

**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
EUTF RETIREES WITH ERS MEMBERSHIP DATES ON OR BEFORE JUNE 30, 2001
EFFECTIVE JANUARY 1, 2020**

Retiree Monthly
Premium

1A	MEDICAL & PRESCRIPTION DRUG	Monthly Premium	HMSA	Monthly Premium	Kaiser
	A. Non-Medicare - Self	<input type="checkbox"/>	\$812.96	<input type="checkbox"/>	\$759.64
	B. Non-Medicare - 2-Party	<input type="checkbox"/>	\$1,583.92	<input type="checkbox"/>	\$1,534.48
	C. Non-Medicare - Family	<input type="checkbox"/>	\$2,348.22	<input type="checkbox"/>	\$2,263.74
	D. Medicare - Self	<input type="checkbox"/>	\$478.98	<input type="checkbox"/>	\$460.18
	E. Medicare - 2-Party	<input type="checkbox"/>	\$933.06	<input type="checkbox"/>	\$897.36
	F. Medicare - Family	<input type="checkbox"/>	\$1,383.32	<input type="checkbox"/>	\$1,329.88

If you want medical & prescription drug, select one plan above and enter the premium amount on line 1A.

If you want medical only and NOT prescription drug, skip this section and go to MEDICAL ONLY (1B).

If you want prescription drug only and NOT medical, skip this section and go to PRESCRIPTION DRUG ONLY (1C).

1A \$ _____

1B	MEDICAL ONLY	Monthly Premium	HMSA
	A. Non-Medicare - Self	<input type="checkbox"/>	\$578.30
	B. Non-Medicare - 2-Party	<input type="checkbox"/>	\$1,126.88
	C. Non-Medicare - Family	<input type="checkbox"/>	\$1,670.58
	D. Medicare - Self	<input type="checkbox"/>	\$258.98
	E. Medicare - 2-Party	<input type="checkbox"/>	\$504.68
	F. Medicare - Family	<input type="checkbox"/>	\$748.16

Select one plan above and enter the premium amount on line 1B.

If you selected a plan in 1A, skip this section.

1B \$ _____

1C	PRESCRIPTION DRUG ONLY	Monthly Premium
	A. Non-Medicare - Self	<input type="checkbox"/> \$234.66
	B. Non-Medicare - 2-Party	<input type="checkbox"/> \$457.04
	C. Non-Medicare - Family	<input type="checkbox"/> \$677.64
	D. Medicare - Self	<input type="checkbox"/> \$220.00
	E. Medicare - 2-Party	<input type="checkbox"/> \$428.38
	F. Medicare - Family	<input type="checkbox"/> \$635.16

Select one plan above and enter the premium amount on line 1C.

If you selected a plan in 1A, skip this section.

1C \$ _____

2	DENTAL	Monthly Premium	HDS
	Non-Medicare/Medicare		
	Self	<input type="checkbox"/>	\$42.00
	2-Party	<input type="checkbox"/>	\$81.90
	Family	<input type="checkbox"/>	\$100.38

Select one plan above and enter the premium amount on line 2.

2 \$ _____

3	VISION	Monthly Premium	VSP
	Non-Medicare/Medicare		
	Self	<input type="checkbox"/>	\$4.64
	2-Party	<input type="checkbox"/>	\$9.30
	Family	<input type="checkbox"/>	\$12.48

Select one plan above and enter the premium amount on line 3.

3 \$ _____

4 Add lines 1A or 1B, 1C, 2, and 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"/> \$507.38	<input type="checkbox"/> \$761.08	<input type="checkbox"/> \$1014.78
	B. Non-Medicare - 2-Party	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$1,022.70	<input type="checkbox"/> \$1,534.06	<input type="checkbox"/> \$2,045.42
	C. Non-Medicare - Family	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$1,496.86	<input type="checkbox"/> \$2,245.28	<input type="checkbox"/> \$2,993.72
	D. Medicare - Self	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$361.44	<input type="checkbox"/> \$542.18	<input type="checkbox"/> \$722.90
	E. Medicare - 2-Party	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$724.44	<input type="checkbox"/> \$1,086.66	<input type="checkbox"/> \$1,448.88
	F. Medicare - Family	<input type="checkbox"/> \$0.00	<input type="checkbox"/> \$1,055.12	<input type="checkbox"/> \$1,582.70	<input type="checkbox"/> \$2,110.26

Check your medical selection on line 1A or 1B. (For example, if you selected 1A-A, your employer contribution will be Non-Medicare Self.) Enter your employer contribution amount on line 5.

5 \$ _____

6 Subtract line 5 from line 4 and enter the AMOUNT YOU OWE monthly on line 6.

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 201 Merchant Street, Suite 1700, Honolulu, HI 96813.