SPECIFICATIONS

INTRODUCTION

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) is procuring the services of a printer to print and distribute Open Enrollment Materials to Active Employees and Retirees.

The EUTF administers health and other benefit plans for State and county employees, retirees, and their dependents. The benefit plans include medical, prescription drug, dental, vision, chiropractic, and life insurance. The EUTF currently provides benefit plans to approximately 68,500 employees and 45,300 retirees.

Active employee plans are on a fiscal year basis (July 1 to June 30); however, retiree plans are on a calendar year basis (January 1 to December 31). Open enrollment occurs twice a year. The active employee open enrollment usually occurs in April and retirees in October. Open enrollment materials are printed and distributed twice a year to active employees and retirees.

SIGNIFICANT DATES

The following schedule sets forth the significant dates and deadlines applicable to this solicitation. The dates are merely estimates and not binding on the EUTF. Nevertheless, by submitting a proposal, each Offeror: a) agrees to complete its proposal in compliance with the dates and deadlines set forth in the following schedule, unless the EUTF expressly agrees to modify such schedule; and b) represents and warrants to the EUTF that such Offeror has the ability to comply with such schedule.

Solicitation release date	June 30, 2017
Proposals Due	July 14, 2017; 4:30 PM, HST
Notice of Award	July 17, 2017
Contract Start Date	July 24, 2017

CONTRACT PERIOD

The term of the contract will be for three (3) years.

RESPONSIBILITY OF OFFERORS

Offerors are advised that in order to be awarded a contract under this solicitation, the Offerors will be required to be compliant with the following chapters of HRS pursuant to HRS §103D-310(c) upon award of a contract:
Chapter 237, General Excise Tax Law;
Chapter 383, Hawaii Employment Security Law;
Chapter 386, Worker's Compensation Law;
Chapter 392, Temporary Disability Insurance;
Chapter 393, Prepaid Health Care Act; and

§103D-310(c), Certificate of Good Standing (COGS) for entities doing business in the State. If the Offeror is not compliant with the above HRS chapters at the time of award, the Offeror will not receive the award. To demonstrate compliance, Offerors are encouraged to subscribe to Hawaii Compliance Express (HCE). Offerors who do not participate in HCE may submit paper compliance certificates to the ERS/EUTF.

The HCE is an electronic system that allows vendors/contractors/service providers doing business with the State to quickly and easily demonstrate compliance with applicable laws. It is an online system that replaces the necessity of obtaining paper compliance certificates from the Department of Taxation, Federal Internal Revenue Service; Department of Labor and Industrial Relations, and Department of Commerce and Consumer Affairs.

Offerors who are interested in registering in HCE should do so prior to submitting an offer at https://vendors.ehawaii.gov. The annual registration fee is currently $12.00 and the 'Certificate of Vendor Compliance' is accepted for the execution of a contract and final payment.

INSURANCE REQUIREMENTS

The contractor shall maintain in full force and effect during the life of the contract, commercial general liability, automobile liability, and commercial crime insurance with the limits specified below.

Coverage	Limits
Commercial General Liability	$1,000,000 per occurrence for bodily injury and property damage; $1,000,000 per occurrence for personal and advertising injury; policy includes products completed/operations with an aggregated limit of $2,000,000.
Automobile Liability	$1,000,000 for bodily injury for each person; $1,000,000 for bodily injury for each accident; and $1,000,000 property damage for each accident.
Commercial Crime	$1,000,000 third party liability coverage

The Commercial General Liability and Automobile Liability insurance policies required of the selected bank, including any subcontractor's policy, shall contain the following clauses:

1. "This insurance shall not be canceled, limited in scope of coverage or non-renewed until after 30 days' written notice has been given to the Hawaii Employer-Union Health Benefits Trust Fund, 201 Merchant Street, Suite 1700, Honolulu, Hawaii 96813."

2. "The State of Hawaii, the EUTF, and the EUTF Board of Trustees are added as an additional insured with respect to operations performed for the State of Hawaii."

3. "It is agreed that any insurance maintained by the State of Hawaii and/or the EUTF will apply in excess of, and not contribute with, insurance provided by this policy."

The minimum insurance required shall be in full compliance with the Hawaii Insurance Code throughout the entire selection term, including all extended periods if exercised. The Contractor agrees to deposit with the EUTF, certificate(s) of insurance necessary to satisfy the EUTF that the insurance provisions of this agreement have been complied with and to keep such insurance in effect and the certificate(s) therefore on deposit with the EUTF during the entire term of this agreement, including those of its subcontractor(s), where appropriate. Upon request by the EUTF, Contractor shall be responsible for furnishing a copy of the policy or policies. Failure of the Contractor to provide and keep in force such insurance shall be regarded as material default under this agreement, entitling the State to exercise any or all of the remedies provided in this agreement for a default of the Contractor.

The procuring of such required insurance shall not be construed to limit Contractor's liability hereunder nor to fulfill the indemnification provisions and requirements of this agreement. Notwithstanding said policy or policies of insurance, Contractor shall be obliged for the full and total amount of any damage, injury, or loss caused by negligence or neglect connected with this agreement.

AWARD OF CONTRACT

If an award is made, the successful Offeror will be required to enter into a formal written contract with the EUTF. See sample contract in Attachments.

BUSINESS ASSOCIATE AGREEMENT

The contractor will have access to protected health information and personal information maintained by the EUTF. Thus, the Offeror selected by the EUTF for an award of contract shall be required to enter into a Business Associate Agreement (BAA) with the EUTF. See sample BAA in Attachments.

SPECIFICATIONS

The specifications for the open enrollment materials are listed below:

Requirements (Retirees)

1. Open Enrollment Reference Guides: Print, trim, saddle stitch, bundle, mail
2. Enrollment Forms (EC-2 and EC-2H): Print, cello 100
3. EUTF and HSTA VB COBRA Open Enrollment Memo, Rate Sheets, and Enrollment Form: Print, staple, mail

Requirements (Active Employees)

4. Open Enrollment Reference Guides: Print, trim, saddle stitch, bundle, mail
5. Enrollment Forms (EC-1 and EC-1H): Print, cello 100
6. EUTF and HSTA VB COBRA Open Enrollment Memo, Rate Sheets, and Enrollment Form: Print, staple, mail
7. Open Enrollment Flyers and Rate Sheets: Print and mail

See Attachments for samples of the open enrollment materials for retirees and active employees.

RETIREES

Item No. 1: Open Enrollment Reference Guides

- Print 51,000 each year (2017, 2018, 2019)
- 8 ½ x 11
- Total of 128 pages (double-sided)
- The first ten (10) pages and the last ten (10) pages will be on 60# White Offset, printed in black ink
- There will be 108 pages of text on 28# newsprint <or comparable recycled paper> printed in black throughout
- The following pages shall be perforated for recipients to tear out (pages are at the end of the guide): 1) EC-2; 2) EC-2H; 3) Medicare Part B Premium Reimbursement Request; 4) Direct Deposit Agreement
- Books are to be saddle-stitched
- File furnished in Word format and PDF format. Vendor to fix file as necessary for print (i.e., margins, page numbers, state seal, etc.)
- Vendor to provide two (2) sets of proofs prior to final printing. One (1) set of hard copy proofs and one (1) in Word format and one (1) in PDF format.

Item No. 1a

- Cost to add on to print additional Reference Guides in increments of 100 (more than 51,000). The total cost will be adjusted as per the prices quoted on this item

Item No. 1b

- Reduced cost in four (4)-page increments if pages are subtracted (less than 128 pages). The total cost will be adjusted as per the prices quoted on this item.

Item No. 1c

- Additional cost in four (4)-page increments if pages are added (more than 128 pages). The total cost will be adjusted as per the prices quoted on this item.

Item No. 1d

- Cost to reprint Reference Guide for Retirees in increments of 500 (reprint at a later date)

Item No. 1e: Mailing

- Mail approximately 45,000 (29,000 on Oahu, 12,500 on Neighbor Islands, and 3,500 on Mainland) Open Enrollment Reference Guides to Retirees. Address and EUTF indicia to be printed on the back cover of each Reference Guide. Guides shall not be mailed in envelopes. Address lists to be furnished in Excel format. Reference Guides will be bundled and delivered to USPS and mailed via the most cost effective and/or expeditious manner using the EUTF indicia.
- Remaining Reference Guides to be delivered to the EUTF office at 201 Merchant Street, Suite 1700.

Item No. 2: Enrollment Forms

- Print 7,100 two (2)-part forms (7,000 EC-2; 100 EC-2H) each year (2017, 2018, and 2019)
- 8 ½ x 11 5/8 (5/8" stub at top for tear out)
- 2 parts 20# White Bond
- Print black ink front and back of each part. Each part prints different front and back
- Cello 100
- File furnished in Word and PDF format
- Vendor to provide two (2) sets of proof prior to final printing
- Forms shall be delivered to EUTF office at 201 Merchant Street, Suite 1700

Item No. 2a:

- Cost to reprint additional enrollment forms in increments of 500

Item No. 3: EUTF and HSTA VB COBRA Open Enrollment Memo, Rate Sheets, and Enrollment Form

- Print 600 double-sided (10 pages, 5 sheets of paper, double-sided) of COBRA Open Enrollment Memo, Rate Sheets, and Enrollment Form (500 – EUTF and 100 – HSTA VB) each year (2017, 2018, and 2019)
- 8 ½ x 11
- 20# White Bond
- Black ink front and back of each
- Stapled
- File furnished in Word and PDF format
- Vendor to provide two (2) sets of proof prior to final printing

Item No. 3a

- Cost to print one (1) additional page (double-sided) in increments of 600

Item No. 3b

- Cost to print additional COBRA Open Enrollment Memo, Rate Sheets, and Enrollment Forms in increments of 100

Item No. 3c: Mailing

- Vendor shall assemble and mail the following:
  - 1) EUTF COBRA Open Enrollment Memo; 2) Rate Sheet; and 3) Enrollment Form; 4) Reference Guide for Retirees to approximately 500 Retirees
  - 1) HSTA VB COBRA Open Enrollment Memo; 2) Rate Sheet; and 3) Enrollment Form; 4) Reference Guide for Retirees to approximately 100 Retirees
- Address list to be furnished in Excel format. Address and EUTF indicia to be printed on envelope provided by vendor. COBRA packets will be mailed via the most cost effective and/or expeditious manner using the EUTF indicia.
- Remaining COBRA materials to be delivered to the EUTF office at 201 Merchant Street, Suite 1700.

TIMELINE

Open enrollment for retirees is usually during the month of October. All retirees must receive their open enrollment materials by the end of September. The following schedule represents a projected timeline of due dates for the printing and distribution of the Open Enrollment Materials for retirees:

EUTF to provide vendor Word and PDF file of Reference Guide, Enrollment Forms and COBRA materials	End of July	July 28

First proof from print vendor	3 working days after vendor receives file from EUTF	August 3
EUTF to provide vendor second and final Word and PDF file of Reference Guide, Enrollment Forms and COBRA materials	3 working days after EUTF receives first proof from print vendor	August 8
Second and final proof from print vendor	3 working days after vendor receives file from EUTF	August 11
EUTF to approve final proof	1 working day after EUTF receives final proof	August 14
EUTF to provide vendor with retiree mailing lists and indicia		August 11
EUTF to provide vendor with COBRA mailing lists and indicia	Beginning of September	September 8
Vendor to mail out Reference Guides and COBRA packets to retirees	Mailing shall not commence before September 18 and shall be completed by September 22	Completed by September 22
Vendor to return extra Open Enrollment Materials to EUTF	End of September	September 29

The above dates are estimates and may be subject to change. All reference guides must be received by retirees by the end of September.

ACTIVE EMPLOYEES

Item No. 4: Open Enrollment Reference Guides

- Print 27,000 each year (2017, 2018, 2019)
- 8 ½ x 11
- Total of 96 pages (double-sided)
- The first eight (8) pages and the last eight (8) pages will be on 60# White Offset printed in black ink
- There will be 80 pages of text on 28# newsprint <or comparable recycled paper> printed in black throughout
- The following pages shall be perforated for recipients to tear out (pages are at the end of the guide): 1) EC-1; 2) EC-1H
- Books are to be saddle-stitched
- File furnished in Word format and PDF format. Vendor to fix file as necessary for print (i.e., margins, page numbers, state seal, etc.)
- Vendor to provide two (2) sets of proofs prior to final printing. One (1) set of hard copy proofs and one (1) in Word format and one (1) in PDF format.

Item No. 4a

- Additional cost to add on to print Reference Guides in increments of 100 (more than 27,000). The total cost will be adjusted as per the prices quoted on this item

Item No. 4b

- Reduced cost in four (4)-page increments if pages are subtracted (less than 96 pages). The total cost will be adjusted as per the prices quoted on this item.

Item No. 4c

- Additional cost in four (4)-page increments if pages are added (more than 96 pages). The total cost will be adjusted as per the prices quoted on this item.

Item No. 4d

- Cost to reprint Reference Guide for Active Employees in increments of 500

Item No. 4e: Delivering/Mailing

- Reference Guides for Active Employees on the island of Oahu will be delivered by the vendor to approximately 31 locations with various quantities. Address lists and quantities to be furnished in Excel format.
- Reference Guides for Neighbor Island locations will be mailed to various locations. The reference guides shall be mailed via the most cost effective and/or expeditious manner. Vendor shall provide evidence of actual postage/shipping cost and vendor will be reimbursed for postage (not subject to general excise tax). Quoted total price will be adjusted accordingly.
- Remaining Reference Guides to be delivered to the EUTF office at 201 Merchant Street, Suite 1700.

Item No. 5: Enrollment Forms

- Print 3,200 two (2)-part forms (3,000 EC-1 forms and 200 EC-2 forms) (2017, 2018, and 2019)
- 8 ½ x 11 5/8 (5/8" stub at top for tear out)
- 2 parts 20# White Bond
- Print black ink front and back of each part. Each part prints different front and back
- Cello 100
- File furnished in Word and PDF format
- Vendor to provide two (2) sets of proofs prior to final printing
- Forms shall be delivered to EUTF office at 201 Merchant Street, Suite 1700

Item No. 5a:

- Cost to reprint additional enrollment forms in increments of 500

Item No. 6: EUTF and HSTA VB COBRA Open Enrollment Memo, Rate Sheets, and Enrollment Form

- Print 1900 double-sided (10 pages – 5 sheets of paper double sided) of COBRA Open Enrollment Memo, Rate Sheets, and Enrollment Form (1600 – EUTF and 300 – HSTA VB) each year (2017, 2018, and 2019)
- 8 ½ x 11
- 20# White Bond
- Black ink front and back of each
- Stapled
- File furnished in Word and PDF format
- Vendor to provide two (2) sets of proofs prior to final printing

Item No. 6a

- Cost to print one (1) additional page (double-sided) in increments of 1900

Item No. 6b

- Cost to print additional COBRA Open Enrollment Memo, Rate Sheets, and Enrollment Forms in increments of 100

Item No. 6c: Mailing

- Vendor shall assemble and mail the following:
    - 1) EUTF COBRA Open Enrollment Memo; 2) Rate Sheet; and 3) Enrollment Form; 4) Reference Guide for Active Employees to approximately 500 employees
    - 1) HSTA VB COBRA Open Enrollment Memo; 2) Rate Sheet and; 3) Enrollment Form; 4) Reference Guide for Active Employees to approximately 100 employees
- Address list to be furnished in Excel format. Address and EUTF indicia to be printed on envelope provided by vendor. COBRA packets will be mailed via the most cost effective and/or expeditious manner using the EUTF indicia.
- Remaining COBRA materials to be delivered to the EUTF office at 201 Merchant Street, Suite 1700.

Item No. 7: Open Enrollment Flyers and Rate Sheets

- Print 47,000 double-sided copies (2 pages – 1 sheet of paper) Open Enrollment Flyers
- Print 47,000 double-sided copies (6 pages – 3 sheets of paper) Rate Sheets
- 8 ½ x 11
- 20# White Bond
- Black Ink

- File furnished in Word and PDF format
- Vendor to provide one (1) proof for approval prior to final printing

Item No. 7a:

- Additional cost to add on to print open enrollment flyers (more than 47,000) in increments of 100. The total cost will be adjusted as per the prices quoted on this item

Item No. 7b:

- Additional cost to add on to print Rate Sheets (more than 47,000) in increments of 100. The total cost will be adjusted as per the prices quoted on this item

Item No. 7c:

- Additional cost to print one (1) additional page of open enrollment flyers or rate sheets for 47,000. The total cost will be adjusted as per the prices quoted on this item

Item No. 7d: Mailing

- Vendor shall box and deliver flyers and rate sheets to post office for mailing (approximately 215 addresses on Oahu and 110 addresses on the Neighbor Island). Vendor shall provide evidence of actual postage/shipping costs and vendor will be reimbursed for postage (not subject to general excise tax). Quoted total price will be adjusted accordingly. All items shall be mailed using the most cost effective and/or expeditious manner.
- Address list to be furnished to vendor in Excel format
- Remaining flyers and rate sheets to be delivered to the EUTF office at 201 Merchant Street, Suite 1700.

TIMELINE

Open enrollment for active employees is usually during the month of April. All employees must receive their open enrollment materials by the end of March. The following schedule represents a projected timeline of due dates for the printing and distribution of the Open Enrollment Materials for active employees:

EUTF to provide vendor Word and PDF file of Open Enrollment Flyer, Rate Sheets, Enrollment Forms, Reference Guide, and COBRA materials	End of January	January 24
First proof from print vendor	3 working days after vendor receives file from EUTF	January 29
EUTF to provide vendor second and final Word and PDF file of Reference	3 working days after EUTF receives first	February 1

Guide, Enrollment Forms and COBRA materials	proof from print vendor	
Second and final proof from print vendor	3 working days after vendor receives file from EUTF	February 5
EUTF to approve final proof	1 working day after EUTF receives final proof	February 8
EUTF to provide vendor with employer mailing lists		February 16
Vendor to mail out Open Enrollment Flyers and rate sheets to employers		March 9
EUTF to provide vendor COBRA mailing lists	Beginning of March	March 9
Vendor to mail/deliver Reference Guides and COBRA packets to retirees	Mailing shall not commence before March 23 and shall be completed by March 28	Completed by March 28
Vendor to return extra Open Enrollment Materials	End of March	March 30

The above dates are estimates and may be subject to change. Open Enrollment Flyers and Rate Sheets must be received by employers by March 9th. Reference Guides for Active Employees must be received by employers by March 28th.

FEE PROPOSAL FORM
RETIREES

		Period 1 (2017)	Period 2 (2018)	Period 3 (2019)	Total
1.	Reference Guide for Retirees				
1a.	Additional cost to add on to print in 100 increment				
1b.	Reduced cost in 4-page increment				
1c.	Additional Cost in 4-page increment				
1d.	Additional Cost to reprint in 500 increment				
1e.	Mailing of Reference Guides				
2.	Enrollment Forms				
2a.	Cost to print additional forms in 500 increment				
3.	COBRA packet				
3a	Cost to print 1 additional page in increments of 100				
3b	Cost to print additional packet in increments of 100				
3c	Mailing of COBRA packet				
	TOTAL				

FEE PROPOSAL FORM
ACTIVE EMPLOYEES

		Period 1 (2017)	Period 2 (2018)	Period 3 (2019)	Total
4	Reference Guide for Active Employees				
4a	Additional cost to add on to print in 100 increment				
4b	Reduced cost in 4 page increment				
4c.	Additional Cost in 4 page increment				
4d	Additional Cost to reprint in 500 increment				
4e	Mailing/Delivering of Reference Guides				
5	Enrollment Forms				
5a.	Cost to print additional forms in 500 increment				
6	COBRA packet				
6a	Cost to print 1 additional page in increments of 1,600				
6b	Cost to print additional packet in increments of 100				
6c	Mailing of COBRA packet				
7	Open Enrollment Flyers and Rate Sheets				
7a	Additional cost to add on to print open enrollment flyers in increments of 100				
7b.	Additional cost to add on to print Rate Sheets in increments of 100				
7c.	Additional cost to print one additional page of open enrollment flyers or rate sheets				
7d.	Mailing of OE Flyers and Rate Sheets				
	TOTAL				

FEE PROPOSAL FORM
GRAND TOTAL

		Period 1 (2017)	Period 2 (2018)	Period 3 (2019)	Total
1	Retirees Total				
2.	Active Employees Total				
	Total				

ATTACHMENTS

Contract and General Conditions
Business Associate Agreement
Sample Reference Guide for Retirees
Sample Reference Guide for Active Employees
EC-2/EC-2H
EC-1/EC-1H
COBRA Packet for Actives
COBRA Packet for Retirees
OE Flyers and Rate Sheets

STATE OF HAWAII

CONTRACT FOR GOODS OR SERVICES BASED UPON COMPETITIVE SEALED PROPOSALS

This Contract, executed on the respective dates indicated below, is effective as of _____, _____, between _____,
(Insert name of state department, agency, board or commission)
State of Hawaii ("STATE"), by its _____,
(Insert title of person signing for State)
(hereafter also referred to as the HEAD OF THE PURCHASING AGENCY or designee ("HOPA")), whose address is _____
_____ and _____
("CONTRACTOR"), a _____
(Insert corporation, partnership, joint venture, sole proprietorship, or other legal form of the Contractor)
under the laws of the State of _____, whose business address and federal and state taxpayer identification numbers are as follows: _____
_____

RECITALS

A. The STATE desires to retain and engage the CONTRACTOR to provide the goods or services, or both, described in this Contract and its attachments, and the CONTRACTOR is agreeable to providing said goods or services or both.

B. The STATE has issued a request for competitive sealed proposals, and has received and reviewed proposals submitted in response to the request.

C. The solicitation for proposals and the selection of the CONTRACTOR were made in accordance with section 103D-303, Hawaii Revised Statutes ("HRS"), Hawaii Administrative Rules, Title 3, Department of Accounting and General Services, Subtitle 11 ("HAR"), Chapter 122, Subchapter 6, and applicable procedures established by the appropriate Chief Procurement Officer ("CPO").

D. The CONTRACTOR has been identified as the responsible and responsive offeror whose proposal is the most advantageous for the STATE, taking into consideration price and the evaluation factors set forth in the request.

E. Pursuant to _____, the STATE
(Legal authority to enter into this Contract)
is authorized to enter into this Contract.

F. Money is available to fund this Contract pursuant to:

(1) _____
(Identify state sources)
or (2) _____
(Identify federal sources)
or both, in the following amounts: State $ _____
Federal $ _____

NOW, THEREFORE, in consideration of the promises contained in this Contract, the STATE and the CONTRACTOR agree as follows:

1. Scope of Services. The CONTRACTOR shall, in a proper and satisfactory manner as determined by the STATE, provide all the goods or services, or both, set forth in the request for competitive sealed proposals number _____ ("RFP") and the CONTRACTOR'S accepted proposal ("Proposal"), both of which, even if not physically attached to this Contract, are made a part of this Contract.

2. Compensation. The CONTRACTOR shall be compensated for goods supplied

or services performed, or both, under this Contract in a total amount not to exceed _____ DOLLARS ($_____), including approved costs incurred and taxes, at the time and in the manner set forth in the RFP and CONTRACTOR'S Proposal.

3. Time of Performance. The services or goods required of the CONTRACTOR under this Contract shall be performed and completed in accordance with the Time of Performance set forth in Attachment-S3, which is made a part of this Contract.

4. Bonds. The CONTRACTOR ☐ is required to provide or ☐ is not required to provide: ☐ a performance bond, ☐ a payment bond, ☐ a performance and payment bond in the amount of _____ DOLLARS ($_____).

