EUTF Claim Form

ATTENTION	**The plan year is from July 1, 2020 to June 30, 2021.** The filing deadline for dates of service between July 1, 2020 and June 30, 2021 is December 28, 2021 or 180 days after your termination date, whichever is earlier. The plan will not pay any claims received after the filing deadline.

Please follow the Claim Filing Requirements on the back of this form. Complete the information below for medical care and/or prescription drug expenses that were incurred by you or your eligible dependents. The services must have been paid by your primary health insurance plan to be eligible for reimbursement. Failure to complete this form or follow the Claim Filing Requirements will result in a delay in processing your claim.

Employee Name: _____ (First Name) _____ (Last Name) _____ (MI)

Phone Number: _____ **Email Address:** _____

	Date of Service	Name of Person Receiving Service	Date of Birth	Description of Service	Amount
1					$
2					$
3					$
4					$
5					$
6					$
				Total Requested Reimbursement Amount	**$**

To the best of my knowledge, the information on this Claim Form is complete and true. I certify that these are eligible medical care and/or prescription drug expenses that my dependents or I have incurred. I understand that these expenses must qualify as benefits under the EUTF Supplemental Health & Pharmacy Plan, and cannot be reimbursed by any other source or used as a deduction on my personal income tax return. I have read and followed the claim filing requirements on the back of this form.

☐ I have attached receipts or documents in support of these services.

Employee's Signature: _____ **Date:** _____

For Official HMA Use Only

EUTF Claim Filing Requirements

ATTENTION	**The plan year is from July 1, 2020 to June 30, 2021.** The filing deadline for dates of service between July 1, 2020 and June 30, 2021 is December 28, 2021 or 180 days after your termination date, whichever is earlier. The plan will not pay any claims received after the filing deadline.

PLEASE NOTE: Failure to complete the Claim Form or follow the Claim Filing Requirements will result in a delay in processing or denial of your claim.

For Claim Submissions

To expedite the claim submission process, we strongly recommend submitting all claims online.

1) **Visit www.hma-hi.com/eutf and select the "File a Claim" button.**

2) **Complete all the information requested on the claim form.**

3) **For reimbursement of medical services,** please attach your insurance payment reports (e.g., HMSA Report to Member) or Explanation of Benefits statements from your primary health insurance plan. If your primary health insurance plan is with Kaiser Permanente, please attach your copayment receipts.

   Please Note: Billing statements and payment receipts from your health care provider will not be accepted.

4) **For reimbursement of prescription drugs**, please attach insurance payment reports or prescription drug receipts from your pharmacy that shows the patient's name, physician's name, Rx number, drug name, date of service and amount of copayment.

5) **For paper claim submissions only, please sign and date the claim form**.
   Mail or fax a completed claim form and all supporting documents to:

   Hawaii-Mainland Administrators
   ATTN: Claims Department
   P.O. Box 135005
   Honolulu, Hawaii 96801-5005
   Fax: (808) 951-4620

   Please Note: (Mailing Paper Claims Only) Be sure to submit a photocopy of your claim form and supporting documents. Any documents submitted to HMA for processing are not returned. Additional claim forms can be downloaded online at www.hma-hi.com/eutf.

Schedule of Benefits	
Plan Year	July 1, 2020 through June 30, 2021.
Plan Type	Group Supplemental Health & Pharmacy Plan is a secondary payer.
Plan Year Benefit Maximum	$2,750 per covered participant Prescription Drug Sublimit: $250
Prescription Drug Benefit	The maximum reimbursement for prescription drug copayment charges is $20 per 30-day supply, $40 per 60-day supply, and $60 per 90-day supply. Reimbursements for prescription drug copayment charges shall not exceed $250 per plan year per covered participant. Reimbursements for prescription drug copayments count towards the $2,750 Plan Year Maximum.