your records. I
not hear from you in writing within 15 calendar days from the date of this notic
will remain in effect as indicated. Any additional changes to your plans will not
next Open Enrollment period, unless you experience a mid-year qualifying even
changes under the EUTF Administrative Rules.



Health and Wellness Benefits

Health and Wellness Benefits

Annual Physical Examination

Annual Physical Exam

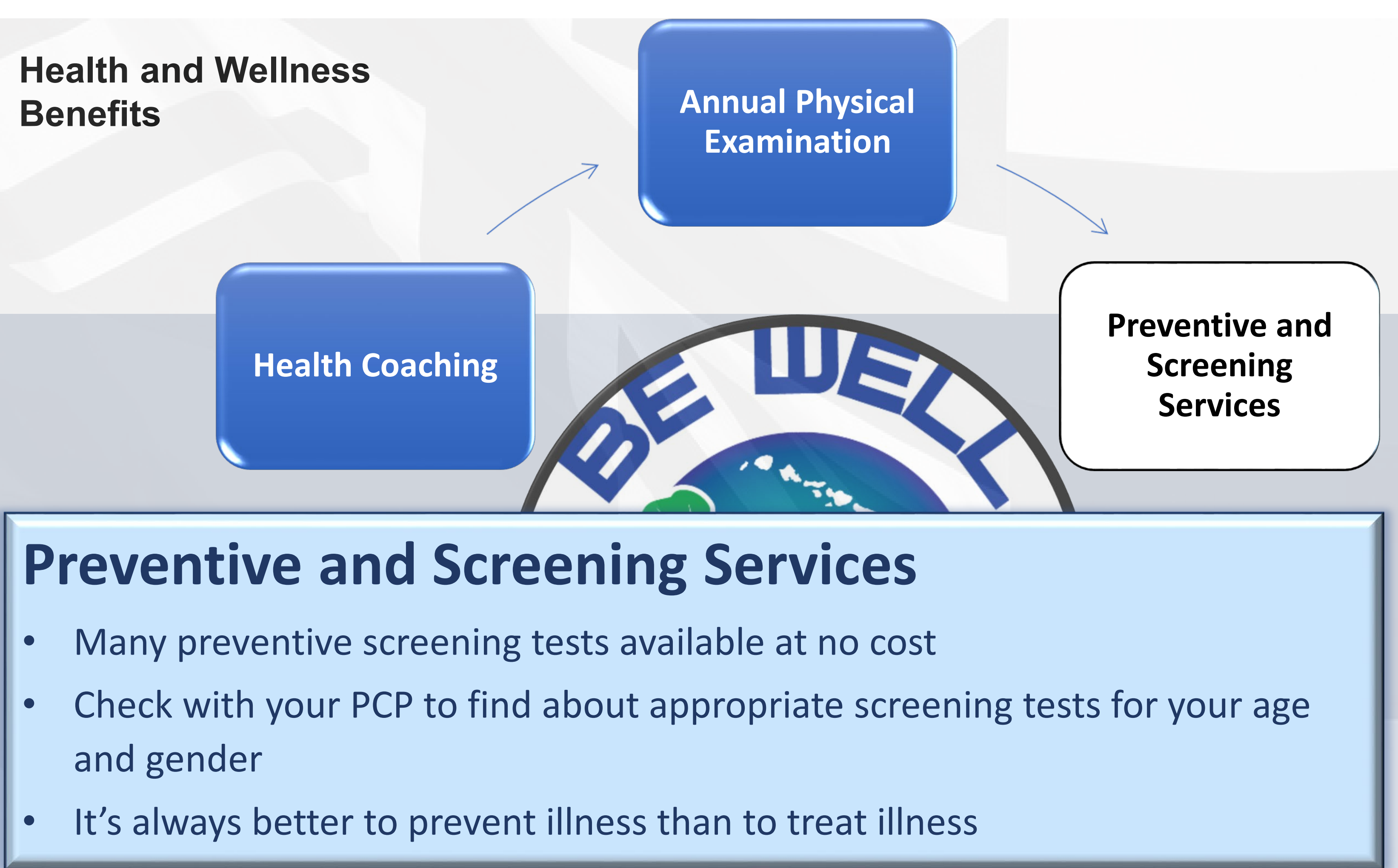
- No cost for most EUTF medical plans
- The PCP will:
    - Assess your overall health
    - Identify risk factors for chronic diseases
    - Recommend preventative services and immunizations
    - Early detection of illness and disease increase the effectiveness of treatment
- If you haven’t seen your doctor in the last year, we encourage you to make an appointment to get your annual physical

Disease Management Programs

Tobacco Cessation Products & Programs

Diabetic Meter Program

Health and Wellness Benefits



Preventive and Screening Services

- Many preventive screening tests available at no cost
- Check with your PCP to find about appropriate screening tests for your age and gender
- It’s always better to prevent illness than to treat illness

Programs

Programs

Diabetic Meter Program

Health and Wellness Benefits

Annual Physical

Tobacco Cessation

- Another no cost benefit
- Smoking is a major risk factor for chronic diseases
- Trained counselors are available by phone to provide guidance, support and recommendation of products to help to you quit smoking
- Contact
  - HMSA QuitNet program (855)329-5461
  - Kaiser tobacco cessation (808)643-4622
  - CVS Caremark tobacco cessation product information and recommendations (855)801-8263

Disease Management Programs

Tobacco Cessation Products & Programs

Diabetic Meter Program

Annual Physical Examination

Preventive and Screening Services

Health Coaching

Diabetes Products

- No cost blood glucose meters to help monitor blood glucose levels
- For CVS Caremark members
- Contact CVS Caremark Diabetic Meter Team at (800)588-4456

Diabetic Meter Program

Health and Wellness Benefits

Annual Physical

Disease Management (DM)

- Diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension and heart disease
- DM programs through HMSA and Kaiser
  - ✓ Contact members with diagnosed conditions
  - ✓ Provide one-on-one support from a healthcare professional
- To take advantage of these programs talk to your PCP, HMSA or Kaiser

Disease Management Programs

Tobacco Cessation Products & Programs

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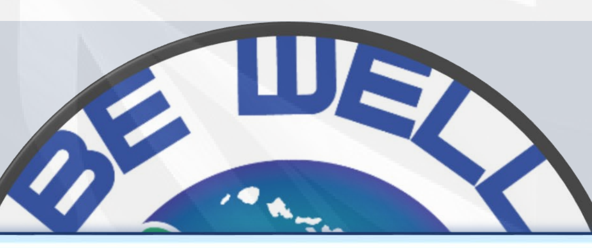

Telephonic Health Coaching

- Another no cost benefit
- Coaches provide guidance and support to manage conditions such as diabetes and help with lifestyle changes such as eating better, managing your weight and reducing stress
- A personal coach will help you create and stick with a plan for reaching your goals
- Contact
  - HMSA Well-Being Connection (855)329-5461
  - Kaiser (808)432-2262 or (808)432-2260

Program

Health and Wellness Benefits

Annual Physical Examination

Dr. Ornish Program for Reversing Heart Disease

- HMSA EUTF active employees
- Scientifically proven to reverse heart disease using lifestyle changes
- Eighteen four hour sessions over 9 weeks
- Cost is $20 per session for eligible HMSA members
- Contact an Ornish care specialist at (877)888-3091

Diabetic Meter Program

Mahalo