5. Standards of Conduct Declaration. The Standards of Conduct Declaration of the CONTRACTOR is attached to and made a part of this Contract.

6. Other Terms and Conditions. The General Conditions and any Special Conditions are attached to and made a part of this Contract. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control. In the event of a conflict among the documents, the order of precedence shall be as follows: (1) this Contract, including all attachments and addenda; (2) the RFP, including all attachments and addenda; and (3) the Proposal.

7. Liquidated Damages. Liquidated damages shall be assessed in the amount of _____ DOLLARS ($_____) per day, in accordance with the terms of paragraph 9 of the General Conditions.

8. Notices. Any written notice required to be given by a party to this Contract shall be (a) delivered personally, or (b) sent by United States first class mail, postage prepaid. Notice to the STATE shall be sent to the HOPA'S address indicated in the Contract. Notice to the CONTRACTOR shall be sent to the CONTRACTOR'S address indicated in the Contract. A notice shall be deemed to have been received three (3) days after mailing or at the time of actual receipt, whichever is earlier. The CONTRACTOR is responsible for notifying the STATE in writing of any change of address.

IN VIEW OF THE ABOVE, the parties execute this Contract by their signatures, on the dates below, to be effective as of the date first above written.

STATE

_____
(Signature)

_____
(Print Name)

_____
(Print Title)

_____
(Date)

CONTRACTOR

CORPORATE SEAL
(If available)

_____
(Name of Contractor)

_____
(Signature)

_____
(Print Name)

_____ *
(Print Title)

_____
(Date)

APPROVED AS TO FORM:

_____
Deputy Attorney General

* Evidence of authority of the CONTRACTOR'S representative to sign this Contract for the CONTRACTOR must be attached.

STATE OF HAWAII

CONTRACTOR'S ACKNOWLEDGMENT

STATE OF _____)
) **SS.**
_____ **COUNTY OF** _____)

On this _____ day of _____, _____ before me appeared

_____ and _____, to me known, to be the person(s) described in and, who, being by me duly sworn, did say that he/she/they is/are

_____ and _____ of _____, the CONTRACTOR named in the foregoing instrument, and that he/she/they is/are authorized to sign said instrument on behalf of the CONTRACTOR, and acknowledges that he/she/they executed said instrument as the free act and deed of the CONTRACTOR.

_____
(Signature)

(Notary Stamp or Seal)

_____
(Print Name)

Notary Public, State of _____

My commission expires: _____

Doc. Date: _____ # Pages: _____

Notary Name: _____ _____ Circuit

Doc. Description: _____

_____ (Notary Stamp or Seal)

_____

_____

Notary Signature Date

NOTARY CERTIFICATION

STATE OF HAWAII

CONTRACTOR'S STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

"Agency" means and includes the State, the legislature and its committees, all executive departments, boards, commissions, committees, bureaus, offices; and all independent commissions and other establishments of the state government but excluding the courts.

"Controlling interest" means an interest in a business or other undertaking which is sufficient in fact to control, whether the interest is greater or less than fifty per cent (50%).

"Employee" means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and employees under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and judges. (Section 84-3, HRS).

On behalf of _____, CONTRACTOR, the undersigned does declare as follows:

1. CONTRACTOR ☐ is* ☐ is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).
2. CONTRACTOR has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).
3. CONTRACTOR has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).
4. CONTRACTOR has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

CONTRACTOR understands that the Contract to which this document is attached is voidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawaii Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the declarations above. Additionally, any fee, compensation, gift, or profit received by any person as a result of a violation of the Code of Ethics may be recovered by the STATE.

* Reminder to Agency: If the "is" block is checked and if the Contract involves goods or services of a value in excess of $10,000, the Contract must be awarded by competitive sealed bidding under section 103D-302, HRS, or a competitive sealed proposal under section 103D-303, HRS. Otherwise, the Agency may not award the Contract unless it posts a notice of its intent to award it and files a copy of the notice with the State Ethics Commission. (Section 84-15(a), HRS).

CONTRACTOR

By _____
(Signature)

Print Name _____

Print Title _____

Name of Contractor _____

Date _____

STATE OF HAWAII

SCOPE OF SERVICES

STATE OF HAWAII

COMPENSATION AND PAYMENT SCHEDULE

STATE OF HAWAII

TIME OF PERFORMANCE

STATE OF HAWAII

CERTIFICATE OF EXEMPTION FROM CIVIL SERVICE

1. By Heads of Departments Delegated by the Director of the Department of Human Resources Development ("DHRD").*

Pursuant to a delegation of the authority by the Director of DHRD, I certify that the services to be provided under this Contract, and the person(s) providing the services under this Contract are exempt from the civil service, pursuant to § 76-16, Hawaii Revised Statutes (HRS).

(Signature) _____ (Date) _____

(Print Name) _____

(Print Title) _____

* This part of the form may be used by all department heads and the heads of attached agencies to whom the Director of DHRD expressly has delegated authority to certify § 76-16, HRS, civil service exemptions. The specific paragraph(s) of § 76-16, HRS, upon which an exemption is based should be noted in the contract file. If an exemption is based on § 76-16(b)(15), the contract must meet the following conditions:

(1) It involves the delivery of completed work or product by or during a specific time;
(2) There is no employee-employer relationship; and
(3) The authorized funding for the service is from other than the "A" or personal services cost element.

NOTE: Not all attached agencies have received a delegation under § 76-16(b)(15). If in doubt, attached agencies should check with the Director of DHRD prior to certifying an exemption under § 76-16(b)(15). Authority to certify exemptions under §§76-16(b)(2), and 76-16(b)(12), HRS, has not been delegated; only the Director of DHRD may certify §§ 76-16(b)(2), and
76-16(b)(12) exemptions.

2. By the Director of DHRD, State of Hawaii.

I certify that the services to be provided under this Contract, and the person(s) providing the services under this Contract are exempt from the civil service, pursuant to §76-16, HRS.

(Signature) _____ (Date) _____

(Print Name) _____

(Print Title, if designee of the Director of DHRD) _____

GENERAL CONDITIONS

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1. Coordination of Services by the STATE. The head of the purchasing agency ("HOPA") (which term includes the designee of the HOPA) shall coordinate the services to be provided by the CONTRACTOR in order to complete the performance required in the Contract. The CONTRACTOR shall maintain communications with HOPA at all stages of the CONTRACTOR'S work, and submit to HOPA for resolution any questions which may arise as to the performance of this Contract. "Purchasing agency" as used in these General Conditions means and includes any governmental body which is authorized under chapter 103D, HRS, or its implementing rules and procedures, or by way of delegation, to enter into contracts for the procurement of goods or services or both.

2. Relationship of Parties: Independent Contractor Status and Responsibilities, Including Tax Responsibilities.

   a. In the performance of services required under this Contract, the CONTRACTOR is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE'S opinion, the services are being performed by the CONTRACTOR in compliance with this Contract. Unless otherwise provided by special condition, it is understood that the STATE does not agree to use the CONTRACTOR exclusively, and that the CONTRACTOR is free to contract to provide services to other individuals or entities while under contract with the STATE.

   b. The CONTRACTOR and the CONTRACTOR'S employees and agents are not by reason of this Contract, agents or employees of the State for any purpose, and the CONTRACTOR and the CONTRACTOR'S employees and agents shall not be entitled to claim or receive from the State any vacation, sick leave, retirement, workers' compensation, unemployment insurance, or other benefits provided to state employees.

   c. The CONTRACTOR shall be responsible for the accuracy, completeness, and adequacy of the CONTRACTOR'S performance under this Contract. Furthermore, the CONTRACTOR intentionally, voluntarily, and knowingly assumes the sole and entire liability to the CONTRACTOR'S employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the CONTRACTOR, or the CONTRACTOR'S employees or agents in the course of their employment.

   d. The CONTRACTOR shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the CONTRACTOR by reason of this Contract, including but not limited to (i) income taxes, (ii) employment related fees, assessments, and taxes, and (iii) general excise taxes. The CONTRACTOR also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.

   e. The CONTRACTOR shall obtain a general excise tax license from the Department of Taxation, State of Hawaii, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The CONTRACTOR shall obtain a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of the Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The CONTRACTOR shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under sections 103-53 and 103D-328, HRS, and paragraph 17 of these General Conditions.

   f. The CONTRACTOR is responsible for securing all employee-related insurance coverage for the CONTRACTOR and the CONTRACTOR'S employees and agents that is or may be required by law, and for payment of all premiums, costs, and other liabilities associated with securing the insurance coverage.

g. The CONTRACTOR shall obtain a certificate of compliance issued by the Department of Labor and Industrial Relations, State of Hawaii, in accordance with section103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

h. The CONTRACTOR shall obtain a certificate of good standing issued by the Department of Commerce and Consumer Affairs, State of Hawaii, in accordance with section 103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

i. In lieu of the above certificates from the Department of Taxation, Labor and Industrial Relations, and Commerce and Consumer Affairs, the CONTRACTOR may submit proof of compliance through the State Procurement Office's designated certification process.

3. Personnel Requirements.

a. The CONTRACTOR shall secure, at the CONTRACTOR'S own expense, all personnel required to perform this Contract.

b. The CONTRACTOR shall ensure that the CONTRACTOR'S employees or agents are experienced and fully qualified to engage in the activities and perform the services required under this Contract, and that all applicable licensing and operating requirements imposed or required under federal, state, or county law, and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

4. Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the CONTRACTOR, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

5. Conflicts of Interest. The CONTRACTOR represents that neither the CONTRACTOR, nor any employee or agent of the CONTRACTOR, presently has any interest, and promises that no such interest, direct or indirect, shall be acquired, that would or might conflict in any manner or degree with the CONTRACTOR'S performance under this Contract.

6. Subcontracts and Assignments. The CONTRACTOR shall not assign or subcontract any of the CONTRACTOR'S duties, obligations, or interests under this Contract and no such assignment or subcontract shall be effective unless (i) the CONTRACTOR obtains the prior written consent of the STATE, and (ii) the CONTRACTOR'S assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR'S assignee or subcontractor have been paid. Additionally, no assignment by the CONTRACTOR of the CONTRACTOR'S right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in section 40-58, HRS.

a. Recognition of a successor in interest. When in the best interest of the State, a successor in interest may be recognized in an assignment contract in which the STATE, the CONTRACTOR and the assignee or transferee (hereinafter referred to as the "Assignee") agree that:

(1) The Assignee assumes all of the CONTRACTOR'S obligations;

(2) The CONTRACTOR remains liable for all obligations under this Contract but waives all rights under this Contract as against the STATE; and

(3) The CONTRACTOR shall continue to furnish, and the Assignee shall also furnish, all required bonds.

b. Change of name. When the CONTRACTOR asks to change the name in which it holds this Contract with the STATE, the procurement officer of the purchasing agency (hereinafter referred to as the "Agency procurement officer") shall, upon receipt of a document acceptable or satisfactory to the

Agency procurement officer indicating such change of name (for example, an amendment to the CONTRACTOR'S articles of incorporation), enter into an amendment to this Contract with the CONTRACTOR to effect such a change of name. The amendment to this Contract changing the CONTRACTOR'S name shall specifically indicate that no other terms and conditions of this Contract are thereby changed.

c. Reports. All assignment contracts and amendments to this Contract effecting changes of the CONTRACTOR'S name or novations hereunder shall be reported to the chief procurement officer (CPO) as defined in section 103D-203(a), HRS, within thirty days of the date that the assignment contract or amendment becomes effective.

d. Actions affecting more than one purchasing agency. Notwithstanding the provisions of subparagraphs 6a through 6c herein, when the CONTRACTOR holds contracts with more than one purchasing agency of the State, the assignment contracts and the novation and change of name amendments herein authorized shall be processed only through the CPO's office.

7. Indemnification and Defense. The CONTRACTOR shall defend, indemnify, and hold harmless the State of Hawaii, the contracting agency, and their officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys' fees, and all claims, suits, and demands therefore, arising out of or resulting from the acts or omissions of the CONTRACTOR or the CONTRACTOR'S employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.

8. Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the CONTRACTOR in connection with this Contract, the CONTRACTOR shall pay all costs and expenses incurred by or imposed on the STATE, including attorneys' fees.

9. Liquidated Damages. When the CONTRACTOR is given notice of delay or nonperformance as specified in paragraph 13 (Termination for Default) and fails to cure in the time specified, it is agreed the CONTRACTOR shall pay to the STATE the amount, if any, set forth in this Contract per calendar day from the date set for cure until either (i) the STATE reasonably obtains similar goods or services, or both, if the CONTRACTOR is terminated for default, or (ii) until the CONTRACTOR provides the goods or services, or both, if the CONTRACTOR is not terminated for default. To the extent that the CONTRACTOR'S delay or nonperformance is excused under paragraph 13d (Excuse for Nonperformance or Delay Performance), liquidated damages shall not be assessable against the CONTRACTOR. The CONTRACTOR remains liable for damages caused other than by delay.

10. STATE'S Right of Offset. The STATE may offset against any monies or other obligations the STATE owes to the CONTRACTOR under this Contract, any amounts owed to the State of Hawaii by the CONTRACTOR under this Contract or any other contracts, or pursuant to any law or other obligation owed to the State of Hawaii by the CONTRACTOR, including, without limitation, the payment of any taxes or levies of any kind or nature. The STATE will notify the CONTRACTOR in writing of any offset and the nature of such offset. For purposes of this paragraph, amounts owed to the State of Hawaii shall not include debts or obligations which have been liquidated, agreed to by the CONTRACTOR, and are covered by an installment payment or other settlement plan approved by the State of Hawaii, provided, however, that the CONTRACTOR shall be entitled to such exclusion only to the extent that the CONTRACTOR is current with, and not delinquent on, any payments or obligations owed to the State of Hawaii under such payment or other settlement plan.

11. Disputes. Disputes shall be resolved in accordance with section 103D-703, HRS, and chapter 3-126, Hawaii Administrative Rules ("HAR"), as the same may be amended from time to time.

12. Suspension of Contract. The STATE reserves the right at any time and for any reason to suspend this Contract for any reasonable period, upon written notice to the CONTRACTOR in accordance with the provisions herein.

a. Order to stop performance. The Agency procurement officer may, by written order to the CONTRACTOR, at any time, and without notice to any surety, require the CONTRACTOR to stop all or any part of the performance called for by this Contract. This order shall be for a specified

period not exceeding sixty (60) days after the order is delivered to the CONTRACTOR, unless the parties agree to any further period. Any such order shall be identified specifically as a stop performance order issued pursuant to this section. Stop performance orders shall include, as appropriate: (1) A clear description of the work to be suspended; (2) Instructions as to the issuance of further orders by the CONTRACTOR for material or services; (3) Guidance as to action to be taken on subcontracts; and (4) Other instructions and suggestions to the CONTRACTOR for minimizing costs. Upon receipt of such an order, the CONTRACTOR shall forthwith comply with its terms and suspend all performance under this Contract at the time stated, provided, however, the CONTRACTOR shall take all reasonable steps to minimize the occurrence of costs allocable to the performance covered by the order during the period of performance stoppage. Before the stop performance order expires, or within any further period to which the parties shall have agreed, the Agency procurement officer shall either:

(1) Cancel the stop performance order; or

(2) Terminate the performance covered by such order as provided in the termination for default provision or the termination for convenience provision of this Contract.

b. Cancellation or expiration of the order. If a stop performance order issued under this section is cancelled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the CONTRACTOR shall have the right to resume performance. An appropriate adjustment shall be made in the delivery schedule or contract price, or both, and the Contract shall be modified in writing accordingly, if:

(1) The stop performance order results in an increase in the time required for, or in the CONTRACTOR'S cost properly allocable to, the performance of any part of this Contract; and

(2) The CONTRACTOR asserts a claim for such an adjustment within thirty (30) days after the end of the period of performance stoppage; provided that, if the Agency procurement officer decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.

c. Termination of stopped performance. If a stop performance order is not cancelled and the performance covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop performance order shall be allowable by adjustment or otherwise.

d. Adjustment of price. Any adjustment in contract price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

13. Termination for Default.

a. Default. If the CONTRACTOR refuses or fails to perform any of the provisions of this Contract with such diligence as will ensure its completion within the time specified in this Contract, or any extension thereof, otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of this Contract, the Agency procurement officer may notify the CONTRACTOR in writing of the delay or non-performance and if not cured in ten (10) days or any longer time specified in writing by the Agency procurement officer, such officer may terminate the CONTRACTOR'S right to proceed with the Contract or such part of the Contract as to which there has been delay or a failure to properly perform. In the event of termination in whole or in part, the Agency procurement officer may procure similar goods or services in a manner and upon the terms deemed appropriate by the Agency procurement officer. The CONTRACTOR shall continue performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

b. CONTRACTOR'S duties. Notwithstanding termination of the Contract and subject to any directions from the Agency procurement officer, the CONTRACTOR shall take timely, reasonable, and

necessary action to protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest.

c. Compensation. Payment for completed goods and services delivered and accepted by the STATE shall be at the price set forth in the Contract. Payment for the protection and preservation of property shall be in an amount agreed upon by the CONTRACTOR and the Agency procurement officer. If the parties fail to agree, the Agency procurement officer shall set an amount subject to the CONTRACTOR'S rights under chapter 3-126, HAR. The STATE may withhold from amounts due the CONTRACTOR such sums as the Agency procurement officer deems to be necessary to protect the STATE against loss because of outstanding liens or claims and to reimburse the STATE for the excess costs expected to be incurred by the STATE in procuring similar goods and services.

d. Excuse for nonperformance or delayed performance. The CONTRACTOR shall not be in default by reason of any failure in performance of this Contract in accordance with its terms, including any failure by the CONTRACTOR to make progress in the prosecution of the performance hereunder which endangers such performance, if the CONTRACTOR has notified the Agency procurement officer within fifteen (15) days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of a public enemy; acts of the State and any other governmental body in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, the CONTRACTOR shall not be deemed to be in default, unless the goods and services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the CONTRACTOR to meet the requirements of the Contract. Upon request of the CONTRACTOR, the Agency procurement officer shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the CONTRACTOR'S progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the STATE under this Contract. As used in this paragraph, the term "subcontractor" means subcontractor at any tier.

e. Erroneous termination for default. If, after notice of termination of the CONTRACTOR'S right to proceed under this paragraph, it is determined for any reason that the CONTRACTOR was not in default under this paragraph, or that the delay was excusable under the provisions of subparagraph 13d, "Excuse for nonperformance or delayed performance," the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to paragraph 14.

f. Additional rights and remedies. The rights and remedies provided in this paragraph are in addition to any other rights and remedies provided by law or under this Contract.

14. Termination for Convenience.

a. Termination. The Agency procurement officer may, when the interests of the STATE so require, terminate this Contract in whole or in part, for the convenience of the STATE. The Agency procurement officer shall give written notice of the termination to the CONTRACTOR specifying the part of the Contract terminated and when termination becomes effective.

b. CONTRACTOR'S obligations. The CONTRACTOR shall incur no further obligations in connection with the terminated performance and on the date(s) set in the notice of termination the CONTRACTOR will stop performance to the extent specified. The CONTRACTOR shall also terminate outstanding orders and subcontracts as they relate to the terminated performance. The CONTRACTOR shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated performance subject to the STATE'S approval. The Agency procurement officer may direct the CONTRACTOR to assign the CONTRACTOR'S right, title, and interest under terminated orders or subcontracts to the STATE. The CONTRACTOR must still complete the performance not terminated by the notice of termination and may incur obligations as necessary to do so.

c. Right to goods and work product. The Agency procurement officer may require the CONTRACTOR to transfer title and deliver to the STATE in the manner and to the extent directed by the Agency procurement officer:

(1) Any completed goods or work product; and

(2) The partially completed goods and materials, parts, tools, dies, jigs, fixtures, plans, drawings, information, and contract rights (hereinafter called "manufacturing material") as the CONTRACTOR has specifically produced or specially acquired for the performance of the terminated part of this Contract.

The CONTRACTOR shall, upon direction of the Agency procurement officer, protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest. If the Agency procurement officer does not exercise this right, the CONTRACTOR shall use best efforts to sell such goods and manufacturing materials. Use of this paragraph in no way implies that the STATE has breached the Contract by exercise of the termination for convenience provision.

d. Compensation.

(1) The CONTRACTOR shall submit a termination claim specifying the amounts due because of the termination for convenience together with the cost or pricing data, submitted to the extent required by chapter 3-122, HAR, bearing on such claim. If the CONTRACTOR fails to file a termination claim within one year from the effective date of termination, the Agency procurement officer may pay the CONTRACTOR, if at all, an amount set in accordance with subparagraph 14d(3) below.

(2) The Agency procurement officer and the CONTRACTOR may agree to a settlement provided the CONTRACTOR has filed a termination claim supported by cost or pricing data submitted as required and that the settlement does not exceed the total Contract price plus settlement costs reduced by payments previously made by the STATE, the proceeds of any sales of goods and manufacturing materials under subparagraph 14c, and the Contract price of the performance not terminated.

(3) Absent complete agreement under subparagraph 14d(2) the Agency procurement officer shall pay the CONTRACTOR the following amounts, provided payments agreed to under subparagraph 14d(2) shall not duplicate payments under this subparagraph for the following:

(A) Contract prices for goods or services accepted under the Contract;

(B) Costs incurred in preparing to perform and performing the terminated portion of the performance plus a fair and reasonable profit on such portion of the performance, such profit shall not include anticipatory profit or consequential damages, less amounts paid or to be paid for accepted goods or services; provided, however, that if it appears that the CONTRACTOR would have sustained a loss if the entire Contract would have been completed, no profit shall be allowed or included and the amount of compensation shall be reduced to reflect the anticipated rate of loss;

(C) Costs of settling and paying claims arising out of the termination of subcontracts or orders pursuant to subparagraph 14b. These costs must not include costs paid in accordance with subparagraph 14d(3)(B);

(D) The reasonable settlement costs of the CONTRACTOR, including accounting, legal, clerical, and other expenses reasonably necessary for the preparation of settlement claims and supporting data with respect to the terminated portion of the Contract and for the termination of subcontracts thereunder, together with reasonable storage, transportation, and other costs incurred in connection with the protection or disposition of property allocable to the terminated portion of this Contract. The total sum to be paid the CONTRACTOR under this subparagraph shall not exceed the

total Contract price plus the reasonable settlement costs of the CONTRACTOR reduced by the amount of payments otherwise made, the proceeds of any sales of supplies and manufacturing materials under subparagraph 14d(2), and the contract price of performance not terminated.

(4) Costs claimed, agreed to, or established under subparagraphs 14d(2) and 14d(3) shall be in accordance with Chapter 3-123 (Cost Principles) of the Procurement Rules.

15. Claims Based on the Agency Procurement Officer's Actions or Omissions.

a. Changes in scope. If any action or omission on the part of the Agency procurement officer (which term includes the designee of such officer for purposes of this paragraph 15) requiring performance changes within the scope of the Contract constitutes the basis for a claim by the CONTRACTOR for additional compensation, damages, or an extension of time for completion, the CONTRACTOR shall continue with performance of the Contract in compliance with the directions or orders of such officials, but by so doing, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, damages, or an extension of time for completion; provided:

(1) Written notice required. The CONTRACTOR shall give written notice to the Agency procurement officer:

(A) Prior to the commencement of the performance involved, if at that time the CONTRACTOR knows of the occurrence of such action or omission;

(B) Within thirty (30) days after the CONTRACTOR knows of the occurrence of such action or omission, if the CONTRACTOR did not have such knowledge prior to the commencement of the performance; or

(C) Within such further time as may be allowed by the Agency procurement officer in writing.

(2) Notice content. This notice shall state that the CONTRACTOR regards the act or omission as a reason which may entitle the CONTRACTOR to additional compensation, damages, or an extension of time. The Agency procurement officer, upon receipt of such notice, may rescind such action, remedy such omission, or take such other steps as may be deemed advisable in the discretion of the Agency procurement officer;

(3) Basis must be explained. The notice required by subparagraph 15a(1) describes as clearly as practicable at the time the reasons why the CONTRACTOR believes that additional compensation, damages, or an extension of time may be remedies to which the CONTRACTOR is entitled; and

(4) Claim must be justified. The CONTRACTOR must maintain and, upon request, make available to the Agency procurement officer within a reasonable time, detailed records to the extent practicable, and other documentation and evidence satisfactory to the STATE, justifying the claimed additional costs or an extension of time in connection with such changes.

b. CONTRACTOR not excused. Nothing herein contained, however, shall excuse the CONTRACTOR from compliance with any rules or laws precluding any state officers and CONTRACTOR from acting in collusion or bad faith in issuing or performing change orders which are clearly not within the scope of the Contract.

c. Price adjustment. Any adjustment in the price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

16. Costs and Expenses. Any reimbursement due the CONTRACTOR for per diem and transportation expenses under this Contract shall be subject to chapter 3-123 (Cost Principles), HAR, and the following guidelines:

a. Reimbursement for air transportation shall be for actual cost or coach class air fare, whichever is less.

b. Reimbursement for ground transportation costs shall not exceed the actual cost of renting an intermediate-sized vehicle.

c. Unless prior written approval of the HOPA is obtained, reimbursement for subsistence allowance (i.e., hotel and meals, etc.) shall not exceed the applicable daily authorized rates for inter-island or out-of-state travel that are set forth in the current Governor's Executive Order authorizing adjustments in salaries and benefits for state officers and employees in the executive branch who are excluded from collective bargaining coverage.

17. Payment Procedures; Final Payment; Tax Clearance.

a. Original invoices required. All payments under this Contract shall be made only upon submission by the CONTRACTOR of original invoices specifying the amount due and certifying that services requested under the Contract have been performed by the CONTRACTOR according to the Contract.

b. Subject to available funds. Such payments are subject to availability of funds and allotment by the Director of Finance in accordance with chapter 37, HRS. Further, all payments shall be made in accordance with and subject to chapter 40, HRS.

c. Prompt payment.

(1) Any money, other than retainage, paid to the CONTRACTOR shall be disbursed to subcontractors within ten (10) days after receipt of the money in accordance with the terms of the subcontract; provided that the subcontractor has met all the terms and conditions of the subcontract and there are no bona fide disputes; and

(2) Upon final payment to the CONTRACTOR, full payment to the subcontractor, including retainage, shall be made within ten (10) days after receipt of the money; provided that there are no bona fide disputes over the subcontractor's performance under the subcontract.

d. Final payment. Final payment under this Contract shall be subject to sections 103-53 and 103D-328, HRS, which require a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid. Further, in accordance with section 3-122-112, HAR, CONTRACTOR shall provide a certificate affirming that the CONTRACTOR has remained in compliance with all applicable laws as required by this section.

18. Federal Funds. If this Contract is payable in whole or in part from federal funds, CONTRACTOR agrees that, as to the portion of the compensation under this Contract to be payable from federal funds, the CONTRACTOR shall be paid only from such funds received from the federal government, and shall not be paid from any other funds. Failure of the STATE to receive anticipated federal funds shall not be considered a breach by the STATE or an excuse for nonperformance by the CONTRACTOR.

19. Modifications of Contract.

a. In writing. Any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract permitted by this Contract shall be made by written amendment to this Contract, signed by the CONTRACTOR and the STATE, provided that change orders shall be made in accordance with paragraph 20 herein.

b. No oral modification. No oral modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract shall be permitted.

c. Agency procurement officer. By written order, at any time, and without notice to any surety, the Agency procurement officer may unilaterally order of the CONTRACTOR:

(A) Changes in the work within the scope of the Contract; and

(B) Changes in the time of performance of the Contract that do not alter the scope of the Contract work.

d. Adjustments of price or time for performance. If any modification increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, an adjustment shall be made and this Contract modified in writing accordingly. Any adjustment in contract price made pursuant to this clause shall be determined, where applicable, in accordance with the price adjustment clause of this Contract or as negotiated.

e. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if written modification of the Contract is not made prior to final payment under this Contract.

f. Claims not barred. In the absence of a written contract modification, nothing in this clause shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under this Contract or for a breach of contract.

g. Head of the purchasing agency approval. If this is a professional services contract awarded pursuant to section 103D-303 or 103D-304, HRS, any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract which increases the amount payable to the CONTRACTOR by at least $25,000.00 and ten per cent (10%) or more of the initial contract price, must receive the prior approval of the head of the purchasing agency.

h. Tax clearance. The STATE may, at its discretion, require the CONTRACTOR to submit to the STATE, prior to the STATE'S approval of any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract, a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid.

i. Sole source contracts. Amendments to sole source contracts that would change the original scope of the Contract may only be made with the approval of the CPO. Annual renewal of a sole source contract for services should not be submitted as an amendment.

20. Change Order. The Agency procurement officer may, by a written order signed only by the STATE, at any time, and without notice to any surety, and subject to all appropriate adjustments, make changes within the general scope of this Contract in any one or more of the following:

(1) Drawings, designs, or specifications, if the goods or services to be furnished are to be specially provided to the STATE in accordance therewith;

(2) Method of delivery; or

(3) Place of delivery.

a. Adjustments of price or time for performance. If any change order increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, whether or not changed by the order, an adjustment shall be made and the Contract modified in writing accordingly. Any adjustment in the Contract price made pursuant to this provision shall be determined in accordance with the price adjustment provision of this Contract. Failure of the parties to agree to an adjustment shall not excuse the CONTRACTOR from proceeding with the Contract as changed, provided that the Agency procurement officer promptly and duly makes the provisional adjustments in payment or time for performance as may be reasonable. By

proceeding with the work, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, or any extension of time for completion.

b. Time period for claim. Within ten (10) days after receipt of a written change order under subparagraph 20a, unless the period is extended by the Agency procurement officer in writing, the CONTRACTOR shall respond with a claim for an adjustment. The requirement for a timely written response by CONTRACTOR cannot be waived and shall be a condition precedent to the assertion of a claim.

c. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if a written response is not given prior to final payment under this Contract.

d. Other claims not barred. In the absence of a change order, nothing in this paragraph 20 shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under the Contract or for breach of contract.

21. Price Adjustment.

a. Price adjustment. Any adjustment in the contract price pursuant to a provision in this Contract shall be made in one or more of the following ways:

(1) By agreement on a fixed price adjustment before commencement of the pertinent performance or as soon thereafter as practicable;

(2) By unit prices specified in the Contract or subsequently agreed upon;

(3) By the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as specified in the Contract or subsequently agreed upon;

(4) In such other manner as the parties may mutually agree; or

(5) In the absence of agreement between the parties, by a unilateral determination by the Agency procurement officer of the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as computed by the Agency procurement officer in accordance with generally accepted accounting principles and applicable sections of chapters 3-123 and 3-126, HAR.

b. Submission of cost or pricing data. The CONTRACTOR shall provide cost or pricing data for any price adjustments subject to the provisions of chapter 3-122, HAR.

22. Variation in Quantity for Definite Quantity Contracts. Upon the agreement of the STATE and the CONTRACTOR, the quantity of goods or services, or both, if a definite quantity is specified in this Contract, may be increased by a maximum of ten per cent (10%); provided the unit prices will remain the same except for any price adjustments otherwise applicable; and the Agency procurement officer makes a written determination that such an increase will either be more economical than awarding another contract or that it would not be practical to award another contract.

23. Changes in Cost-Reimbursement Contract. If this Contract is a cost-reimbursement contract, the following provisions shall apply:

a. The Agency procurement officer may at any time by written order, and without notice to the sureties, if any, make changes within the general scope of the Contract in any one or more of the following:

(1) Description of performance (Attachment 1);

(2) Time of performance (i.e., hours of the day, days of the week, etc.);

(3) Place of performance of services;

(4) Drawings, designs, or specifications when the supplies to be furnished are to be specially manufactured for the STATE in accordance with the drawings, designs, or specifications;

(5) Method of shipment or packing of supplies; or

(6) Place of delivery.

b. If any change causes an increase or decrease in the estimated cost of, or the time required for performance of, any part of the performance under this Contract, whether or not changed by the order, or otherwise affects any other terms and conditions of this Contract, the Agency procurement officer shall make an equitable adjustment in the (1) estimated cost, delivery or completion schedule, or both; (2) amount of any fixed fee; and (3) other affected terms and shall modify the Contract accordingly.

c. The CONTRACTOR must assert the CONTRACTOR'S rights to an adjustment under this provision within thirty (30) days from the day of receipt of the written order. However, if the Agency procurement officer decides that the facts justify it, the Agency procurement officer may receive and act upon a proposal submitted before final payment under the Contract.

d. Failure to agree to any adjustment shall be a dispute under paragraph 11 of this Contract. However, nothing in this provision shall excuse the CONTRACTOR from proceeding with the Contract as changed.

e. Notwithstanding the terms and conditions of subparagraphs 23a and 23b, the estimated cost of this Contract and, if this Contract is incrementally funded, the funds allotted for the performance of this Contract, shall not be increased or considered to be increased except by specific written modification of the Contract indicating the new contract estimated cost and, if this contract is incrementally funded, the new amount allotted to the contract.

24. Confidentiality of Material.

a. All material given to or made available to the CONTRACTOR by virtue of this Contract, which is identified as proprietary or confidential information, will be safeguarded by the CONTRACTOR and shall not be disclosed to any individual or organization without the prior written approval of the STATE.

b. All information, data, or other material provided by the CONTRACTOR to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS.

25. Publicity. The CONTRACTOR shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, including the HOPA, the CPO, the Agency procurement officer, or to the services or goods, or both, provided under this Contract, in any of the CONTRACTOR'S brochures, advertisements, or other publicity of the CONTRACTOR. All media contacts with the CONTRACTOR about the subject matter of this Contract shall be referred to the Agency procurement officer.

26. Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished, which is developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract, and all such material shall be considered "works made for hire." All such material shall be delivered to the STATE upon expiration or termination of this Contract. The STATE, in its sole discretion, shall have the exclusive right to copyright any product, concept, or material developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract.

27. Liens and Warranties. Goods provided under this Contract shall be provided free of all liens and provided together with all applicable warranties, or with the warranties described in the Contract documents, whichever are greater.

28. Audit of Books and Records of the CONTRACTOR. The STATE may, at reasonable times and places, audit the books and records of the CONTRACTOR, prospective contractor, subcontractor, or prospective subcontractor which are related to:

a. The cost or pricing data, and

b. A state contract, including subcontracts, other than a firm fixed-price contract.

29. Cost or Pricing Data. Cost or pricing data must be submitted to the Agency procurement officer and timely certified as accurate for contracts over $100,000 unless the contract is for a multiple-term or as otherwise specified by the Agency procurement officer. Unless otherwise required by the Agency procurement officer, cost or pricing data submission is not required for contracts awarded pursuant to competitive sealed bid procedures.

If certified cost or pricing data are subsequently found to have been inaccurate, incomplete, or noncurrent as of the date stated in the certificate, the STATE is entitled to an adjustment of the contract price, including profit or fee, to exclude any significant sum by which the price, including profit or fee, was increased because of the defective data. It is presumed that overstated cost or pricing data increased the contract price in the amount of the defect plus related overhead and profit or fee. Therefore, unless there is a clear indication that the defective data was not used or relied upon, the price will be reduced in such amount.

30. Audit of Cost or Pricing Data. When cost or pricing principles are applicable, the STATE may require an audit of cost or pricing data.

31. Records Retention.

(1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

(2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

32. Antitrust Claims. The STATE and the CONTRACTOR recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the CONTRACTOR hereby assigns to STATE any and all claims for overcharges as to goods and materials purchased in connection with this Contract, except as to overcharges which result from violations commencing after the price is established under this Contract and which are not passed on to the STATE under an escalation clause.

33. Patented Articles. The CONTRACTOR shall defend, indemnify, and hold harmless the STATE, and its officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys fees, and all claims, suits, and demands arising out of or resulting from any claims, demands, or actions by the patent holder for infringement or other improper or unauthorized use of any patented article, patented process, or patented appliance in connection with this Contract. The CONTRACTOR shall be solely responsible for correcting or curing to the satisfaction of the STATE any such infringement or improper or unauthorized use, including, without limitation: (a) furnishing at no cost to the STATE a substitute article, process, or appliance acceptable to the STATE, (b) paying royalties or other required payments to the patent holder, (c) obtaining proper authorizations or releases from the patent holder, and (d) furnishing such security to or making such arrangements with the patent holder as may be necessary to correct or cure any such infringement or improper or unauthorized use.

34. Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawaii. Any action at law or in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawaii.

35. Compliance with Laws. The CONTRACTOR shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the CONTRACTOR'S performance of this Contract.

36. Conflict Between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the procurement rules, the procurement rules in effect on the date this Contract became effective shall control and are hereby incorporated by reference.

37. Entire Contract. This Contract sets forth all of the agreements, conditions, understandings, promises, warranties, and representations between the STATE and the CONTRACTOR relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings, promises, warranties, and representations, which shall have no further force or effect. There are no agreements, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the CONTRACTOR other than as set forth or as referred to herein.

38. Severability. In the event that any provision of this Contract is declared invalid or unenforceable by a court, such invalidity or unenforceability shall not affect the validity or enforceability of the remaining terms of this Contract.

39. Waiver. The failure of the STATE to insist upon the strict compliance with any term, provision, or condition of this Contract shall not constitute or be deemed to constitute a waiver or relinquishment of the STATE'S right to enforce the same in accordance with this Contract. The fact that the STATE specifically refers to one provision of the procurement rules or one section of the Hawaii Revised Statutes, and does not include other provisions or statutory sections in this Contract shall not constitute a waiver or relinquishment of the STATE'S rights or the CONTRACTOR'S obligations under the procurement rules or statutes.

40. Pollution Control. If during the performance of this Contract, the CONTRACTOR encounters a "release" or a "threatened release" of a reportable quantity of a "hazardous substance," "pollutant," or "contaminant" as those terms are defined in section 128D-1, HRS, the CONTRACTOR shall immediately notify the STATE and all other appropriate state, county, or federal agencies as required by law. The Contractor shall take all necessary actions, including stopping work, to avoid causing, contributing to, or making worse a release of a hazardous substance, pollutant, or contaminant, and shall promptly obey any orders the Environmental Protection Agency or the state Department of Health issues in response to the release. In the event there is an ensuing cease-work period, and the STATE determines that this Contract requires an adjustment of the time for performance, the Contract shall be modified in writing accordingly.

41. Campaign Contributions. The CONTRACTOR is hereby notified of the applicability of 11-355, HRS, which states that campaign contributions are prohibited from specified state or county government contractors during the terms of their contracts if the contractors are paid with funds appropriated by a legislative body.

42. Confidentiality of Personal Information.

a. Definitions.

"Personal information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either name or data elements are not encrypted:

(1) Social security number;

(2) Driver's license number or Hawaii identification card number; or

(3) Account number, credit or debit card number, access code, or password that would permit access to an individual's financial information.

Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

"Technological safeguards" means the technology and the policy and procedures for use of the technology to protect and control access to personal information.

b. Confidentiality of Material.

(1) All material given to or made available to the CONTRACTOR by the STATE by virtue of this Contract which is identified as personal information, shall be safeguarded by the CONTRACTOR and shall not be disclosed without the prior written approval of the STATE.

(2) CONTRACTOR agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.

(3) CONTRACTOR agrees to implement appropriate "technological safeguards" that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.

(4) CONTRACTOR shall report to the STATE in a prompt and complete manner any security breaches involving personal information.

(5) CONTRACTOR agrees to mitigate, to the extent practicable, any harmful effect that is known to CONTRACTOR because of a use or disclosure of personal information by CONTRACTOR in violation of the requirements of this paragraph.

(6) CONTRACTOR shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by CONTRACTOR on behalf of the STATE.

c. Security Awareness Training and Confidentiality Agreements.

(1) CONTRACTOR certifies that all of its employees who will have access to the personal information have completed training on security awareness topics relating to protecting personal information.

(2) CONTRACTOR certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:

(A) The personal information collected, used, or maintained by the CONTRACTOR will be treated as confidential;

(B) Access to the personal information will be allowed only as necessary to perform the Contract; and

(C) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

d. Termination for Cause. In addition to any other remedies provided for by this Contract, if the STATE learns of a material breach by CONTRACTOR of this paragraph by CONTRACTOR, the STATE may at its sole discretion:

(1) Provide an opportunity for the CONTRACTOR to cure the breach or end the violation; or

(2) Immediately terminate this Contract.

In either instance, the CONTRACTOR and the STATE shall follow chapter 487N, HRS, with respect to notification of a security breach of personal information.

e. Records Retention.

(1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

(2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

BUSINESS ASSOCIATE AGREEMENT

This Agreement is effective as of _____, between the Hawai‘i Employer-Union Health Benefits Trust Fund, State of Hawai‘i (hereinafter the "STATE"), by its Administrator, whose address is 201 Merchant Street, Suite 1700, Honolulu, Hawai‘i 96813, and _____(hereinafter "BUSINESS ASSOCIATE"), a _____, whose business address is as follows: _____.

RECITALS

A. The STATE has entered into a contract with BUSINESS ASSOCIATE and/or procured the following goods and services from BUSINESS ASSOCIATE: _____

B. BUSINESS ASSOCIATE's contract and/or provision of goods and performance of services may require that: (1) Protected Health Information (defined below) or Electronic Protected Health Information (defined below) be disclosed to or used by BUSINESS ASSOCIATE; (2) BUSINESS ASSOCIATE create, receive, maintain or transmit Protected Health Information or Electronic Protected Health Information on behalf of the STATE; and/or (3) BUSINESS ASSOCIATE be provided or have access to Personal Information (defined below).

C. Both parties are committed to complying with the Privacy and Security Laws (defined below) with respect to Protected Health Information, Electronic Protected Health Information, and Personal Information.

D. This Agreement sets forth the terms and conditions pursuant to which the following will be handled: (1) Protected Health Information and Electronic Protected Health Information that is disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; (2) Protected Health Information and Electronic Protected Health Information that is created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of the STATE; and (3) Personal Information provided to BUSINESS ASSOCIATE or to which BUSINESS ASSOCIATE will have access by virtue of a contract with the STATE.

TERMS AND CONDITIONS

1. Introduction: The STATE, as defined in this Agreement, has determined that it is a Covered Entity or a Health Care Component of a Covered Entity under HIPAA (defined below) and the Privacy and Security Rules (defined below). In addition, the STATE is subject to use and disclosure restrictions regarding Personal Information under Act 10 (defined below) and Chapters 487N and 487R, Hawai‘i Revised Statutes.

The parties acknowledge that entry into this Agreement is necessary and desirable in order to: (a) protect the privacy and security of Protected Health Information and Electronic Protected Health Information in accordance with the Privacy and Security Laws and because BUSINESS ASSOCIATE is a "business associate" of the STATE as that term is used in 45 Code of Federal Regulations ("C.F.R.") § 160.103; and (b) protect against the unauthorized use and disclosure of Personal Information that BUSINESS ASSOCIATE has been provided or to which BUSINESS ASSOCIATE has access by virtue of a contract with the STATE.

2. Definitions:

a. Except as otherwise defined herein, any and all capitalized terms in this Agreement shall have the definitions set forth in the Privacy and Security Laws.

b. Act 10. "Act 10" shall mean Act 10, 2008 Session Laws of Hawai'i, Special Session.

c. Agreement. "Agreement" shall mean this agreement between STATE and BUSINESS ASSOCIATE and any and all attachments, exhibits and special conditions attached hereto.

d. ARRA. "ARRA" shall mean the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, and the rules and regulations promulgated under the ARRA.

e. Breach. "Breach" shall have the meaning set forth in the ARRA.

f. De-identified Information. "De-identified Information" shall have the meaning set forth in 45 C.F.R. §§ 164.514(a)-(b).

g. Electronic Protected Health Information. "Electronic Protected Health Information" shall have the meaning set forth in 45 C.F.R. § 160.103. For purposes of this Agreement, "Electronic Protected Health Information" is limited to Electronic Protected Health Information that is: (i) disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; and/or (ii) created, received, maintained, or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.

h. Electronic Transactions Rule. "Electronic Transactions Rule" shall mean the final rule set forth in 45 C.F.R. §§ 160 and 162.

i. HIPAA. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

j. Individual. "Individual" means the person who is the subject of Protected Health Information, and shall include a person who qualifies as a personal representative under 45 C.F.R. § 164.502(g).

k. Individually Identifiable Health Information. "Individually Identifiable Health Information" shall have the meaning set forth in 45 C.F.R. § 160.103.

l. Personal Information. "Personal Information" shall have the meaning set forth in Section 487N-1, Hawai'i Revised Statutes. For purposes of this Agreement,

"Personal Information" is limited to Personal Information provided to BUSINESS ASSOCIATE or to which BUSINESS ASSOCIATE has access by virtue of a contract with the STATE.

m. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as the same may be amended from time to time.

n. Privacy and Security Laws. "Privacy and Security Laws" shall include: (1) the provisions of HIPAA that relate to the privacy and security of Protected Health Information and Electronic Protected Health Information; (2) the Privacy and Security Rules; (3) the provisions of ARRA, including the rules and regulations promulgated under the ARRA, that relate to the privacy and security of Protected Health Information and Electronic Protected Health Information; (4) Act 10 and, to the extent applicable, Chapters 487N and 487R, Hawai'i Revised Statutes; and (5) other Federal and State privacy or security statutes and regulations that apply to Protected Health Information, Electronic Protected Health Information, or Personal Information.

o. Protected Health Information. "Protected Health Information" shall have the meaning set forth in 45 C.F.R. § 160.103. For purposes of this Agreement, "Protected Health Information" is limited to Protected Health Information that is: (i) disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; and/or (ii) created, received, maintained, or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.

p. Secretary. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or designee.

q. Security Rule. "Security Rule" shall mean the Health Insurance Reform: Security Standards at 45 C.F.R. Part 160, Part 162, and Part 164, Subparts A and C, as the same may be amended from time to time.

r. Unsecured Protected Health Information. "Unsecured Protected Health Information" shall have the meaning set forth in the ARRA.

3. Obligations and Activities of BUSINESS ASSOCIATE

a. BUSINESS ASSOCIATE agrees to not use or disclose Protected Health Information, Electronic Protected Health Information, and Personal Information other than as permitted or required by this Agreement or as required by law.

b. BUSINESS ASSOCIATE agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information, Electronic Protected Health Information, and Personal Information other than as provided for by this Agreement.

c. BUSINESS ASSOCIATE agrees to implement administrative, physical, and technical safeguards (as those terms are defined in the Security Rule) that reasonably and appropriately protect the confidentiality, integrity and availability

of Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the STATE. Without limiting the foregoing, BUSINESS ASSOCIATE agrees to implement administrative, physical, and technical safeguards to comply with 45 C.F.R. §§ 164.308, 164.310, and 164.312, as and to the extent that such is required of business associates under the Privacy and Security Laws (as amended by the ARRA).

(i) Required Safeguards. BUSINESS ASSOCIATE shall use all appropriate safeguards to prevent use or disclosure of Protected Health Information received from, or created or received on behalf of, STATE, other than as provided for in this Agreement or as required by law. These safeguards will include, but are not limited to:

(I) Training. Providing annual training to relevant employees, contractors, and subcontractors on how to prevent the improper use or disclosure of Protected Health Information; and updating and repeating training on a regular basis;

(II) Administrative Safeguards. Adopting policies and procedures regarding the safeguarding of Protected Health Information; and enforcing those policies and procedures, including sanctions for anyone not found in compliance;

(III) Technical and Physical Safeguards. Implementing appropriate technical safeguards to protect Protected Health Information, including access controls, authentication, and transmission security; and implementing appropriate physical safeguards to protect Protected Health Information, including workstation security and device and media controls.

d. In accordance with Part V of Act 10, BUSINESS ASSOCIATE agrees to implement: (i) technological safeguards to reduce exposure to unauthorized access to Personal Information, (ii) mandatory training on security awareness topics relating to Personal Information protection for BUSINESS ASSOCIATE's employees, and (iii) confidentiality agreements to be signed by BUSINESS ASSOCIATE's employees. BUSINESS ASSOCIATE further agrees to safeguard Protected Health Information, Electronic Protected Health Information, and Personal Information in accordance with any rules, policies, procedures and directions adopted or implemented by STATE to the extent that such are communicated to BUSINESS ASSOCIATE.

e. BUSINESS ASSOCIATE agrees to ensure that any agent (including a contractor or subcontractor) to whom it provides Protected Health Information, Electronic Protected Health Information, or Personal Information agrees to the same restrictions and conditions that apply to BUSINESS ASSOCIATE with respect to such information under this Agreement and the Privacy and Security Laws. BUSINESS ASSOCIATE further agrees to ensure that any such agent shall safeguard such Protected Health Information, Electronic Protected Health Information, and Personal Information in accordance with any rules, policies,

procedures and directions adopted or implemented by STATE to the extent that such are communicated to BUSINESS ASSOCIATE. BUSINESS ASSOCIATE agrees to ensure that any such agent shall implement reasonable and appropriate safeguards to protect Protected Health Information.

f. BUSINESS ASSOCIATE agrees to implement reasonable policies and procedures to comply with 45 C.F.R. § 164.316, as and to the extent that such is required of business associates under the Privacy and Security Laws (as amended by the ARRA).

g. BUSINESS ASSOCIATE agrees to provide access to Protected Health Information in the Designated Record Set to STATE or, as directed by STATE, to an Individual to the extent and in the manner required by 45 C.F.R. § 164.524.

h. BUSINESS ASSOCIATE agrees to make Protected Health Information available for amendment and to incorporate any amendments to Protected Health Information that the STATE directs or agrees to in accordance with the requirements of 45 C.F.R. § 164.526.

i. BUSINESS ASSOCIATE agrees to document disclosures of Protected Health Information, disclosures of Electronic Protected Health Information and information related to such disclosures as would be required for STATE to respond to a request by an Individual for an accounting of disclosures of: (1) Protected Health Information in accordance with 45 C.F.R. § 164.528; and (2) Electronic Protected Health Information in accordance Section 13405(c) of the ARRA. BUSINESS ASSOCIATE further agrees to collect and provide to STATE, any and all information that is reasonably necessary for STATE to timely respond to such requests by an Individual for an accounting of disclosures.

j. BUSINESS ASSOCIATE agrees to keep a log of Breaches of Unsecured Protected Health Information in such form and with such information as to enable the STATE to comply with Section 13402(e)(3) of the ARRA and the rules and regulations promulgated under ARRA.

k. BUSINESS ASSOCIATE agrees to keep a complete log of disclosures made of Personal Information in accordance with Section 8(b)(6) of Act 10.

l. BUSINESS ASSOCIATE agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information and Electronic Protected Health Information available to STATE and/or to the Secretary, at reasonable times and places or as designated by the STATE and/or the Secretary, for purposes of determining compliance with the Privacy and Security Laws. BUSINESS ASSOCIATE further agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Personal Information available to STATE, at reasonable times and places or as designated by the STATE, for purposes of determining compliance with this Agreement, Act 10, and other Federal and State laws regarding the use and disclosure of Personal Information.

m. BUSINESS ASSOCIATE agrees to report to STATE any disclosure or use of Protected Health Information not provided for by this Agreement, of which BUSINESS ASSOCIATE becomes aware, but in no event later than five (5) business days of first learning of any such use or disclosure. BUSINESS ASSOCIATE further agrees to report to STATE any security incidents that are required to be reported by or to the STATE under 45 C.F.R. Part 164, particularly 45 C.F.R. § 164.314. BUSINESS ASSOCIATE agrees that if any of its employees, agents, subcontractors, and/or representatives use and/or disclose Protected Health Information received from, or created or received on behalf of, STATE, or any derivative De-identified Information in a manner not provided for in this Agreement, BUSINESS ASSOCIATE shall ensure that such employees, agents, subcontractors, and/or representatives shall receive training on BUSINESS ASSOCIATE's procedures for compliance with the Privacy Rule, or shall be sanctioned or prevented from accessing any Protected Health Information BUSINESS ASSOCIATE receives from, or creates or receives on behalf of, STATE. Continued use of Protected Health Information in a manner contrary to the terms of this Agreement shall constitute a material breach of this Agreement.

n. If there is a Breach of Unsecured Protected Health Information, BUSINESS ASSOCIATE shall: (i) notify the STATE in writing of the Breach no later than twenty (20) calendar days after BUSINESS ASSOCIATE's discovery of the Breach; (ii) investigate and report to STATE on the causes of the Breach including, without limitation, any steps that BUSINESS ASSOCIATE will take to mitigate the Breach and prevent the occurrence of future similar Breaches; (iii) in consultation with STATE, provide all notifications regarding the Breach that STATE and/or BUSINESS ASSOCIATE are required to make under ARRA including, without limitation, written notices to individuals, notices to the media, and notices to the Secretary or any other governmental entity, all such notices to be made in accordance with all ARRA requirements; (iv) unless the Breach is primarily caused by the negligence or other fault of the STATE, indemnify and hold STATE harmless from all claims, lawsuits, administrative proceedings, judgments, damages, liabilities, penalties, and costs arising from the Breach, including all costs of investigating the Breach, providing all required notices, and otherwise complying with all ARRA requirements; and (v) provide a log of all Breaches of Unsecured Protected Health Information to the STATE no later than twenty (20) calendar days after the end of each calendar year, which log shall include all information that STATE needs in order to comply with Section 13402(e)(3) of the ARRA.

o. If there is a "security breach" regarding Personal Information as that term is defined in Section 487N-1, Hawai'i Revised Statutes, BUSINESS ASSOCIATE shall: (i) notify the STATE in writing of the security breach no later than twenty (20) calendar days after BUSINESS ASSOCIATE's discovery of the security breach; (ii) investigate and report to STATE on the causes of the security breach including, without limitation, any steps that BUSINESS ASSOCIATE will take to mitigate the Breach and prevent the occurrence of future similar Breaches; (iii) in consultation with STATE, provide all notifications regarding the security breach that STATE and/or BUSINESS ASSOCIATE are required to make under Chapter 487N and other applicable Hawai'i Revised Statutes; (iv) unless the security

breach is primarily caused by the negligence or other fault of the STATE, indemnify and hold STATE harmless from all claims, lawsuits, administrative proceedings, judgments, damages, liabilities, penalties, and costs arising from the security breach, including all costs of investigating the security breach, providing all required notices, and otherwise complying with Chapter 487N and other applicable Hawai‘i Revised Statutes; and (v) assist the State in providing any written report to the legislature or other government entities that is required by Chapter 478N and other applicable Hawai‘i Revised Statutes.

p. BUSINESS ASSOCIATE agrees to mitigate, to the extent practicable, any harmful effect that is known to BUSINESS ASSOCIATE of: (1) a security breach or disclosure or use of Protected Health Information, Electronic Protected Health Information, or Personal Information by BUSINESS ASSOCIATE in violation of the requirements of this Agreement; and/or (2) a Breach of Unsecured Protected Health Information by BUSINESS ASSOCIATE or any of its officers, employees, or agents (including contractors and subcontractors).

q. BUSINESS ASSOCIATE shall, upon notice from STATE, accommodate any restriction to the use or disclosure of Protected Health Information and any request for confidential communications to which STATE has agreed in accordance with the Privacy Rule.

r. BUSINESS ASSOCIATE shall comply with any other requirements of the Privacy Law, the Privacy Rule, the Security Law, and the Security Rule not expressly specified in this Agreement, as and to the extent that such requirements apply to business associates under the Privacy Law, the Privacy Rule, the Security Law, and the Security Rule, as they may be amended from time to time.

4. Permitted Uses and Disclosures by BUSINESS ASSOCIATE

a. General Use and Disclosure Provisions. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose or use Protected Health Information, Electronic Protected Health Information, and Personal Information to perform functions, activities, or services for, or on behalf of, STATE as specified in this Agreement, provided that such disclosure or use would not violate any Privacy and Security Laws if done by STATE.

b. Specific Use and Disclosure Provisions

(i) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use Protected Health Information and Personal Information for the proper management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE.

(ii) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose Protected Health Information for the proper management and administration of the BUSINESS ASSOCIATE, for disclosures that are Required By Law, or where BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as required

by law or for the purpose for which it was disclosed to the person and the person agrees to notify BUSINESS ASSOCIATE of any instances where the confidentiality of the information has been breached. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose Personal Information where such disclosure is permitted by applicable Federal or State laws.

(iii) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use Protected Health Information to provide Data Aggregation services to STATE as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

(iv) BUSINESS ASSOCIATE may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).

c. Further Uses Prohibited. Except as provided in sections 4.a and 4.b, above, BUSINESS ASSOCIATE is prohibited from further using or disclosing any information received from STATE, or from any other Business Associate of STATE, for any commercial purposes of BUSINESS ASSOCIATE including, for example, "data mining."

5. Minimum Necessary. BUSINESS ASSOCIATE shall only request, use, and disclose the minimum amount of Protected Health Information necessary to accomplish the purpose of the request, use, or disclosure.

6. Prohibited, Unlawful, or Unauthorized Use and Disclosure of Protected Health Information. BUSINESS ASSOCIATE shall not use or further disclose any Protected Health Information received from, or created or received on behalf of, STATE, in a manner that would violate the requirements of the Privacy Rule, if done by STATE.

7. Indemnity by BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall defend, indemnify and hold harmless STATE and STATE's officers, employees, and agents (including contractors and subcontractors) from and against any and all claims, demands, lawsuits, administrative or other proceedings, judgments, liabilities, damages, losses, fines, penalties, and costs, including reasonable attorneys' fees, that are caused by or arise out of a breach or failure to comply with any provision of this Agreement and/or by a violation of any provision of the Privacy and Security Laws, including the ARRA, by BUSINESS ASSOCIATE or any of BUSINESS ASSOCIATE's officers, employees, or agents (including contractors and subcontractors).

8. Permissible Requests by STATE. STATE shall not request BUSINESS ASSOCIATE to disclose or use Protected Health Information, Electronic Protected Health Information, or Personal Information in any manner that would not be permissible under the Privacy and Security Laws if done by STATE.

9. Standard Electronic Transactions. STATE and BUSINESS ASSOCIATE agree that BUSINESS ASSOCIATE shall, on behalf of STATE, transmit data for transactions that are required to be conducted in standardized format under the Electronic Transactions Rule. BUSINESS ASSOCIATE shall comply with the Electronic

Transactions Rule for all transactions conducted on behalf of STATE that are required to be in standardized format. BUSINESS ASSOCIATE shall ensure that any of its subcontractors to whom it delegates any of its duties under its contract with STATE, agrees to conduct and agrees to require its agents or subcontractors to comply with the Electronic Transactions Rule for all transactions conducted on behalf of STATE that are required to be in standardized format.

10. Termination for Cause. In addition to any other remedies provided for by this Agreement, upon STATE's knowledge of a material breach or violation by BUSINESS ASSOCIATE of the terms of this Agreement, STATE may either:

    a. Provide an opportunity for BUSINESS ASSOCIATE to cure the breach or end the violation, and terminate this Agreement if BUSINESS ASSOCIATE does not cure the breach or end the violation within the time specified by the STATE; or

    b. Immediately terminate this Agreement if BUSINESS ASSOCIATE has breached or violated a material term of this Agreement and cure is not possible; and

    c. If neither termination nor cure is feasible, STATE shall report any violation of the federal Privacy and Security Rules to the Secretary.

11. Effect of Termination.

    a. Upon any termination of this Agreement, until notified otherwise by STATE, BUSINESS ASSOCIATE shall extend all protections, limitations, requirements, and other provisions of this Agreement to: (i) all Protected Health Information received from or on behalf of STATE or created or received by BUSINESS ASSOCIATE on behalf of STATE; (ii) all Electronic Protected Health Information created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of STATE; and (iii) all Personal Information.

    b. Upon any termination of this Agreement, STATE shall determine whether it is feasible for BUSINESS ASSOCIATE to return to STATE or destroy all or any part of: (i) all Protected Health Information received from or on behalf of STATE or created or received by BUSINESS ASSOCIATE on behalf of STATE that BUSINESS ASSOCIATE maintains in any form and shall retain no copies of such information; (ii) all Electronic Protected Health Information created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of STATE; and (iii) all Personal Information. In connection with the foregoing, upon any termination of the Agreement, BUSINESS ASSOCIATE shall notify the STATE in writing of any and all conditions that make return or destruction of such information not feasible and shall provide STATE with any requested information related to the STATE's determination as to whether the return or destruction of such information is feasible.

    c. If STATE determines that return or destruction of all or any part of the Protected Health Information, Electronic Protected Health Information, and Personal Information is feasible, at STATE's option, BUSINESS ASSOCIATE shall return or destroy such information. If STATE directs that BUSINESS ASSOCIATE return or destroy all or any part of the Protected Health Information, Electronic

Protected Health Information, and Personal Information, it is understood and agreed that BUSINESS ASSOCIATE shall retain no copies of such information. Destruction of Personal Information shall be performed in accordance with Chapter 487R, Hawai‘i Revised Statutes. Notwithstanding the foregoing, BUSINESS ASSOCIATE shall not destroy any Protected Health Information in less than six (6) years from the date that it is received by BUSINESS ASSOCIATE.

d. If STATE determines that return or destruction of all or any part of the Protected Health Information, Electronic Protected Health Information, and Personal Information is not feasible or opts not to require the return or destruction of such information, BUSINESS ASSOCIATE shall extend the protections, limitations, requirements, and other provisions of this Agreement to such information for so long as BUSINESS ASSOCIATE maintains such information. STATE understands that BUSINESS ASSOCIATE's need to maintain portions of the Protected Health Information in records of actuarial determinations and for other archival purposes related to memorializing advice provided, can render return or destruction infeasible.

e. The provisions of this Section 11 shall apply with respect to all terminations of this Agreement, for any reason whatsoever, and to any and all Protected Health Information, Electronic Protected Health Information, and Personal Information in the possession or control of any and all agents and subcontractors of BUSINESS ASSOCIATE.

12. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy and Security Laws means the section in effect or as amended.

b. Amendment. BUSINESS ASSOCIATE and STATE agree to take all actions necessary to amend this Agreement in order for STATE to comply with the requirements of the Privacy Rule, Security Rule, HIPAA, ARRA, and/or any other Federal or State law that is determined to apply to the Protected Health Information, Electronic Protected Health Information, or Personal Information covered by this Agreement. All amendments shall be in writing and executed by both parties.

c. Survival. The respective rights and obligations of STATE and BUSINESS ASSOCIATE under Sections 3, 5, and 8 above, shall survive the termination of this Agreement.

d. Interpretation. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the Privacy and Security Laws, as amended, the Privacy and Security Laws shall control. Where provisions of this Agreement are different than those mandated in the Privacy or Security Laws, but are nonetheless permitted by the Privacy or Security Laws, the provisions of this Agreement shall control. Any ambiguity in this Agreement shall be resolved to permit STATE to comply with the Privacy and Security Laws.

e. Third Parties. This Agreement is solely between BUSINESS ASSOCIATE and the STATE, and may be enforced only by BUSINESS ASSOCIATE or the STATE. This Agreement shall not be deemed to create any rights in any third parties or to create any obligations or liabilities of BUSINESS ASSOCIATE or the STATE to any third party.

HAWAIʻI EMPLOYER-UNION HEALTH BENEFITS TRUST FUND ("STATE")

By _____
Its Administrator

Date: _____, 2017

[*name of business associate*]
("BUSINESS ASSOCIATE")

By _____

Its _____

Date: _____, 2017

APPROVED AS TO FORM:

_____
Deputy Attorney General

Hawaii Employer-Union Health Benefits Trust Fund

RETIREE BENEFIT PLANS REFERENCE GUIDE (EUTF and HSTA VB)

Effective January 1, 2017 – December 31, 2017

Retirees and their dependents who are or soon will be eligible for Medicare and anyone considering retirement or who is covering a dependent eligible for Medicare, please note: Hawaii law requires that you enroll in Medicare Part B when you become eligible in order to enroll in any EUTF or HSTA VB retiree medical and/or prescription drug plan. Please see page 53 for more information on this important topic.

Disclaimer: This Reference Guide offers general information on your health and other benefit plans which are exclusively governed by the Hawaii Revised Statutes, the EUTF Administrative Rules as they are amended from time to time and the carrier plan documents all of which are available at eutf.hawaii.gov. Nothing in this Reference Guide is intended to amend, change, or contradict these documents. This Reference Guide is not a legal document or contract and the information in the Reference Guide is not intended as legal advice or to create any legal or contractual liabilities.

This guide can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990. Please contact the EUTF office at 808-586-7390 or toll free at 1-800-295-0089 for special needs.

Aloha Retirees,

We are pleased to present the 2017 Reference Guide for Retirees. This Reference Guide provides information on the health benefit plans available to you for the calendar year January 1, 2017 through December 31, 2017. You may make changes to your enrollment in these plans during the October 10-31, 2016 open enrollment period or if you have a qualifying event during the year. Any changes you make during open enrollment will take effect on January 1, 2017.

It is our goal to provide you with quality health benefit plan options. You earned these important benefits through the dedication and hard work you provided as a State or County employee. The information contained in this Reference Guide is intended to help you make good use of your benefits and make choices that best address your needs.

We're also pleased to share with you our new well-being program logo, "Be Well. Be Strong." It serves to encourage us to take action to improve our well-being. You can start, or strengthen your efforts, by taking advantage of the well-being programs available to you.

This Reference Guide is also posted on the EUTF website at eutf.hawaii.gov. If you need any assistance, please call one of our helpful staff at 586-7390 or toll free at 1-800-295-0089.

Mahalo,

Roderick Becker, Chair
EUTF Board of Trustees

The EUTF administers health and life insurance plans for all eligible State and County active employees, retirees and their eligible dependents. Due to a decision by Judge Sakamoto in December 2010 related to the HSTA VEBA members who statutorily were required to become enrolled in EUTF plans, EUTF created new plans exclusively for the HSTA VEBA members, both active and retirees, that matched their standard of benefits they received under their HSTA VEBA plans. Throughout this Guide there are descriptions of plans for those HSTA VEBA members, referred to as HSTA VB plans. Additionally, there are descriptions for EUTF's plans for all other State and County retirees, referred to as EUTF plans. If there is uncertainty by the reader of which plans are being referenced in this Guide, contact EUTF Customer Call Center at (808) 586-7390 or toll-free at 1-800-295-0089 for clarification.

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All Retirees

Welcome to Open Enrollment for EUTF Retiree Benefit Plans

The Open Enrollment period for EUTF Retiree Health and Life insurance plans will be from October 10, 2016 through October 31, 2016.

Why is Open Enrollment special?
Now is the time when you should stop and think about health coverage for yourself and your family and determine which plan offered will best meet your needs? During open enrollment you can:

- Add a plan, change from one plan to another, or drop a plan
- Add an eligible dependent or drop a dependent
- Change coverage tiers such as changing from single to family or family to 2-party
- Now is also a good time to tell us if you've had a change of address

Open enrollment is your only opportunity to make changes without a qualifying event such as needing to enroll a new dependent due to marriage or a birth. Paperwork must be submitted during the open enrollment period for changes to become effective January 1, 2017. So, **now is the time to think about health benefits.**

Here are the important dates:

- **Open Enrollment Election Period: October 10, 2016 through October 31, 2016**
- New coverage becomes effective: January 1, 2017
- Rates change effective: January 1, 2017
- The Base Monthly Contribution amount which sets the employer contribution may change January 1, 2017
- Plan Period: January 1, 2017 through December 31, 2017

Here's what you need to do now:

- **Know what you are enrolled in now:** What plans are you enrolled in? Who are the dependents enrolled on your plans? You may contact the EUTF at 808-586-7390 or toll free at 1-800-295-0089, to inquire about which EUTF or HSTA VB plans you are enrolled in.
- **If you or your dependent are eligible for Medicare or will be in 2017:** Review the Medicare section so you are aware of how this will affect your plans and the statutory Medicare Part B enrollment requirements.
- **Learn what's being offered:** Read this Reference Guide to learn more about the plans and their cost. Attend an Open Enrollment Informational Session to get more details and talk to carrier representatives.
- **Make a decision about which plans best suit your needs**
- **Fill out the appropriate form:** Please refer to page 6 for complete enrollment instructions.

IF YOU DO NOT WANT TO MAKE ANY CHANGES – DO NOTHING. If you do not fill out a Form, your current plan selections and eligible covered dependents will continue into the new plan year.

Plan Changes – What's New?

1. EUTF Kaiser Medicare Medical Plan – Residential room and board (in a hospice facility) is now covered at 100%.

2. EUTF HMSA Medical Plan – Physical Examinations (routine annual checkup) are now covered at 100% when received by an in-network provider and 70% prior to any plan deducible when rendered by an out-of-network provider.

3. Medicare Members – If you've had Part B for longer than 12 months, you can get a yearly "Wellness" visit. This visit is covered once every 12 months, free of charge, if the doctor or other qualified health care provider accepts assignment.

Plan Changes – 2016

1. EUTF Non-Medicare Prescription Drug Plan – added the Retail 90 network with copayments of 2 times the 30-day supply copayment for a 90-day supply of medications filled at Retail 90 network pharmacies and mail order, and copayments of 3 times the 30-day supply copayment for medications filled at non-Retail 90 network pharmacies.

2. EUTF and HSTA VB HMSA and Kaiser Medical Plans – added autism spectrum disorder and applied behavior analysis benefits for individuals under 14 years of age up to $25,000 per plan year.

3. EUTF and HSTA VB HMSA and Kaiser Medical Plans – added orthodontic services for the treatment of orofacial anomalies resulting from birth defects for children up to $5,500 per treatment phase.

4. EUTF HMSA Non-Medicare Medical Plan – added coverage for screening colonoscopies.

5. EUTF HMSA Medical Plan – added advanced care planning office visits.

6. HSTA VB HDS Dental Plans – increased the annual plan maximum benefit from $1,000 to $2,000 per member.

7. HSTA VB HDS Dental Plan – increased from 1 to 2 fluoride treatments through the age of 19.

8. HSTA VB HDS Dental Plan – implant benefit provides a higher reimbursement which will limit the patient share and removed the requirement that the implant benefit only apply when the tooth is missing between two natural teeth.

Open Enrollment Instructions

Step 1: **Review the choices available to you and decide whether you want to change** or keep your plans. If you decide to keep your current plans, do nothing. <u>You are not required to complete any forms to keep your current plans.</u>

Step 2: **Gather Information**: If you have questions about plan choices, please attend an Open Enrollment Informational Session. The schedule of sessions with location information is on page 9.

Representatives from the health plans and life insurance carrier will be on site to present an overview of their plans and answer your questions.

Step 3: **Which Plans do you want to enroll in?** Review this Reference Guide and determine which selection of health plans best meets your needs. The EUTF website, eutf.hawaii.gov, includes links to insurance carriers' web pages along with the latest information regarding open enrollment. Questions regarding specific plan provisions should be directed to the carriers.

Step 4: **How much will it cost you?** The premium rates which appear in this Guide show the full cost for each plan. If you pay a percentage of the cost, you will also need to reference the 2017 Base Monthly Contribution (BMC) amounts which should be available in December and can be found on the EUTF website at eutf.hawaii.gov.

Step 5: **Who do you need to cover?** You may add eligible dependents or drop dependents from your plan, including a spouse, domestic partner (DP), civil union partner (CUP) or eligible children. Adding a spouse, DP or CUP requires additional documentation. Please refer to page 15 for more information or visit the EUTF website at eutf.hawaii.gov to download forms. Refer to the Retiree and Dependent Eligibility section of this Guide found on page 14 for details on who can be enrolled as an eligible dependent.

Also, if your dependent is **eligible for Medicare**, he/she must be enrolled in Medicare Part B to be covered under your EUTF or HSTA VB retiree medical and/or prescription drug plans.

Step 6: **Complete the Enrollment Form: Make your selections on the EC-2 Enrollment Form for EUTF Retirees or EC-2H Enrollment Form for those already enrolled in the HSTA VB retiree plans, and submit the completed and signed form to the EUTF, postmarked no later than October 31, 2016.**

A: To make changes to your personal information, such as your address, complete Section 1, Retiree Data, on the appropriate EC-2 or EC-2H form.

B: To change your plans or coverage selection, complete Section 3, Plan Selection, on the EC-2 or EC-2H form. Please mark all the coverages you want to be enrolled in, ***not*** just the ones you want to change. If no selection is made, EUTF will assume no changes are being made.

C: To change dependent information, including continuing, adding or dropping dependents or updating their data, complete Section 4, Dependent Information and Plan Selections, of the EC-2 or EC-2H form.

NOTE: If you are adding a dependent, you are required to submit your dependent's Social Security Number (SSN) at the initial enrollment (the SSN for a newborn must be submitted to the EUTF within 60 days of submitting your enrollment form).

Step 7: **THE MOST IMPORTANT STEP: REVIEW YOUR COMPLETED FORM.** Make sure these are the plans you want and the dependents you are enrolling are eligible for coverage.

Last Step: **Submit the completed and signed form to the EUTF postmarked no later than October 31, 2016.**

FORMS SUBMITTED AFTER OCTOBER 31, 2016 WILL NOT BE PROCESSED.

The EUTF will send you an enrollment **confirmation notice** after processing is completed. The confirmation notice allows you to review the changes that were made to your coverages. If you note an error, you will 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 the EUTF within 10 calendar days from the date of the confirmation notice.

Although your coverage changes are effective on January 1, 2017, your enrollment may not be processed right away. Therefore, if you need to fill a prescription or go to the doctor prior to receiving your ID cards you should email EUTF at eutf@hawaii.gov. In the email subject line type "URGENT – Confirmation of coverage needed". EUTF checks this email daily and will contact the carrier to rush your enrollment after it receives the EC-2 or EC-2H Enrollment Form.

IMPORTANT: If any of your dependents are no longer eligible due to a divorce, legal separation or your dependent enters the uniformed services, they cannot continue to be covered under EUTF or HSTA VB plans. You are required to notify the EUTF and make these terminations when these events occur. Do not wait for open enrollment to submit these terminations. If your dependent is reaching the maximum age, disenrollment will occur automatically and an enrollment form is not necessary.

ATTENTION: COBRA PARTICIPANTS

The COBRA Open Enrollment is also taking place October 10 – 31, 2016. Please refer to page 93 for more information.

Schedule of Open Enrollment Informational Sessions for Retirees

Date	Island	Location	Time
Oct 10	Maui	UH Maui College	9:00am, 11:00am
Oct 10	Online	Webinar	8:00am, 1:00pm
Oct 11	Oahu	Hawaii State Capitol	9:00am, 11:00am
Oct 12	Hawaii - Hilo	Aunty Sally Kaleohano's Luau Hale	1:00pm, 3:00pm
Oct 13	Molokai	Kualapuu Park & Community Center	9:00am
Oct 13	Lanai	Lanai Community Center	9:00am
Oct 14	Oahu	Windward Community College	9:00am, 11:00am
Oct 17	Kauai	Kauai Community College	9:00am, 11:00am
Oct 18	Oahu	Hawaii State Capitol	9:00am, 11:00am
Oct 19	Hawaii - Kona	West Hawaii Civic Center	9:00am, 11:00am
Oct 19	Online	Webinar	8:00am, 1:00pm
Oct 20	Oahu	UH Manoa	9:00am, 11:00am
Oct 21	Oahu	Leeward Community College	9:00am, 11:00am

MOLOKAI
Kualapuu Park & Community Center
1 Uwao Street
Kualapuu, HI 96757

LANAI
Lanai Community Center
8th Street
Lanai City, HI 96763

KAUAI
Kauai Community College
OCET Room 106 C and D
3-1901 Kaumualii Highway
Lihue, Hawaii 96766

MAUI
UH Maui College
Pilina Multi-Purpose Room
310 W. Kaahumanu Ave.
Kahului, HI 96732

HAWAII - KONA
West Hawaii Civic Center
Community Meeting Hale, Bldg. G
74-5044 Ane Keohokalole Highway
Kailua-Kona, HI 96740

HAWAII - HILO
Aunty Sally Kaleohano's Luau Hale
799 Piilani Street
Hilo, HI 96720

OAHU

Hawaii State Capitol
Auditorium
415 S. Beretania Street
Honolulu, HI 96813

University of Hawaii at Manoa
Kuykendall Auditorium
2445 Campus Road
Honolulu, HI 96822

Windward Community College
Hale Palanakila, Room 104
45-720 Keaahala Road
Kaneohe, HI 96744

Leeward Community College
Education Building
Lecture Hall 201 A and B
96-045 Ala Ike Street
Pearl City, HI 96782

How to Access the Webinar

1) Go to eutf.hawaii.gov
2) In the top menu bar select "Training/Resources" and click on "Members"
3) Select the "Webinars" tab
4) Select the desired webinar link

WHAT YOU CAN DO TO MAINTAIN GOOD HEALTH

HMSA Members

Staying healthy is the best way to control your health care costs. Take care of yourself all year long. See your provider early. Don't let a minor health problem become a major one. HMSA members are eligible for preventive services such as cancer screenings and an annual wellness visit for members in Medicare. Talk to your doctor to learn about recommended preventive services and screening tests appropriate for your age and gender, such as colorectal, breast, or cervical cancer screenings.

If you haven't seen your doctor in the last year, we encourage you to make an appointment for an annual visit. If you don't have a doctor, visit hmsa.com, click on "Find a Doctor" in the top right corner. For help with finding a participating doctor, call 808-948-6499 or 1-800-776-4672 toll-free, Monday – Friday 7:00 a.m. – 7:00 p.m.

Disease Management Services

Disease management is a no-cost service available to members with asthma, chronic obstructive pulmonary disease, coronary artery disease, heart failure, diabetes, or chronic kidney disease. Services are also available for members with behavioral health conditions. This program helps you and your doctor manage your care and make informed choices. For more information, call 1-855-329-5461 toll-free, Monday – Friday 8:00 a.m. – 7:00 p.m. and Saturday 8:00 a.m. – 5:00 p.m.

QuitNet

QuitNet® is a free tobacco cessation program. Quit smoking for good with the support of local coaches and the world's largest online quit-smoking community. To get started, call 1-855-329-5461 toll-free and talk to a health coach, Monday – Friday 8:00 a.m. – 7:00 p.m. and Saturday 8:00 a.m. – 5:00 p.m.

HMSA's Online Care®

See a doctor on your smartphone or tablet 24 hours a day, seven days a week, including holidays to answer questions or help with your concerns. No appointment or copayment is needed. Online Care doctors and specialists can diagnose conditions and prescribe medication when necessary. To learn more, go to hmsaonlinecare.com.

Health Coaching

Health coaching is a free service to help you reduce stress, manage your weight, develop a healthy eating plan, or manage chronic conditions. Call 1-855-329-5461 toll-free to talk with a health coach, Monday – Friday 8:00 a.m. – 7:00 p.m. and Saturday 8:00 a.m. – 5:00 p.m.

Gallup-Healthways Well-Being 5™ survey

Get a better understanding of your well-being and how to improve it, such as learning how to manage your finances and stress less about your financial well-being. Go to hmsa.com/well-being to take the survey.

DO YOU KNOW ABOUT THESE HEALTH PLAN BENEFITS?

Kaiser Permanente Members

Preventive Services. *Prevention makes good health possible!*

Many preventive screening tests are covered at no cost to you once per benefit year. Depending on your age and gender some screenings may not be necessary. Screenings may include:

- Age-appropriate preventive medical examinations;
- Preventive annual physical exam;
- Blood pressure screening;
- Colon cancer screening (for adults 50 to 75);
- Depression screening;
- Diabetes screening (type 2) for adults with high blood pressure; *and much more.*

If you have questions about screenings recommended for you or what you are due for, please talk to your health care provider today.

Health Coaching. *Get the motivation and guidance you need!*

Take an active role in your health with our local health coaches. A personal coach can help you create-and stick with-a plan for reaching your goals including:

- Getting more active
- Eating better
- Managing your weight
- Reducing stress

There is no charge for telephonic health coaching. To schedule a convenient telephone session with your personal coach call 808-432-2262 or 808-432-2260, Monday – Friday 8:00 a.m. – 4:00p.m.

Tobacco Cessation. *Break the habit for good!*

The tobacco cessation program is a benefit provided free of charge to members. Trained counselors are available by phone to provide quit support and guidance. You may also be eligible to receive free tobacco cessation medications at no cost with a doctor's prescription. To talk to a counselor call 808-643-4622 Monday – Friday 8:30 a.m. – 2:30 p.m.

DO YOU KNOW ABOUT THESE PHARMACY PLAN BENEFITS?

CVS Caremark Members

Diabetes Products

Regular blood glucose testing is essential for people with diabetes. One of the best ways to manage diabetes is to check blood sugar every day with a blood glucose meter. **The Diabetic Meter Program** provides eligible members with a no-cost blood glucose meter. The meters are funded by LifeScan Inc. the manufacturer of your prescription benefit plan's preferred glucose meters (One Touch).

To find out if you qualify for this benefit call the CVS Caremark Member Services Diabetic Meter Team toll-free at 1-800-588-4456.

Tobacco Cessation Products

Tobacco cessation products are provided as a plan benefit to support our members to quit smoking. CVS Caremark provides education and plan recommendations for certain products at low cost to members such as nicotine patches and other prescription medications.

To learn more about this program and covered medications call CVS Caremark customer service center 24/7 at 1-855-801-8263.

FOR MEDICARE RETIREES AND THEIR DEPENDENTS
Medicare Prevention & Wellness Benefits

Under the Affordable Care Act (the health care reform law), Medicare pays for an annual wellness visit, which includes the creation of a personalized prevention plan and detection of possible cognitive impairment.

During the first 12 months that you have Medicare Part B, you can get a "Welcome to Medicare" preventive visit. This visit includes a review of your medical and social history related to your health, and education and counseling about preventive services, including certain screenings, shots, and referrals for other care, if needed.

If you've had Medicare Part B for longer than 12 months, you visit your primary care provider for an annual "Wellness" visit to develop or update a personalized plan to prevent disease or disability based on your current health and risk factors. This visit is covered once every 12 months.

- Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit. The questions are based on years of medical research and advice from the Centers for Disease Control and Prevention.
- You pay nothing for the yearly "Wellness" visit or the "Welcome to Medicare" preventative visit if the doctor or other qualified health care provider accepts assignment.

MONEY SAVING TIPS

Properly using your EUTF health insurance coverage can save you and your family hundreds or even thousands of dollars. Making simple, cost effective decisions and being aware of how to effectively use your benefits will also keep you healthy while saving you $$. Start using the following information today:

Pick the Right Facility

If you have a nagging cough, do not go the Emergency Room (ER). The ER should be reserved for serious emergency situations.

If you have a non-emergency illness or injury, go to your regular doctor or an urgent care clinic. For example, the total cost of a typical office visit is around $100 while an emergency room visit could cost upwards of $1,000

Other options include Kaiser or HMSA's online or telephonic care and clinics such as the CVS Minute Clinic.

Participating Providers

Going to a non-participating doctor can be, in some cases, more than twice as expensive as going to a participating provider. Seeing doctors in your network is an easy way to keep your costs low.

TIPS FOR USING YOUR PRESCRIPTION DRUG BENEFITS

All Plan Members

There are a number of ways to save money on your prescription drug costs. One of the easiest and most cost effective ways is to ask your prescribing doctor if you can switch to a generic drug. Taking a brand name drug over a generic can end up costing you three or four times more per year. For example, if you are on Crestor ask your prescribing doctor if you can switch to rosuvastatin or another generic equivalent. Doing so could save you up to $300 annually per prescription. Additionally, these changes could potentially save the EUTF hundreds of thousands of dollars annually which would result in lower plan premiums.

Another great way to save money is by switching to mail order. In addition to saving money, mail order offers the added convenience of receiving your prescriptions at your doorstep saving you time and money by not having to make regular trips to the pharmacy. For more information visit caremark.com or call CVS Customer Care at 1-855-801-8263. For Kaiser members, if you have not done so already, you'll need to register for a secure kp.org account in order to refill prescriptions online. You also can set up mail-order services when you visit your Kaiser Permanente or call the number on the prescription label.

Retiree and Dependent Eligibility

Eligibility for coverage is determined by Hawaii Revised Statutes and by the EUTF Administrative Rules adopted by the EUTF Board of Trustees. Requests for enrollments, terminations, and other changes must be submitted directly to the EUTF. If you have any questions concerning eligibility provisions, you should refer to the EUTF Administrative Rules posted on the EUTF website at eutf.hawaii.gov.

You may also call EUTF Customer Service at 808-586-7390 or toll free at 1-800-295-0089 or email your inquiry to eutf@hawaii.gov.

Retiree Eligibility: The following persons are eligible to enroll in the benefit plans offered or sponsored by the EUTF for Retirees:

- A retired employee. You do not need to be covered under an EUTF or HSTA VB Active Employee Plan at the time of retirement to be eligible to enroll in the EUTF or HSTA VB retiree plans. EUTF must receive a copy of your Employees' Retirement System (ERS) Retirement Estimate letter which indicates your ERS membership date and your earned membership service for retirement eligibility.
- The surviving spouse, Domestic Partner or Civil Union Partner (DP/CUP) of a deceased retired employee, provided the spouse or DP/CUP does not remarry or enter into another domestic or civil union partnership.
- The unmarried child of a deceased retired employee, provided the child is under age 19 with no surviving parent.

Dependent Eligibility: The following persons are eligible for coverage as dependents in the benefit plans offered or sponsored by the EUTF for Retirees:

- The Retiree's legal spouse, Domestic Partner or Civil Union Partner (DP/CUP).

  Note: A spouse or DP/CUP who is eligible for Medicare must be enrolled in Medicare Part B to be covered by an EUTF or HSTA VB retiree medical and/or prescription drug plan.
- You and/or your spouse's or DP's/CUP's unmarried children under age 19. This includes children by birth, marriage or adoption. Dependent children by legal guardianship are covered to age 18.
- You and/or your spouse's or DP's/CUP's unmarried children under the age of 24 provided they are full-time students attending an accredited school, college, university or technical school. This includes children who are away at school and dependent upon you for support.
- An unmarried child, regardless of age, who is incapable of self-support because of mental or physical incapacity that existed prior to the child reaching the age of 19.
- An unmarried child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order (QMCSO).

NOTE: The Affordable Care Act, including the dependent eligibility provisions extending coverage to age 26, does not apply to retiree-only plans such as the EUTF or HSTA VB retiree plans. For more information on this, please refer to Healthcare.gov.

Special Eligibility Requirements for Domestic and Civil Union Partners

Domestic Partner: Person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

1. Intends to remain in a domestic partnership with each other indefinitely.

2. Have a common residence and intend to reside together indefinitely.
3. Jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care.
4. Neither are married or a member of another domestic or civil union partnership.
5. Not related by blood in a way that would prevent them from being married to each other in the State of Hawaii.
6. Both at least 18 years of age and mentally competent to contract.
7. Consent to the domestic partnership has not been obtained by force, duress or fraud.
8. Both sign and file a declaration of domestic partnership (affidavit) with the EUTF.

Civil Union Partner: A person who has entered into a civil union partnership under the rules established by the State of Hawaii Department of Health.

NOTE: There may be Federal and State Income Tax consequences with employer paid coverage for domestic partners. There may be Federal Income Tax consequences with employer paid coverage for civil union partners. If your domestic partner or civil union partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic partner will be deemed taxable income and reported to you on the appropriate federal or state tax form. If your civil union partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your civil union partner will be deemed taxable income and reported to you on the appropriate federal tax form. Consult your tax advisor to determine your domestic or civil union partner's status. If you determine that your domestic partner or civil union partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available along with information/instructions on the EUTF website at eutf.hawaii.gov) to the EUTF.

Enrollment

To enroll you must complete an EC-2 Enrollment Form (or EC-2H to make changes only for HSTA VB enrollees) (see the perforated pages at the end of this Guide). The plan year for retiree plans begins January 1 and ends December 31 of each year.

Retirees who are already enrolled in HSTA VB plans who change to the EUTF plans may NOT change back to HSTA VB plans in the future. Additionally, retirees enrolled in the HSTA VB plans may not enroll in some HSTA VB plans and some EUTF plans – they must be enrolled in all HSTA VB plans or all EUTF plans.

ID Cards
After you enroll for the first time, you will receive identification cards from the plans as follows:

- CVS Caremark, SilverScript and HDS issues ID cards showing the name of the subscriber.
- HMSA, Kaiser and UHC issue an ID card for each enrolled member of a family upon initial enrollment.
- ChiroPlan Hawaii under Royal State National, USAble Life and VSP do not issue ID cards. ID cards are not required to obtain services.

Dual Family Enrollment (Two EUTF (or HSTA VB) Retiree Two-Party or Family Enrollments) Is Not Allowed

No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled by more than one retiree/active employee (dual enrollment). In addition, if you and your spouse/DP/CUP are both retirees/active employees, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. However, both retirees/active employees are able to select EUTF Self-only plans.

Special Enrollment Period Due to a Qualifying Event (See Common Qualifying Events That Allow Enrollment Changes for Retirees section of this Guide.)

You are eligible to make changes other than during the Open Enrollment period for the following reasons:

1. You marry and want to enroll your spouse and/or newly eligible dependent children. A copy of your marriage certificate is required.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide appropriate documents verifying the adoption in order to have the application accepted. To enroll a newborn you do not need to attach a copy of the birth certificate or submit the Social Security Number with your EC-2 or EC-2H form. A copy of the birth certificate is required only if the child has a different last name from the retiree. A Social Security Number is required within 60 days of submitting your enrollment form to the EUTF.
3. You have a change in family status involving the loss of eligibility of a family member (e.g., legal separation; divorce; death; child marries, no longer lives with you, loses student status or turns age 19 or 24 if a student).
4. Your spouse's, DP's/CUP's, or eligible dependent's employment status changes resulting in a loss of health coverage. Submit a copy of the Loss of Coverage letter from the previous employer/plan detailing the type of coverage lost (e.g. medical, dental, prescription drug, vision), the effective date of the loss of coverage, and the name(s) of dependent(s) who lost the coverage.
5. If you and/or your dependents acquire coverage through a non-EUTF employer or Medicaid plan you have 30 days from the effective date of the other coverage to disenroll from the EUTF plans. You must provide the EUTF with a copy of a letter from the new employer/plan detailing the type of coverage acquired (e.g. medical, dental, prescription drug, vision), the effective date of coverage, and the name(s) of covered dependent(s).
6. You move out of your plan's service area.

To change your coverage, you must complete the EC-2 or EC-2H Enrollment form and submit it to the EUTF within 30 days of the date of the event, except in the case of birth where you have 180 days to submit your EC-2/EC-2H Form. Generally, deletion of dependents is effective on the first day of the first pay period following the occurrence of the event. Dependent children are automatically terminated as of the end of the pay period they attain age 19, or 24 if they are full-time students, and do not require the completion of an EC-2/EC-2H form to delete coverage.

Certain qualifying life events allow for a selection of the Coverage and Premium Contribution Start Dates. These events include: Adoption, Birth, Guardianship, Marriage, New Domestic Partner, New Civil Union Partner, Newly Eligible Student and Placement for Adoption.

End of Coverage
Common situations resulting in the loss of coverage are:

1. You do not make required premium payments (if applicable).
2. You die, subject to exceptions for your surviving spouse or DP/CUP and unmarried children under age 19.
3. You fail to comply with the EUTF Administrative Rules.
4. You file fraudulent claims.
5. Your surviving spouse or DP/CUP remarries.

Coverage for your dependents will end if:

1. Your dependent is no longer eligible for coverage such as due to a divorce, legal separation or overage children.
2. Your surviving spouse or DP/CUP partner remarries, or enters into a new partnership.

Effective Date of Termination
In general, when an event causes you or your dependent's coverage to terminate, such termination will be effective on the first day of the first pay period following the occurrence of the event (e.g., divorce, end of domestic or civil union partnership, death, surviving spouse remarries, or child ceases to be eligible for coverage). There may be certain instances in which the effective date of termination is different. You may obtain additional information by referring to the EUTF Administrative Rules that are posted on the EUTF website at eutf.hawaii.gov.

Rejection of Enrollment
Enrollment in EUTF or HSTA VB benefit plans is contingent on meeting all eligibility criteria detailed in the EUTF Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required.

An enrollment application shall be rejected if:

1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
2. The application is not filed within the time limitations prescribed by the EUTF Administrative Rules;
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The retiree owes past due contributions or other amounts to the EUTF;
5. Acceptance of the application would violate applicable federal or state law or any other provision of the EUTF Administrative Rules; or
6. Centers for Medicare and Medicaid Services (CMS) deems you not eligible.

Retirees will be notified of the rejection of any enrollment application.

MEDICARE AND ENROLLMENT IN EUTF OR HSTA VB PLANS

Medicare eligible retirees and their dependents (spouse/DP/CUP/disabled child) must enroll in Medicare Part B to be covered under an EUTF or HSTA VB retiree medical and/or prescription drug plan.

Medicare Part B Premium Reimbursement
Retirees and their eligible spouse or DP/CUP who are enrolled in Medicare Part B and are paying Medicare Part B premiums are eligible for Medicare Part B premium reimbursements. This does not apply to dependent children or active employees and their dependents covered by EUTF or HSTA VB active employee plans. However, if you are an active employee enrolled in Medicare Part B and covered by an EUTF or HSTA VB **retiree** plan through your spouse or DP/CUP, your spouse or DP/CUP is entitled to Medicare Part B reimbursement for you. Note: If your Medicare Part B premium is being paid by another entity, such as the Medicare Savings Program, you are not eligible for a reimbursement from EUTF.

For additional information on Medicare and EUTF or HSTA VB plans, please refer to the sections for Medicare eligible participants, which are included at the end of the Guide:

- EUTF Medicare Part B Reimbursement
- EUTF and HSTA VB Medicare Part D Prescription Drug Plan

Checklist for New Retirees

IMPORTANT
PLEASE READ

1. **Applying for your EUTF Retiree Health Insurance Benefits:**
   The EUTF administers your health and life insurance benefits. After filing your retirement application with the Employees' Retirement System (ERS), please submit an EC-2 form to the EUTF to enroll in your retiree health and life insurance benefits plans. EUTF also requires a copy of your ERS Retirement Estimate Letter.

2. **Completing the EC-2 Enrollment Form:**
   Instructions on how to complete the EC-2 form can be found in the back of this Guide. Complete the EC-2 form, sign and submit it to the EUTF within 60 days of your retirement date. Do not submit the EC-2 form until you are certain that you are going to retire.

3. **EUTF rules:**
   EUTF rules specify that if both you and your spouse, domestic partner (DP), or civil union partner (CUP) are employees and/or retirees of the State of Hawaii or one of the Counties, you may enroll in one Family or 2-party plan, or two Self-plans.

   If your spouse, DP, or CUP is an employee of the State of Hawaii or one of the Counties and you are going to cover your spouse, DP, or CUP on your retiree plan, your spouse, DP, or CUP must notify his/her Department Personnel Officer or enrollment designee to cancel his/her active employee plans.

   If your spouse, DP, or CUP is a retiree of the State of Hawaii or one of the Counties and you are the only dependent listed on your spouse/partner's retiree plan, you may split your plans and enroll in two Self-only plans or enroll in a 2-party plan. Please check the rates located in the back section of this Guide to determine which option is less costly. If you and your spouse/partner decide to enroll in two Self-only plans, you will both have to fill out an EC-2 form to enroll into Self-only plans. In addition, both you and your spouse/partner should enroll in the life insurance plan which is paid for by the employer for retirees only.

4. **Federal Medicare Part B (Age 65 or qualified disabled):**
   If you and/or your eligible dependent are eligible for Medicare at the time of your retirement, you must provide EUTF a copy of your Medicare card showing enrollment in Medicare Part B in order to be covered under the EUTF retiree medical and/or prescription drug plans. If you do not provide proof of Medicare Part B enrollment within 60 days of your retirement date you and/or your dependent(s) medical and/or prescription drug plan will be cancelled.

   Retirees and/or their eligible spouse, DP, or CUP that are enrolled in Medicare must also submit a completed Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement form, and letter from the Social Security Administration indicating your Medicare Part B premium amount. Forms may be found on the EUTF website at eutf.hawaii.gov.

Medicare Part B premium is reimbursable to all retirees and their spouse/partner, provided you are paying for your Medicare Part B premium and it is not being paid by another entity such as the Medicare Savings Program or Medicaid. Reimbursement begins the effective date of your Medicare Part B coverage or the first of the month that you provide EUTF with a copy of your Medicare Part B card, whichever is later.

5. **Canceling your Retirement:**
   If you decide to cancel your retirement or change the date of your retirement, you must notify your Department Personnel Officer or enrollment designee immediately and have them send EUTF an EC-1 (or EC-1H form for HSTA VB) form to re-activate your employee plans.

6. **Life Insurance**:
   If you wish to update your beneficiary or if you are enrolling into the EUTF or HSTA VB Life Insurance Plan for the first time, please complete a USAble Life Beneficiary Designation Form which can be found on the USAble Life website at www.usablelife.com/portal/eutf.

7. **Questions:**
   If you have any questions regarding claims or benefit information, please contact the insurance carriers listed in the back of this guide.

8. **EUTF Contact Information:**

Location:	201 Merchant Street, City Financial Tower, Suite 1700
Mailing Address:	P. O. Box 2121, Honolulu, HI 96805-2121
Telephone:	808-586-7390 or Toll-free 1-800-295-0089
Email:	eutf@hawaii.gov
Website:	eutf.hawaii.gov

Premium Payment – Determination of Employer Contribution for Retiree Plans

The amount of the employer premium contribution is determined by statute and is based on three factors:

- Date the employee was hired
- Length of service taking into account breaks in service
- The Base Monthly Contribution (BMC) amount, which determines the maximum amount the employer will contribute towards your retiree coverage.

Certification of the retiree's membership date and length of service is provided by the Employees' Retirement System (ERS) and will help determine what percentage of the BMC will be available for a retiree to cover plan premiums. You will need to provide EUTF with a copy of the ERS Retirement Estimate letter.

The BMC may be adjusted every January 1st depending on the percentage increase or decrease in the Medicare Part B premium rate from the previous year.

The percentage determined by the retiree's years of credited service and membership date is multiplied by the BMC to determine the monthly employer contribution. The retiree pays the difference between the total monthly premium for the plans selected and the amount of the employer contribution set by the BMC calculation.

It is important to note that plan premiums usually increase each year and at some point some plans rates may exceed 100% of BMC. All retirees including those in the 100% category should review the plan premium rates and the BMC amount annually to determine if they will be required to contribute to the cost of coverage.

The Base Monthly Contribution is more fully described in Chapter 87A, Hawaii Revised Statutes (HRS).

Years of Credited Service (excluding sick leave)	**Employer's Contribution Percentage of the Base Monthly Contribution* If You Were Hired:**		
	On or Before 6/30/96	**On or Between 7/1/96 – 6/30/01**	**On or After 7/1/01****
Less than 10 years	50%	0%	0%
10 yrs less than 15	100%	50%	50%
15 yrs less than 25	100%	75%	75%
25 yrs or more	100%	100%	100%

*The Employer's percentage of the Base Monthly Contribution for the year determines the maximum employer contribution payable. Any difference between the employer contribution and total premium for plans selected will be paid by the retiree.

**If you were hired on or after 07/01/01, the monthly employer-sponsored contribution will be applied to the self only BMC.

Administrative Appeals (not related to Claim Filing and Appeals Information for Self-Insurance Plan Administered Benefits)

Under EUTF Administrative Rule 2.04, a person aggrieved by one of the following decisions by the EUTF may appeal to the EUTF Board of Trustees (Board) for relief from that decision:

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF.

The first step in the appeal process is an appeal to the EUTF Administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the EUTF's office within one hundred and eighty days (180) of the date of the adverse decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the Administrator nor the Board shall be required to hear any appeal that is filed after the one hundred and eighty day (180) period has expired. The written appeal need not be in any particular form but should contain the following information:

1. The aggrieved person's name, address, and telephone number;
2. A description of the decision with respect to which relief is requested, including the date of the decision;
3. A statement of the relevant and material facts; and
4. A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

If the aggrieved person is dissatisfied with the Administrator's action or if no action is taken by the Administrator on the aggrieved person's written appeal within thirty (30) days of its being filed in the EUTF's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the Board. A written appeal to the Board must be filed in duplicate in the EUTF's office within ninety (90) days of the Administrator's actions. If no action is taken by the Administrator within thirty (30) days of the written appeal to the Administrator being filed in the EUTF's office, then the written appeal to the Board must be filed in duplicate in the EUTF's office within one-hundred twenty (120) days of the written appeal to the Administrator being filed in the EUTF's office. The written appeal need not be in any particular form but shall contain the following information:

1. The aggrieved person's name, address and telephone number;
2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;
3. A description of the decision with respect to which relief is requested, including, the date of the decision;
4. A complete statement of the relevant and material facts;
5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the Board may reject any appeal that does not contain the foregoing information.

The Board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

The Board shall grant or deny the appeal within forty-five (45) days of the date of the postmark of the request for appeal. The Board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the Board may set such hearing before the Board, a special, or standing committee of the Board, a hearings officer, or any other person or entity authorized by the Board to hear the matter in question. Please note that nothing in the EUTF Administrative Rules shall require the Board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the EUTF Administrative Rules by submitting such a waiver in writing to the EUTF's office. The Board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

For emergency appeals of eligibility, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

Retiree Benefit Plan Summaries

The following section provides condensed summaries of the health plans and life insurance coverage available for retirees. Remember that certain limitations and exclusions apply to all insurance plans. More complete information on the plans can be obtained directly from the carriers or from the EUTF website at eutf.hawaii.gov. If there should be any discrepancy between the information provided in this Reference Guide and that contained in the carriers' Guide to Benefits, the language in the carriers' Guide to Benefits will take precedence.

Medicare has a significant impact on EUTF and HSTA VB medical and prescription drug plans; therefore, there are two sections of information in this guide:

- Non-Medicare Retirees or Dependents: Medical and Prescription Drug Plans
- Medicare Retirees or Dependents: Medical and Medicare Part D Prescription Drug Plans

Please refer to the section that applies to your Medicare enrollment status.

Following the Medicare Part D prescription drug section there is additional information on Medicare enrollment and how you may be reimbursed for your Medicare Part B premium.

Dental, Vision and Life Insurance plans are the same for Medicare and non-Medicare retirees. The plan summaries for these plans follow after the Medicare information.

Medical Plan Options

Understanding the Plan Designs

The EUTF offers the following medical plan options:

- Preferred Provider Organization (PPO) Plans:
  - HMSA 90/10 PPO plan
  - UnitedHealthcare Group Medicare Advantage (PPO) plan (available only to those enrolled in Medicare Part A & B)
- Health Maintenance Organization (HMO) Plans:
  - Kaiser Comprehensive HMO /Senior Advantage Plan (includes Kaiser Prescription Drug)

Preferred Provider Organization Plans (PPO): A PPO plan is a medical plan that is based on a network of preferred medical providers who have contracts with the carrier. Coverage is also provided if you go to a provider who is not in the network. A PPO plan gives you the flexibility to visit the providers you choose – inside or outside of the Plan's network. With the HMSA PPO plan, your out-of-pocket medical costs will likely be lower if you receive care from an in-network provider or facility. The numbers in the plan title – 90/10 – refer to the percent of the eligible charges that the plan pays for most network services – 90% – and the amount the retiree is responsible for – 10%. It's important to note that when you participate in a PPO, you are responsible for asking if your medical provider is in the network or not. With the HMSA PPO plan, if you use an out-of-network provider, your out-of-pocket costs may be higher. Also, you'll often be responsible for submitting your own claims. Services provided by an out-of-network provider will impact your total cost. In addition to possible higher copayments, you are responsible for the difference between the provider's billed charge and the plan's eligible charge.

For Medicare-eligible retirees, the UnitedHealthcare Group Medicare Advantage PPO plan works differently. With this PPO plan, you pay the same copay or coinsurance for **both** in- and out-of-network services. You can use any provider anywhere in the United States as long as they participate in Medicare and accept payment from UnitedHealthcare. In most instances, out-of-network providers are willing to submit claims directly to UnitedHealthcare for payment. However, on occasion, it may be necessary for you to submit your own claim and receive reimbursement from UnitedHealthcare.

Health Maintenance Organization (HMO): Under an HMO, you agree to use the health care professionals and facilities associated with that HMO. Except in emergencies, HMO's do not cover the cost of services you receive from doctors or other providers outside of the HMO's network. With an HMO, there are no claim forms. You must select a Primary Care Physician to coordinate your care.

Retirees and their dependents eligible for Medicare who are enrolled in the EUTF's Kaiser Comprehensive HMO plan are required to enroll in the EUTF Kaiser Senior Advantage plan. Please contact Kaiser Permanente at 808-432-5250 (Oahu) or Toll-free at 1-800-966-5955 (neighbor islands) for more information and to learn how to enroll into the Kaiser Senior Advantage plan.

Important Information for Out-of-State Retirees Enrolled in Kaiser Permanente Medical Plan

Act 167, 2006 SLH changed the contribution method for health insurance premiums for retirees outside of Hawaii effective July 1, 2007. The EUTF no longer offers group coverage for Kaiser Permanente members residing on the mainland. However, you may be able to enroll in an individual Kaiser Permanente medical plan of your choice if one is available in your area. You will be

reimbursed for the premiums paid for an individual health insurance policy with Kaiser Permanente. Each Kaiser Permanente region has individual conversion options which ensure continuous coverage with no break in coverage and no medical screening. Rates and benefits vary by region.

Your premium reimbursement will be the lesser of:

(1) The actual cost of the personal health insurance policy; or

(2) The amount of the State of Hawaii or county contribution for the most comparable Kaiser health benefits plan.

Reimbursements are paid by the EUTF on a quarterly basis upon receipt of documentation that the premiums for an individual health insurance policy have been paid by the employee-beneficiary.

If you feel you need coverage outside of the State of Hawaii due to relocation, or if you spend longer periods of time out of state, you should consider enrolling in the EUTF's PPO plans administered by HMSA or UHC during open enrollment.

Chiropractic Plan Benefits: HSTA VB PLAN ONLY

Chiropractic benefits are not offered under the EUTF retiree plans. HSTA VB retiree medical plans include chiropractic coverage under Royal State National Insurance Company, Ltd., through ChiroPlan Hawaii, Inc.

The plan benefit includes the initial exam, any necessary x-rays (when taken in a ChiroPlan provider's office), therapeutically necessary chiropractic treatment and therapeutic modalities. The copayment is $12 per visit up to 20 visits per calendar year. Visits must be therapeutically necessary and chiropractic services must be received from a credentialed ChiroPlan Provider. A complete list of ChiroPlan providers and plan information may be obtained from the EUTF website at eutf.hawaii.gov. Please refer to the plan certificate for complete information on benefits, limitations and exclusions.

Medical Plan Coverage Chart (HMSA and Kaiser) – EUTF

This summary chart is intended to provide a condensed summary of plan benefits. Certain limitations, restrictions and exclusions apply. For complete information on plan benefits, please refer to the HMSA or Kaiser Guide to Benefits, which may be obtained from HMSA or Kaiser directly or from the EUTF website at eutf.hawaii.gov. In the case of a discrepancy between the information provided in this Reference Guide and that contained in the carriers' Guide to Benefits, the language in the carriers' Guide to Benefits will take precedence.

SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN Benefits will be administered as described in each plan's documents.			
Plan Provisions	**HMSA PPO**		**Kaiser HMO**
General			
Calendar Year Deductible Single/Family	$100 per person Maximum $300 per family		None/None
Calendar Year Out-of-Pocket Limit Single/Family	$2,500 per person Maximum $7,500 per family		$2,000 per person Maximum $6,000 per family
Lifetime Benefit Maximum	None		None
	Your Copayment		
	In-Network	**Out-of-Network**	
Physician Services			
Primary Care Office Visit	10%*	30%	$15
Specialist Office Visit	10%*	30%	$15
Annual Wellness Visit (Covered under Medicare for Dependents with Medicare)	No Charge	No Charge	No Charge
Routine Physical Exams	No Charge	30%*	No Charge
Mammography	20%*	30%*	No Charge (If Preventive)
Second Opinion – Surgery	10%*	30%	$15
Emergency Room (ER care)	10%*	10%*	$50 in area / 20% out
Ambulance	20%	30%	20%
Inpatient Hospital Services			
Room & Board	10%*	30%	No Charge
Ancillary Services	10%*	30%	No Charge
Physician Services	10%*	30%	No Charge
Surgery	10%* (Cutting)	30%	No Charge
Anesthesia	10%*	30%	No Charge
Outpatient Services			
Chemotherapy	20%	30%	$15
Radiation Therapy	20%*	30%	$15
Surgery	10%* (Cutting)	30%	$15
Allergy Testing	20%	30%	$15
Other Diag. Lab, X-ray & Psych Testing	20%*	30%	$15
Anesthesia	10%*	30%	$15
Mental Health Services			
Inpatient Care	10%*	30%	No Charge
Outpatient Care	10%*	30%	$15
Other Services			
Durable Medical Equipment	20%	30%	20%
Home Health Care	No Charge*	30%	No Charge
Hospice Care	No Charge*	Not Covered	No Charge
Nursing Facility - Skilled Care	10%*, 120 days per year	30%, 120 days per year	No Charge, 100 days per benefit period
Physical & Occupational Therapy	20%	30%	$15

*Deductible does not apply

NON-MEDICARE RETIREES

Medical Plan Coverage Chart (HMSA and Kaiser) – HSTA VB

This summary chart is intended to provide a condensed summary of plan benefits. Certain limitations, restrictions and exclusions apply. For complete information on plan benefits, please refer to the HMSA or Kaiser Guide to Benefits, which may be obtained from HMSA or Kaiser directly or from the EUTF website at eutf.hawaii.gov. In the case of a discrepancy between the information provided in this Reference Guide and that contained in the carriers' Guide to Benefits, the language in the carriers' Guide to Benefits will take precedence.

SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN Benefits will be administered as described in each plan's documents.			
Plan Provisions	**HMSA PPO**		**Kaiser HMO**
General			
Calendar Year Deductible Single/Family	$100 per person Maximum $300 per family		None/None
Calendar Year Out-of-Pocket Limit Single/Family	$2,000 per person Maximum $6,000 per family		$2,000 per person Maximum $6,000 per family
Lifetime Benefit Maximum	$2,000,000		None
	Your Copayment		
	In-Network	**Out-of-Network**	
Physician Services			
Primary Care Office Visit	10%*	30%	$15
Specialist Office Visit	10%*	30%	$15
Annual Wellness Visit (Covered under Medicare for Dependents with Medicare)	No Charge	No Charge	No Charge
Routine Physical Exams	No Charge*; limited to combined CY dollar max depending on age scale	No Charge*; limited to combined CY dollar max depending on age scale	No Charge
Mammography	10%*	30%	No Charge (If Preventive)
Second Opinion – Surgery	10%*	30%	$15
Emergency Room (ER care)	10%*	10%*	$50 in area / 20% out
Ambulance	10%*	30%	20%
Inpatient Hospital Services			
Room & Board	10%*	30%	No Charge
Ancillary Services	10%*	30%	No Charge
Physician Services	10%*	30%	No Charge
Surgery	10%*	30%	No Charge
Anesthesia	10%*	30%	No Charge
Outpatient Services			
Chemotherapy	10%*	30%	$15
Radiation Therapy	10%*	30%	$15
Surgery	10%*	30%	$15
Allergy Testing	10%*	30%	$15
Other Diag. Lab, X-ray & Psych Testing	10%*	30%	$15
Anesthesia	10%*	30%	$15
Mental Health Services			
Inpatient Care	10%*	30%	No Charge
Outpatient Care	10%*	30%	$15
Other Services			
Durable Medical Equipment	10%*	30%	20%
Home Health Care	No Charge*	30%	No Charge
Hospice Care	No Charge*	Not Covered	No Charge
Nursing Facility - Skilled Care	10%*; 120 days per year	30%; 120 days per year	No Charge, 100 days benefit period
Physical & Occupational Therapy	10%*	30%	$15

*Deductible does not apply.

NON-MEDICARE RETIREES

PPO and HMO Prescription Drug Plans – EUTF

COVERAGE	PPO Prescription Drug Plan (administered by CVS Caremark)*		HMO Prescription Drug Plan (Kaiser)
	Participating Pharmacy	Non-participating Pharmacy**	Copayment up to
RETAIL & MAIL PRESCRIPTION PROGRAM (30/60/90 day supply for CVS Caremark; 30/90 day supply for Kaiser) Maintenance medications must be filled in a 90-day supply after the first 3-30 day initial fills. +			
Generic	$5/$10/$15 copayment	$5/$10/$15 + 20% of eligible charges	$15/$30 mail only
Preferred Brand	$15/$30/$45 copayment	$15/$30/$45 + 20% of eligible charges	$15/$30 mail only
Non-Preferred Brand	$30/$60/$90 copayment	$30/$60/$90 + 20% of eligible charges	$15/$30 mail only
Specialty Drug & Injectables	20% of eligible charges; Up to $250 maximum per prescription fill; $2,000 out-of-pocket maximum per calendar year; $30 copay oral oncology specialty medications. Only dispensed up to a 30-day supply.		Specialty Drugs: $15/$30 mail- order for eligible drugs Injectables: $15 / Not available thru mail-order
Insulin			
Preferred Insulin	$5/$10/$15 copayment	$5/$10/$15 + 20% of eligible charges	$15/ Not available through mail-order
Other Insulin	$15/$30/$45 copayment	$15/$30/$45 + 20% of eligible charges	$15/ Not available through mail-order
Diabetic Supplies			
Preferred Diabetic Supplies	No copayment	$0 + 20% of eligible charges	$15/$30 mail only
Other Diabetic Supplies	$15/$30/$45 copayment	$15/$30/$45 + 20% of eligible charges	$15/$30 mail only
RETAIL 90 PHARMACY & MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)			
	Retail 90 or Mail Pharmacy	**Non-Retail 90 Pharmacy**	
Generic	$10 copayment	$15 copayment	
Preferred Brand	$30 copayment	$45 copayment	
Non-Preferred	$60 copayment	$90 copayment	
Insulin			
Preferred Insulin	$10 copayment	$15 copayment	
Other Insulin	$30 copayment	$45 copayment	
Diabetic Supplies			
Preferred Diabetic Supplies	No copayment	No copayment	
Other Diabetic Supplies	$30 copayment	$45 copayment	

*This plan is the prescription drug coverage for the HMSA PPO medical plan options and is administered by CVS Caremark.

**If you receive services from a non-participating (out-of-network) pharmacy you will pay full price for the prescription and must file a claim for reimbursement. You are responsible for the copayment + coinsurance and any cost difference between the actual charge and the eligible charge.

+Note: Maintenance medication can be filled through mail-order and at any retail network pharmacy.

NON-MEDICARE RETIREES

PPO and HMO Prescription Drug Plans – HSTA VB

COVERAGE	PPO Prescription Drug Plan (administered by CVS Caremark)*		HMO Prescription Drug Plan (Kaiser)
	Participating Pharmacy	Non-participating Pharmacy**	Copayment up to
RETAIL & MAIL PRESCRIPTION PROGRAM (30/60/90 day supply for CVS Caremark; 30/90 day supply for Kaiser)			
Generic and Insulin	$5/$9/$9 copayment	$5/$9/$9 + 30% of eligible charges	$10/$20 mail only. Insulin not available through mail-order
All Covered Brand Name	$15/$27/$27 copayment	$15/$27/$27 + 30% of eligible charges	$10/$20 mail only
Specialty Drug & Injectables	Specialty medications are subject to the applicable Brand/ or Generic copayment. Specialty drugs are not available through mail-order and only dispensed up to a 30-day supply		Specialty Drugs: $10/$20 mail- order for eligible drugs Injectables: $10 /Not available thru mail-order
Lancets, Strips and Meters	No copayment		50% coinsurance

*This plan is the prescription drug coverage for the HMSA PPO medical plan options and is administered by CVS Caremark.

**If you receive services from a nonparticipating (out-of-network) pharmacy you will pay full price for the prescription and must file a claim for reimbursement. You are responsible for the copayment + coinsurance and any cost difference between the actual charge and the eligible charge.

NON-MEDICARE RETIREES

Prescription Drug Plan Provisions – EUTF & HSTAVB

The PPO Prescription Drug plan for all **non-Medicare eligible retiree** participants includes many programs that offer a financial incentive for participants to use the generic or Preferred Brand medication without compromising care as these medications have been determined to provide the same or similar level of effectiveness. Preferred Brand medications usually are priced lower and have lower copayments than Non-Preferred Brand name medications.

Web Service
Members can register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your ID card ready. If you are not currently a member, please visit the CVS Caremark website at www.caremark.com/eutf for plan information.

Customer Care
For assistance with plan information, finding a participating pharmacy, ordering a new ID card, or refilling your mail order, call CVS Caremark toll free at 1-855-801-8263 to speak with a Hawaii representative. Representatives are available 24 hours a day, 7 days a week.

Coordination of Benefits
Some participants may be enrolled in additional prescription drug coverage outside of their EUTF or HSTA VB benefits. If this applies to you, please contact CVS Caremark Customer Care at 1-855-801-8263 to advise if your EUTF or HSTA VB plan is secondary. When you go to the pharmacy, let them know that your EUTF or HSTA VB plan is secondary and they will be able to coordinate benefits for you. You also have the option to send in a paper claim form for reimbursement. Below is a list of the required documentation to submit a paper claim for reimbursement. Please note that Coordination of Benefits does not guarantee 100% coverage of your medication. All EUTF and HSTA VB plan parameters and guidelines will still apply and may conflict with your other benefits in some cases. It is important to advise CVS customer care if you are covered under any other prescription drug coverage to ensure your prescription fills are coordinating and paying properly at the pharmacy.

Required Documentation for Paper Claims:

- Pharmacy receipt including:
  - Patient's name
  - Date of fill
  - Prescription number
  - Name of medication
  - Metric quantity
  - Day supply
  - Amount paid out-of-pocket
  - Pharmacy name & address or pharmacy NABP number
  - Prescribing physicians name or NPI
- Completed claim form with patient signature

NON-MEDICARE RETIREES

All paper claim reimbursement requests should be mailed to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Utilization Management Programs
In an ongoing effort to effectively manage the prescription drug benefit, certain medications are subject to clinical guidelines as part of the prescription benefit plan design.

EUTF and HSTA VB Non-Medicare Retirees

The prescription drug plans for EUTF and HSTA VB non-Medicare retirees include the following clinical programs:

1. **Quantity Limitations** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies and input, review, and approval from the **CVS Caremark** National Pharmacy and Therapeutics (P&T) Committee.

2. **Generic Step Therapy Program (GSTP)** – Generic Step Therapy Program (GSTP) – The EUTF encourages the use of generic medications as an alternative to certain brand medications as an affordable and effective form of treatment to many health conditions. In an effort to promote use of generic medications, CVS Caremark has a generic step therapy program in place for all non-Medicare retirees. For certain non-preferred brand drugs, GSTP may require that you try a generic drug treatment prior to the use of a brand drug. In some situations you may pay a higher copayment, please contact CVS Caremark Customer Care at 1-855-801-8263 for more information. Also see section labeled – Dispensed as Written Program (DAW 1 and/or 2) on page 32 of this guide.

3. **Prior Authorization** – Authorization process to ensure medical necessity of targeted drugs/classes before they are covered by the plan.

4. **Specialty Drug Program** – Specialty medications you receive at your doctor's office or specialty medication that is self-administered in a home setting are covered under the pharmacy drug benefit. Specialty medications you receive at an inpatient hospital setting or in a hospital based outpatient treatment center are covered under your medical plan. Specialty medications may be obtained from a specialty pharmacy or any retail pharmacy that participates in the CVS Caremark network that will supply the medication. CVS Caremark has a specialty pharmacy called CarePlus, located here in Hawaii. Members or physicians can contact CarePlus Pharmacy toll free at 1-800-896-1464 for assistance in ordering specialty medications. At your doctor's office visit, please present your ID card to your physician prior to treatment. Please refer to your medical plan description for additional information about coverage for specialty drugs.

   EUTF participates in CVS Caremark's Specialty Guideline Management (SGM) Program. SGM uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. All specialty medications require prior authorization. Physicians may call SGM at 808-254-4414 to obtain prior authorization.

NON-MEDICARE RETIREES

If you have questions about your prescription drug benefits, call CVS Caremark at 1-855-801-8263. Representatives are available 24-hours, 7 days a week to assist with your questions. You can also view the CVS Caremark Specialty Drug List found on caremark.com for a full listing of specialty therapeutic classes and medications.

EUTF Non-Medicare Retirees

In addition to the programs listed above for both EUTF and HSTA VB Non-Medicare Retirees, the following benefits and programs also apply to the CVS Caremark prescription drug plan for EUTF non-Medicare retirees only:

Dispensed as Written (DAW 1&2) Program
The Dispensed as Written Program requires that participants use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic copayment will apply. However, if a participant or their physician chooses to use a brand medication rather than the generic equivalent, then the copayment becomes the standard generic copayment plus the difference in the cost of the generic and brand medication.

Non-FDA approved topical analgesics, and high cost bulk powders and creams used in compound medications are excluded from the plan.

Voluntary Mail Order Program for Maintenance Medications
Maintenance medications are those prescriptions taken for a period of time to treat chronic conditions such as high blood pressure, diabetes, heart disease, and high cholesterol. The Maintenance Mail Order Program is voluntary, but you are still required to fill maintenance medications in a 90-day supply through the CVS Caremark Mail Order Facility or a retail pharmacy in the CVS Caremark network. Participants are allowed (3) 30-day fills at the retail pharmacy for each new medication or new dosage amount in order to determine if the medication or dosage is correct. Members that fill a 90-day supply of a maintenance medication through the mail order facility or at a Retail 90 pharmacy will pay two times the 30-day supply copayment. Members that fill a 90-day supply of maintenance medication at a non-Retail 90 pharmacy will pay three times the 30-day copayment. The cost to the plan is the lowest if you use the mail-order facility to fill your prescriptions for maintenance medications. You are encouraged to use mail order services to keep plan costs lower.

Specialty Preferred Drug Plan Design: This program requires the use of preferred specialty medications prescribed for the treatment of Multiple Sclerosis, Rheumatoid Arthritis, Hepatitis C, and Growth Hormone Therapy. For coverage of non-preferred specialty medications, your physician may call 808-254-4414 to obtain prior authorization.

Other Specialty: Medications that fall within the Tier 4 category (specialty drugs) will be subject to a 20% participant coinsurance with up to a $250 copayment maximum per prescription fill. There is a $2,000 out-of-pocket maximum per person, per calendar year for specialty drug copayments. Exception: Oral oncology medications provided under the Specialty Drug Program will have a Tier 3 copayment instead of a Tier 4 copayment.

Retail 90 Network: Effective 7/1/16, the CVS Caremark prescription plan added a Retail 90 network for EUTF non-Medicare retiree plans. Members that fill a 90-day supply of medication at a Retail 90 network pharmacy or through the mail pharmacy will pay two times the 30-day supply copayment. Members that fill a 90-day supply of medication at a non-Retail 90 pharmacy will pay three times the 30-day supply copayment.

HSTA VB Non-Medicare Retirees

In addition to the programs listed above for both EUTF and HSTA VB non-Medicare Retirees, the following program also applies to the HSTA VB non-Medicare retiree prescription drug plan:

Dispensed as Written (DAW 2) Program

The Dispensed as Written Program requires participants use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic copayment will apply. However, if a participant chooses to use the brand medication rather than the generic equivalent, then the copayment becomes the standard generic copayment plus the difference in the cost of the generic and brand medication.

MEDICARE RETIREES

Introduction to EUTF and HSTAVB Plans

The following is a brief review of Medicare coverage and enrollment. For full details, please contact the Centers for Medicare and Medicaid Services (CMS) at 1-800-MEDICARE or www.cms.gov.

What is Medicare?

Medicare is the federal health insurance program for people age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant) or amyotrophic lateral sclerosis (Lou Gehrig's disease). The program helps with the cost of health care, but does not cover all medical expenses or the cost of most long-term care.

Medicare has four parts:

- Medicare Part A – Hospital insurance that helps pay for patient care in a hospital or skilled nursing facility (following a hospital stay), hospice care, and some home health care.
- Medicare Part B – Medical insurance that helps pay for doctors' services, outpatient care, medical supplies and preventive services.
- Medicare Part C – Medicare Advantage plans are private insurance plans offered by organizations that contract with Medicare. People with Medicare Part A and B can choose to receive all of their health care services through one of these contracted organizations under Medicare Part C. Medicare Advantage also may include Medicare Part D prescription drug coverage.
- Medicare Part D – Prescription drug coverage that helps pay for medication prescribed by your doctor.

Who is eligible for Medicare?

Medicare Part A – Hospital Insurance
Medicare Part A is available at no premium cost for most people age 65 or older who are citizens or permanent residents of the United States. You are eligible at age 65 if:

- You receive or are eligible to receive Social Security benefits; or
- You receive or are eligible to receive railroad retirement benefits; or
- You or your spouse or DP/CUP (living or deceased, including divorced spouses) worked long enough in a job where Medicare taxes were paid; or
- You are the dependent parent of a fully insured deceased child.

If you do not meet these requirements, you may be able to get Medicare hospital insurance by paying a monthly premium. You can sign up for Medicare Part A when you first become eligible and after that, usually, only during designated enrollment periods.

Medicare Part B – Medical Insurance
Medicare Part B requires a monthly premium payment.
Anyone who is eligible for free Medicare Part A can enroll in Medicare Part B. However, if you are not eligible for premium-free Medicare Part A, you can still purchase Medicare Part B if you are age 65 or older and you are –

- A U.S. citizen; or
- A legal resident who has lived in the United States for at least 5 consecutive years.

You are not required to be enrolled in Medicare Part A coverage to be enrolled in Medicare Part B coverage. The monthly premium is the same for Medicare Part B whether or not you are enrolled in

Medicare Part A. Some beneficiaries with higher incomes will pay a higher monthly Medicare Part B premium.

Please note that Hawaii law requires retirees and their dependents who are eligible for Medicare Part B to enroll in order to be covered by EUTF or HSTA VB retiree medical and/or prescription drug plans.

Medicare Part C – Medicare Advantage Plans
If you have enrolled in Medicare Part A and B, you can join a Medicare Advantage plan. However, Medicare Part A is not required to enroll in the EUTF Kaiser Medical Retiree plan.

Medicare Advantage plans include:

- Medicare Health Maintenance Organization (HMO) plans;
- Medicare Preferred Provider Organization (PPO) plans;

The EUTF and HSTA VB Kaiser Medicare Retiree plan (Senior Advantage) and the EUTF UnitedHealthcare Group Medicare Advantage plan are Medicare Part C plans.

Medicare Part D – Prescription Drug Coverage
Anyone who has Medicare Part A (hospital insurance), Medicare Part B (medical insurance) or a Medicare Part C (Advantage plan) is eligible for Medicare Part D (prescription drug coverage).

Please note: The EUTF and HSTA VB retiree prescription drug plans are Medicare Part D plans and are therefore governed by Medicare rules. Medicare requires that you only be enrolled in one Medicare Part D plan at a time. Therefore, if you enroll in a non-EUTF Medicare Part D plan, you and your dependents will be cancelled from the EUTF retiree prescription drug plan. If you are enrolled in the EUTF Kaiser Comprehensive/Senior Advantage plan or UnitedHealthcare Group Medicare Advantage plan and enroll in a non-EUTF Medicare Part D plan, you and your dependents will be cancelled from the EUTF medical and prescription drug plans. HSTA VB retirees who disenroll from the HSTA VB prescription drug plan will also be cancelled from their HSTA VB medical, vision and chiro plans, which are bundled plans. If your EUTF or HSTA VB plans are cancelled you will lose the employer premium contribution and will not be able to reenroll until the next EUTF Retiree Open Enrollment or unless you experience a qualifying event.

Signing up for Medicare

When should I apply?
Medicare eligible retirees must enroll in Medicare Part B to be covered under an EUTF or HSTA VB retiree medical and/or prescription drug plan. Covered dependents (including a spouse, DP, CUP, or disabled child) must also enroll in Medicare Part B when they become eligible for Medicare, regardless of whether they are retired or actively employed, in order to be enrolled in the EUTF or HSTA VB retiree medical and/or prescription drug plans.

Retirees who are less than 65 years old: Contact Social Security three months prior to your 65th birthday.

Retirees who are 65 years or older at the time of retirement: Contact Social Security to enroll three months prior to your retirement date.

MEDICARE RETIREES

Initial enrollment period for Medicare Part B

You have a seven-month period in which to sign up for Medicare Part B (medical insurance). A delay on your part will cause a delay in coverage and result in higher premiums. If you are eligible at age 65, your initial enrollment period begins three months before your 65th birthday, includes the month you turn age 65 and ends three months after your 65th birthday.

Failure to enroll in Medicare Part B during the initial enrollment period also means you will likely need to wait until the next Medicare Part B general enrollment period which is January 1 – March 31, with an effective date of July 1.

Individuals already receiving Social Security or Railroad Retirement Board benefits at least 4 months before being eligible for Medicare and residing in the United States (except residents of Puerto Rico) are automatically enrolled in both premium-free Medicare Part A and B.

When does my enrollment in Medicare Part B become effective?

If you accept the automatic enrollment in Medicare Part B, or if you enroll in Medicare Part B during the first three months of the initial enrollment period, your Medicare Part B will start with the month you are first eligible. If you enroll during the last four months, your plan will start from one to three months after you enroll.

You must provide the EUTF with proof of your Medicare Part B enrollment within 60 days of becoming eligible. Failure to do so will result in cancellation of your EUTF or HSTA VB retiree medical and/or prescription drug plans.

Medigap & Other Medicare Advantage and Prescription Drug Plans

The EUTF or HSTA VB retiree medical and/or prescription drug plans cover many of the same benefits as a Medigap policy. Therefore, careful consideration should be taken before you enroll in a Medigap plan as enrollment in a non-EUTF Medigap or any other Medicare Advantage and Medicare Part D prescription drug plan may jeopardize your enrollment in an EUTF or HSTA VB retiree medical and/or prescription drug plan.

Medicare enrollment and Active employment

If you are covered under an EUTF or HSTA VB active employee plan, you are not required to enroll in Medicare. Medicare enrollment is only required for coverage under EUTF and HSTA VB retiree plans. However, if you are enrolled in an EUTF or HSTA VB retiree medical and/or prescription drug plan as a dependent and are eligible for Medicare Part B, you are required to enroll in Medicare B even if you are still actively working.

If during your retirement, you are actively employed and covered by another employer's health plan, you will still be required to enroll in Medicare Part B in order to continue coverage under the EUTF or HSTA VB retiree medical and/or prescription drug plans.

Medicare Premium Payment and Reimbursement

The Medicare Part B premium is usually deducted from your monthly Social Security pension. Retirees and their eligible spouse, DP or CUP are eligible for reimbursement of Medicare Part B premiums. However, if your Medicare Part B premium is paid for you from another source, such as the Medicare Savings Program, you are not eligible to receive Medicare Part B reimbursement from EUTF. Please refer to page 53 for more details.

MEDICARE RETIREES

Medical Plan Coverage Chart (HMSA and Kaiser) – EUTF

This summary chart is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions apply. For complete information on plan benefits, please refer to the HMSA or Kaiser Guide to Benefits, which may be obtained from HMSA or Kaiser directly or from, eutf hawaii.gov. In the case of a discrepancy between the information provided in this Reference Guide and that contained in the carriers' Guide to Benefits, the language in the carriers' Guide to Benefits will take precedence.

SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN Benefits will be administered as described in each plan's documents.			
Plan Provisions	**HMSA PPO**		**Kaiser HMO****
General	Your HMSA coverage coordinates with your Medicare coverage. See page 41 for examples		Kaiser Senior Advantage Plan
Calendar Year Deductible Single/Family	$100 per person, Maximum $300 per family		None/None
Calendar Year Out-of-Pocket Limit Single/Family	$2,500 per person Maximum $7,500 per family		$2,000 per person Maximum $6,000 per family
Lifetime Benefit Maximum	None		None
	Your Copayment		
	In-Network	**Out-of-Network**	
Physician Services			
Primary Care Office Visit	10%*	30%	$15
Specialist Office Visit	10%*	30%	$15
Annual Wellness Visit (Covered under Medicare for members with Medicare)	No Charge	No Charge	No Charge
Routine Physical Exams	No Charge	30%*	No Charge
Mammography	20%*	30%*	No Charge
Second Opinion – Surgery	10%*	30%	$15
Emergency Room (ER care)	10%*	10%*	$50
Ambulance	20%	30%	20%
Inpatient Hospital Services			
Room & Board	10%*	30%	No Charge
Ancillary Services	10%*	30%	No Charge
Physician Services	10%*	30%	No Charge
Surgery	10%* (Cutting)	30%	No Charge
Anesthesia	10%*	30%	No Charge
Outpatient Services			
Chemotherapy	20%	30%	$15
Radiation Therapy	20%*	30%	$15
Surgery	10%* (Cutting)	30%	$15
Allergy Testing	20%	30%	$15
Other Diag. Lab, X-ray & Psych Testing	20%*	30%	No Charge
Anesthesia	10%*	30%	$15
Mental Health Services			
Inpatient Care	10%*	30%	No Charge
Outpatient Care	10%*	30%	$15
Other Services			
Durable Medical Equipment	20%	30%	20%
Home Health Care	No Charge*	30%	No Charge
Hospice Care	No Charge*	Not Covered	No Charge
Nursing Facility - Skilled Care	10%*, 120 days per year	30%, 120 days per year	No Charge, 100 days per benefit period
Physical & Occupational Therapy	20%	30%	$15

*Deductible does not apply.

**If you and/or your dependent are Medicare eligible, you must enroll in the Kaiser Senior Advantage Plan. Contact Kaiser Permanente for information about the Senior Advantage plan benefits and how to enroll.

See examples on page 41 for integration of Medicare benefits for EUTF retirees enrolled in the HMSA PPO plan.

MEDICARE RETIREES

UnitedHeathcare Group Medicare Advantage (PPO) Plan – EUTF

What is this plan?
UnitedHealthcare is one of the largest providers of Medicare coverage and offers the Group Medicare Advantage Plan to EUTF retirees and their eligible dependents enrolled in Medicare Part A and B. The plan is a PPO plan which means that you have access to UnitedHealthcare's nationwide (Hawaii and Mainland) network of doctors and hospitals AND you can use doctors and hospitals not in UnitedHealthcare's network as long as they participate in Medicare and accept this plan.

Best of all, there is no difference in what you pay for either in-network or out-of-network services.

Other advantages of the UnitedHealthcare Group Medicare Advantage (PPO) plan

Here are some other reasons to consider the UnitedHealthcare Group Medicare Advantage (PPO) plan:

- Low plan premiums
- Benefits that go beyond Original Medicare such as:
  - Routine physical exams once per calendar year
  - Routine eye exams every 12 months
  - Routine hearing exams every 12 months
  - Hearing aid allowance of $500 every 36 months
  - A discount program that may help you save significantly on the cost of hearing aids
  - A 24-hour nurse help line to help answer your health-related questions
  - A fitness benefit to help you stay active and fit
  - A caregiver support program to make caring for a loved one easier
  - Health and wellness programs to help you manage health conditions, such as diabetes or heart disease
  - Virtual visit – see a doctor by the use of online technology and live audio/video capabilities on your laptop, desktop, tablet or smartphone 24 hours a day, 7 days a week. No copayment needed.

Other important things to know if you enroll in the UnitedHealthcare (UHC) Group Medicare Advantage (PPO) plan

- You can only be enrolled in one Medicare Advantage plan or Medicare prescription drug plan at a time.
  - If you enroll in more than one Medicare Advantage plan or Medicare prescription drug plan, you will be disenrolled in the other Medicare Advantage plan or Medicare prescription drug plan.
- If you enroll in the UHC plan and you want to cover your spouse, he/she must also enroll in the UHC plan and be enrolled in Medicare Part A and B.
- If you are enrolled in a non-EUTF Medicare Part D prescription drug plan (not an EUTF prescription drug plan) and you enroll in the UHC plan, you may be disenrolled in the individual Medicare Part D prescription drug plan.
- If you are enrolled in an HSTA VB retiree plan and change to the EUTF UHC plan you will not be allowed to re-enroll in an HSTA VB retiree plan in the future.
- The UHC plan does not include prescription drug coverage, so if you enroll in the UHC plan and want prescription drug coverage you should also enroll in the EUTF prescription drug plan.

MEDICARE RETIREES

If you plan to enroll in the UnitedHealthcare (UHC) Group Medicare Advantage (PPO) plan during <u>open enrollment:</u>

You must:

- Be enrolled in Medicare Part A and B
- Attach a copy of your Medicare card to your EC-2 Enrollment Form
- Declare whether you have End Stage Renal Disease (ESRD)

If you plan to enroll your spouse/partner:

- Your spouse/partner must be enrolled in Medicare Part A and B
- You must attach a copy of his/her Medicare card to your EC-2 Enrollment Form
- Your spouse/partner must declare whether he/she has End Stage Renal Disease (ESRD)
- Your spouse/partner must sign the EC-2 Enrollment Form

If you plan to enroll in the UnitedHealthcare (UHC) Group Medicare Advantage (PPO) plan <u>when you retire:</u>

You must:

- Be enrolled in Medicare Part A and B at your retirement date
- Attach a copy of your Medicare card to your EC-2 Enrollment Form
    - To avoid a break in coverage, your EC-2 must be signed and dated **prior** to the date of your retirement

If you plan to enroll your spouse/partner:

- Your spouse/partner must be enrolled in Medicare Part A and B at your retirement date
- You must attach a copy of his/her Medicare card to your EC-2 Enrollment Form
- Your spouse/partner must declare whether he/she has End Stage Renal Disease (ESRD)
- Your spouse/partner must sign the EC-2 Enrollment Form

MEDICARE RETIREES

Medical Plan Coverage Chart (UnitedHealthcare [UHC]) – EUTF

This summary chart is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions apply. For complete information on plan benefits, please refer to the UnitedHealthcare Medicare Advantage PPO EOC (Evidence of Coverage), which may be obtained from UnitedHealthcare directly or from eutf.hawaii.gov. In the case of a discrepancy between the information provided in this Reference Guide and that contained in the EOC, the language in the EOC will take precedence. You can also call UnitedHealthcare for a complete pre-enrollment kit.

Plan Provisions	**UnitedHealthcare Group Medicare Advantage (PPO)[3]**	
Calendar Year Deductible	$100 per person	
Calendar Year Out-of-Pocket Limit	$2,500 per person	
Lifetime Benefit Maximum	None	
	Your Copayment	
	In-Network	**Out-of-Network**
Physician Services		
Primary Care Office Visit	10%[1]	10%
Specialist Office Visit	10%[1]	10%
Annual Wellness Visit	No Charge	No Charge
Routine Physical Exams	No Charge, 1 per plan year	
General		
Mammography	20%[1]	20%
Second Opinion – Surgery	10%[1]	10%
Emergency Room (ER care)	$50[1]	$50[1]
Ambulance	20%	20%
Inpatient Hospital Services		
Room & Board	10%[1]	10%
Ancillary Services	10%[1]	10%
Physician Services	10%[1]	10%
Surgery	10%[1]	10%
Anesthesia	10%[1]	10%
Outpatient Services		
Chemotherapy	20%[1]	20%
Radiation Therapy	20%[1]	20%
Surgery	10%[1]	10%
Allergy Testing	20%[1]	20%
Other Diag. Lab, X-ray & Psych Testing	20%[1]	20%
Anesthesia	10%[1]	10%
Mental Health Services		
Inpatient Care	10%[1]	10%
Outpatient Care	10%[1]	30%
Other Services		
Durable Medical Equipment	20%	20%
Home Health Care	No Charge	No Charge
Hospice Care	No Charge	No Charge
Nursing Facility - Skilled Care	10%, 100 days per year[1]	10%, 100 days per year
Physical & Occupational Therapy	20%	20%
Routine Eye Examination every 12 months	10%[1,2]	10%[1,2]
Routine Hearing Exam – every 12 months	No Charge	No Charge
Hearing Aid Allowance – includes Digital hearing aids	$500 allowance every 36 months[1,2]	$500 allowance every 36 months[1,2]

[1] Deductible does not apply.
[2] Covered Service that does not count towards the out-of-pocket limit.
[3] Contact UnitedHealthcare for information about the Medicare Advantage PPO plan benefits and how to enroll.

MEDICARE RETIREES

Coordination of Medicare Benefits (HMSA and UHC) – EUTF

Below are example comparisons of how EUTF's Medicare plans (HMSA PPO and UHC PPO) coordinate with Medicare:

Example 1: Office Visit

Assumptions: Member went to a Participating Provider (for the UHC PPO Plan, the Provider does not have to be a Participating Provider but must accept payment from UHC), Charge is an Eligible Charge and the Provider accepts Medicare assignment. For the HMSA PPO Plan, Medicare pays at 80% after a $166.00 annual deductible (2016 deductible). For the UHC PPO Plan, for an annual wellness visit and most preventative diagnostic services, the retiree would owe $0.

Claim	Service	Date of Service	Charge	Retiree in HMSA PPO Plan Owes	Retiree in UHC PPO Plan Owes
1	Office Visit	01/02/2017	$100.00	$ 10.00	$ 10.00
	Diagnostic Test	01/02/2017	$ 66.00	$ 13.20	$ 13.20
			$166.00	$ 23.20	$ 23.20
2	Office Visit	02/02/2017	$100.00	$ 0.00	$ 10.00
	Diagnostic Test	02/02/2017	$ 66.00	$ 0.00	$ 13.20
			$166.00	$ 0.00	$ 23.20

Example 2: Hospital Stay

Assumptions: Member went to a Participating Provider (for the UHC PPO Plan, the Provider does not have to be a Participating Provider but must accept payment from UHC), Charge is an Eligible Charge and the Provider accepts Medicare assignment. For the HMSA PPO Plan, Medicare pays at 100% after a $1,288.00 annual deductible (2016 deductible) for days 1-60 (per benefit period).

Claim	Service	Date of Service	Charge	Retiree in HMSA PPO Plan Owes	Retiree in UHC PPO Plan Owes
1	Room & Board	01/02/2017	$11,000	$ 0.00	$ 1,100.00
	Anesthesia	01/02/2017	$ 4,000	$ 0.00	$ 400.00
			$15,000	$ 0.00	$ 1,500.00

Example 3: Durable Medical Equipment

Assumptions: Member went to a Participating Provider (for the UHC PPO Plan, the Provider does not have to be a Participating Provider but must accept payment from UHC), Charge is an Eligible Charge, the Provider accepts Medicare assignment and the Plans $100 annual deductible has not been met. For the HMSA PPO Plan, Medicare pays at 80% after a $166.00 annual deductible (2016 deductible).

Claim	Service	Date of Service	Charge	Retiree in HMSA PPO Plan Owes	Retiree in UHC PPO Plan Owes
1	Prosthesis	01/02/2017	$ 500.00	$ 100.00	$ 180.00

*Assumptions are used for illustration purposes only since Medicare deductibles and benefits are subject to change.

MEDICARE RETIREES

Medical Plan Coverage Chart (HMSA and Kaiser) - HSTAVB

This summary chart is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions apply. For complete information on plan benefits, please refer to the HMSA or Kaiser Guide to Benefits, which may be obtained from HMSA or Kaiser directly or from, eutf hawaii.gov. In the case of a discrepancy between the information provided in this Reference Guide and that contained in the Guide to Benefits, the language in the Guide to Benefits will take precedence.

SUMMARY OF YOUR PAYMENT OBLIGATIONS UNDER EACH PLAN Benefits will be administered as described in each plan's documents.			
Plan Provisions	**HMSA PPO**		**Kaiser HMO****
General	Your HMSA coverage coordinates with your Medicare coverage. See page 43 for examples		
Calendar Year Deductible Single/Family	$100 per person Maximum $300 per family		None/None
Calendar Year Out-of-Pocket Limit Single/Family	$2,000 per person Maximum $6,000 per family		$2,000 per person Maximum $6,000 per family
Lifetime Benefit Maximum	$2,000,000		None
	Your Copayment		
	In-Network	**Out-of-Network**	
Physician Services			
Primary Care Office Visit	10%*	30%	$15
Specialist Office Visit	10%*	30%	$15
Annual Wellness Visit (Covered under Medicare for members with Medicare)	No Charge	No Charge	No Charge
Routine Physical Exams	No Charge*; limited to combined CY dollar max depending on age scale	No Charge*; limited to combined CY dollar max depending on age scale	No Charge
Mammography	10%*	30%	No Charge
Second Opinion – Surgery	10%*	30%	$15
Emergency Room (ER care)	10%*	10%*	$50
Ambulance	10%*	30%	20%
Inpatient Hospital Services			
Room & Board	10%*	30%	No Charge
Ancillary Services	10%*	30%	No Charge
Physician Services	10%*	30%	No Charge
Surgery	10%*	30%	No Charge
Anesthesia	10%*	30%	No Charge
Outpatient Services			
Chemotherapy	10%*	30%	$15
Radiation Therapy	10%*	30%	$15
Surgery	10%*	30%	$15
Allergy Testing	10%*	30%	$15
Other Diag. Lab, X-ray & Psych Testing	10%*	30%	No Charge
Anesthesia	10%*	30%	No Charge; $15 office visit copay applies
Mental Health Services			
Inpatient Care	10%*	30%	No Charge
Outpatient Care	10%*	30%	$15
Other Services			
Durable Medical Equipment	10%*	30%	20%
Home Health Care	No Charge*	30%	No Charge
Hospice Care	No Charge*	Not Covered	No Charge, Home Care only
Nursing Facility - Skilled Care	10%*; 120 days per year	30%; 120 days per year	No Charge, 100 days benefit period
Physical & Occupational Therapy	10%*	30%	$15

*Deductible does not apply.

**If you and/or your dependent are Medicare eligible, you must enroll in the Kaiser Senior Advantage Plan. Contact Kaiser Permanente for information about the Senior Advantage plan benefits and how to enroll.

See examples on page 43 for integration of Medicare benefits for HSTA VB retirees enrolled in the HMSA PPO plan.

MEDICARE RETIREES

Coordination of Medicare Benefits (HMSA) – HSTAVB

Below are example comparisons of how HSTA VB's Medicare plans (HMSA PPO) coordinate with Medicare:

Example 1: Office Visit

Assumptions: Member went to a Participating Provider, Charge is an Eligible Charge and the Provider accepts Medicare assignment. For the HMSA PPO Plan, Medicare pays at 80% after a $166.00 annual deductible (2016 deductible).

Claim	Service	Date of Service	Charge	Retiree in HMSA PPO Plan Owes
1	Office Visit	01/02/2017	$100.00	$ 10.00
	Diagnostic Test	01/02/2017	$ 66.00	$ 6.60
			$166.00	$ 16.60
2	Office Visit	02/02/2017	$100.00	$ 0.00
	Diagnostic Test	02/02/2017	$ 66.00	$ 0.00
			$166.00	$ 0.00

Example 2: Hospital Stay

Assumptions: Member went to a Participating Provider, Charge is an Eligible Charge and the Provider accepts Medicare assignment. For the HMSA PPO Plan, Medicare pays at 100% after a $1,288.00 annual deductible (2016 deductible) for days 1-60 (per benefitperiod).

Claim	Service	Date of Service	Charge	Retiree in HMSA PPO Plan Owes
1	Room & Board	01/02/2017	$11,000	$ 0.00
	Anesthesia	01/02/2017	$ 4,000	$ 0.00
			$15,000	$ 0.00

Example 3: Durable Medical Equipment

Assumptions: Member went to a Participating Provider, Charge is an Eligible Charge, the Provider accepts Medicare assignment and the Plans $100 annual deductible has not been met. For the HMSA PPO Plan, Medicare pays at 80% after a $166.00 annual deductible (2016 deductible).

Claim	Service	Date of Service	Charge	Retiree in HMSA PPO Plan Owes
1	Prosthesis	01/02/2017	$ 500.00	$ 0.00

*Assumptions are used for illustration purposes only since Medicare deductibles and benefits are subject to change.

MEDICARE RETIREES

Medicare Part D Prescription Drug Plans – EUTF

The EUTF's Medicare Part D prescription drug plan is administered by SilverScript, the Medicare Part D administrator for CVS Caremark. This plan is the prescription drug coverage for Medicare retirees enrolled in the HMSA and UnitedHealthcare Group Medicare Advantage PPO medical plan options and for stand-alone drug coverage. The Kaiser Medicare Part D prescription drug coverage is included under the Kaiser Senior Advantage Medical Program.

COVERAGE	PPO Prescription Drug Plan (Administered by SilverScript)	HMO Prescription Drug Plan (Kaiser)
	Participating Pharmacy	Copayment up to
RETAIL PRESCRIPTION PROGRAM (30/60/90 day supply)		
Generic	$5/$10/$10 copayment	$15/$30/$45 copayment
Preferred Brand Name	$15/$30/$30 copayment	$15/$30/$45 copayment
Non-Preferred Brand Name	$30/$60/$60 copayment	$15/$30/$45 copayment
Specialty Drug	20% coinsurance Up to a $250 copay max per fill, $2,000 out-of-pocket maximum per calendar year	$15/$30/$45 copayment
Insulin		
Covered Insulin Products	$5/$10/$10 copayment	$15/$30/$45 copayment
Diabetic Supplies		
Lancets, Strips and Meters	No copayment	$15/$30/$45 copayment
MAIL ORDER PRESCRIPTION PROGRAM (30/60/90 day supply)	**SilverScript Mail Order**	
Generic	$5/$10/$10 copayment	$15/$30/$30 copayment
Preferred Brand Name	$15/$30/$30 copayment	$15/$30/$30 copayment
Non-Preferred Brand Name	$30/$60/$60 copayment	$15/$30/$30 copayment
Specialty Drug	Not Available	$15/$30/$30 copayment
Insulin		
Covered Insulin Products	$5/$10/$10 copayment	Not available through mail order
Diabetic Supplies		
Lancets, Strips and Meters	Not available through mail order	$15/$30/$30 copayment

MEDICARE RETIREES

Medicare Part D Prescription Drug Plans – HSTA VB

The HSTA VB's Medicare Part D prescription drug plan is administered by SilverScript, the Medicare Part D administrator for CVS Caremark. This plan is the prescription drug coverage for Medicare retirees enrolled in the HMSA PPO medical plan option. The Kaiser Medicare Part D prescription drug coverage is included under the Kaiser Senior Advantage Medical Program.

COVERAGE	**PPO Prescription Drug Plan (Administered by SilverScript)**	**HMO Prescription Drug Plan (Kaiser)**
	Participating Pharmacy	**Copayment up to**
RETAIL PRESCRIPTION PROGRAM (30/60/90 day supply)		
Generic and Covered Insulin Products	$3/$9/$9 copayment	$10/$20/$30 copayment
All Covered Brand Name	$9/$27/$27 copayment	$10/$20/$30 copayment
Specialty Drug	Specialty medications are subject to the applicable Brand/Generic copayment	$10/$20/$30 copayment
Diabetic Supplies		
Lancets, Strips and Meters	No copayment	20%
MAIL ORDER PRESCRIPTION PROGRAM (30/60/90 day supply)	**SilverScript Mail Order**	
Generic and Covered Insulin Products	$3/$9/$9 copayment	$10/$20/$20 copayment; Insulin not available through mail order
All Covered Brand Name	$9/$27/$27 copayment	$10/$20/$20 copayment
Specialty Drug	Not available	$10/$20/$20 copayment
Diabetic Supplies		
Lancets, Strips and Meters	Not available through mail order	20%

MEDICARE RETIREES

Medicare Part D Prescription Drug Plan Provisions – EUTF& HSTAVB

EUTF's open enrollment period for retirees is from October 10, 2016 through October 31, 2016. You will probably start receiving advertisements from other Medicare plans during this time. Please know that if you are happy with your coverage under the EUTF or HSTA VB Medicare Part D plan, you do not need to take any action. Medicare only allows you to enroll in one Medicare Part D plan. Therefore, if you enroll in a non-EUTF Medicare Part D plan, you will be terminated from the applicable EUTF or HSTA VB Medicare Part D plan or the Kaiser Senior Advantage medical and prescription drug plan and the UHC PPO medical plan, as applicable. Similarly, if you are already enrolled in a non-EUTF Medicare Part D prescription drug plan and enroll in EUTF's or HSTA VB's plan, you may be disenrolled from your non-EUTF Medicare Part D plan.

If you are currently enrolled and want to remain on your current EUTF or HSTA VB Medicare Part D plan you do not need to take action. You will remain enrolled in the EUTF or HSTA VB Medicare Part D plan.

Effective January 1, 2017, the EUTF will implement formulary (drug) changes to the PPO Prescription Drug's preferred medication list for **Medicare retiree** participants as approved by the Centers for Medicare and Medicaid Services (CMS). Formulary changes and other plan changes are outlined in the Annual Notice of Change (ANOC) that is mailed directly to you in the month of September. The ANOC serves as your official notice of plan changes and is also available online at eutf.hawaii.gov, eutf.silverscript.com, or hstavb.silverscript.com. Please take the time to thoroughly review the plan documents, and you should also refer to the Evidence of Coverage (EOC) and Abridged Formulary List for additional details on your plan benefits. You may also contact SilverScript's Customer Care at 1-877-878-5715.

The following utilization management programs are built into the EUTF and HSTA VB SilverScript plans:

Prior Authorization
You or your physician must get a prior authorization for certain drugs. This means that you will need to get approval from the plan before the plan will agree to cover the drug. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Quantity Limits
For certain drugs, the plan limits the amount of the drug that the plan will cover. For example, the plan provides 30 tablets per prescription for *Simvastatin tab 80 mg per 30 days.*

Step Therapy
In some cases, the plan requires you to first try a certain drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the plan will not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

MEDICARE RETIREES

B vs. D Determination

In most cases, medications will be covered through the Medicare D prescription drug plan. There are some medications that will be covered under the Medicare B plan. To confirm if a medication will require this determination you can reference the formulary (drug list) or by calling SilverScript Customer Care at 1-877-878-5715

Temporary Fills during the first 90-days of the plan year

If the medication you are taking is affected by the plan changes that take effect on January 1, 2017, you may be eligible for a temporary supply of your medication during the first 90-days of the plan year. The EUTF and HSTA VB SilverScript plans will allow up to 3-30 day fills or 1-90 day temporary fill during this period. The 90-day transition period will allow you to consult with your physician on getting any required approvals or review other drug therapy options. Please refer to the EOC for details temporary fills.

To avoid paying a higher out-of-pocket co-payment for non-preferred medication, participants are encouraged to speak with their physician to determine if a generic or preferred medication is appropriate for their treatment. Any change in drug therapy will be on a voluntary basis and should be discussed with a physician.

MEDICARE RETIREES

EUTF and HSTAVB Medicare Part D Prescription Drug Plan

Attention: Medicare Eligible Members
If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage through Medicare Part D. The EUTF sponsored prescription drug plan offers benefits that are as good, or better, than the standard Medicare Part D plan coverage. Your Notice of Creditable Coverage is available on the EUTF website. **If you enroll in another Medicare Part D plan, you will be terminated from the applicable EUTF or HSTA VB Medicare Part D plan or the Kaiser Senior Advantage medical and prescription drug plan and the UHC PPO medical plan, as applicable.**

The EUTF and HSTA VB Prescription Drug Plan provided for Medicare eligible retirees and/or dependents is a Medicare Part D plan. You can only enroll in one Medicare Part D plan. If you enroll in a Medicare Part D plan other than the EUTF or HSTA VB plan, your EUTF or HSTA VB prescription drug plan, and **UHC PPO medical or Kaiser Senior Advantage plan (as applicable), will be cancelled**.

The **Medicare Prescription Drug Program** (Medicare Part D) was established to provide prescription drug coverage for eligible Medicare individuals. Your employer is required to inform you whether or not your prescription drug plan is creditable or non-creditable.

Notice of Creditable Coverage (see page 72)
The EUTF is required by law to notify you regarding your rights to Medicare Part D prescription drug coverage. If you are enrolled in an EUTF or HSTA VB prescription drug plan, your prescription drug benefits are as good as or better than the standard Medicare Part D drug benefits. Prescription drug coverage through EUTF and HSTA VB plans are creditable coverage and Medicare will not penalize you if you decide to enroll in a Medicare Part D plan in the future.

If you decide to join a Medicare Part D plan, you should compare the different drugs that are available under your current plan with EUTF (or HSTA VB) and the alternative plans. Not all Medicare Part D plans cover the same drugs, nor provide the coverage at the same cost.

EUTF will enroll all Medicare eligible participants into the EUTF or HSTA VB (if applicable) Medicare Part D Prescription Drug plan. Please contact the EUTF for information on the process involved. What this means to you is, if you are a Medicare eligible participant, **you do not need to leave the EUTF or HSTA VB prescription drug plan and enroll in another Medicare Part D plan to obtain prescription drug benefits.**

For the Kaiser plan, retirees and their qualified dependents who are Medicare eligible must enroll in the Kaiser Senior Advantage Plan (unless you live in Kauai, Molokai, Lanai, and parts of Hawaii Island which include Pahala, Naalehu, and Hawaii Volcanoes National Park). Retirees and their eligible dependents will be required to complete a Kaiser Permanente Senior Advantage enrollment form and may contact Kaiser at 808-432-5955 or toll free at 1-800-966-5955. All Kaiser Medicare eligible members are enrolled in the Medicare Part D plan through Kaiser Senior Advantage.

MEDICARE RETIREES

Frequently Asked Questions and Answers:

Why do I receive communications and marketing materials for other non-EUTF Medicare Part D drug plans?
CMS allows all Medicare Part D plans to reach out to Medicare participants beginning October 15 of each year. Other Medicare Part D plans may contact you to encourage enrollment in their plan during this time, thereby disenrolling you from the EUTF or HSTA VB Medicare prescription drug plan and Kaiser Senior Advantage medical and prescription drug plan and the UHC PPO medical plan, as applicable.

EUTF does not share information about you with any other non-EUTF Medicare Part D plans.

What happens if I choose to enroll in another Medicare Part D drug plan?
If you enroll in a non-EUTF Medicare Part D plan, you will be terminated from the applicable EUTF or HSTA VB Medicare Part D plan or the Kaiser Senior Advantage medical and prescription drug plan and the UHC PPO medical plan, as applicable, because Medicare allows you to enroll in only one Medicare Part D plan. If you are enrolled in the HSTA VB plans, you will also be disenrolled from the medical, vision, and chiropractic plans which are bundled with the HSTA VB prescription drug plan.

Is the EUTF or HSTA VB Medicare plan as good as other Medicare Part D plans?
All Medicare Part D plans must offer a minimum coverage to meet the Medicare Standard Part D plan requirements. The EUTF and HSTA VB Medicare Part D plans exceed this minimum and offer participants richer, more generous coverage than the Medicare Standard Part D plan. The chart on page 52 provides a comparison of benefits under the EUTF Medicare Part D plan and a Standard Medicare Part D plan. Overall, there are no existing Medicare Part D plans that we know of that provide better coverage than the EUTF or HSTA VB prescription drug plan.

What must I do if I enroll in a non-EUTF Medicare Part D plan?
Please notify the EUTF in writing that you have enrolled in another non-EUTF Medicare Part D plan.

What if I have the Kaiser Senior Advantage medical plan?
All Kaiser Senior Advantage members are enrolled in the Medicare Part D plan through the Kaiser Senior Advantage plan. The EUTF enhances the Kaiser Medicare Part D coverage with supplemental drug benefits making Kaiser prescription drug coverage better than the standard Medicare Part D plan.

How do SilverScript and Kaiser choose prescription drugs for their preferred drug lists (formulary)?
Pharmacy Benefit Managers such as SilverScript and health plans like Kaiser Permanente have committees of pharmacists and other health care providers who continually review drug data and studies on new and existing drugs. Based on this data they create prescription drug lists of those medications that have been shown to be the most effective at the most reasonable cost for each therapeutic class of medications.

CMS requires two drugs in every therapeutic category and class. CMS thoroughly evaluates the submitted formulary design to ensure that it contains adequate access to medically necessary drugs and does not discriminate against any groups of beneficiaries.

Does the EUTF reimburse for my EUTF or non-EUTF Medicare Part D premium?
No.

MEDICARE RETIREES

What happens to my spouse's/domestic or civil union partner's EUTF or HSTA VB coverage if my spouse or DP/CUP chooses to enroll in a non-EUTF Medicare Part D plan?
Your spouse or DP/CUP will be terminated from the EUTF or HSTA VB Medicare Part D plan or the Kaiser Senior Advantage medical and prescription drug plan and the UHC PPO medical plan, as applicable.

I have multiple medical and prescription drug plans through different employers. How is it determined how much each plan pays and how much I pay?
Coordinating benefits between multiple plans follows standard nationally recognized rules for Coordination of Benefits. When Medicare is involved, the rules have been set by federal legislation which dictates when Medicare is the primary or secondary payer. Whether one plan is primary or secondary depends on the insured's status and type of plan such as active employee or retiree; insured subscriber or dependent; Medicare or non-Medicare. Additionally each drug plan may have its own rules such as requiring mail order which must be satisfied for any benefits to be available from that plan. Sometimes these rules conflict and it is not possible to receive payment from both plans. If you are currently coordinating multiple medical and drug plans please be aware that primacy rules may change and you may be subject to a copayment or coinsurance in which you weren't previously subject to.

When you and/or your dependent become eligible for Medicare and are enrolled into the EUTF or HSTA VB Medicare prescription drug (Part D) plan as well as a non-EUTF group health plan (active employer plan), your Medicare Part D plan becomes secondary coverage to the non-EUTF group health plan. Medicare Part D coverage follows federally mandated secondary payer rules that may differ from other non-Medicare plans such as the EUTF or HSTA VB non-Medicare retiree prescription drug plan, and you may find that you have to pay a copayment even though you have dual coverage (more than one drug plan). Please contact SilverScript for more information on coordination of benefits and how their plan will coordinate with your non-EUTF active employer plan.

SilverScript will send you a notice if CMS identifies that you have other prescription drug coverage and/or other health insurance coverage. This notice will require you to review and correct and misrepresented information so that SilverScript may correctly pay your claims.

I am enrolled in the Kaiser medical plan. What will happen if I enroll in a Medicare Part D plan other than Kaiser?
If you enroll in Medicare Part D with another carrier, you will be automatically terminated from the Kaiser Senior Advantage medical plan. The Medicare Part D prescription drug plan is part of the Kaiser Senior Advantage plan. You cannot have one without the other.

If I'm enrolled in the EUTF or HSTA VB Medicare Part D drug plan, am I required to get my maintenance drugs by mail order?
No.

I am a retiree enrolled in the HSTA VB plan. If I enroll in a non-EUTF Medicare Part D prescription drug plan, will I lose medical, vision, and chiropractic benefits?
Yes. These are bundled coverages and cannot be enrolled in or disenrolled from separately. Once you disenroll from HSTA VB plans, you will not be able to re-enroll in any HSTA VB plans in the future.

MEDICARE RETIREES

Is the SilverScript preferred drug list (formulary) the same as the formulary for the CVS Caremark plan for non-Medicare retirees?

No. There are prescription drugs that may not be included under the Medicare Part D plan but are covered under the EUTF or HSTA VB non-Medicare retiree plan. The formulary lists for the SilverScript plans are different from the EUTF and HSTA VB non-Medicare retiree plans. However, in April 2013, EUTF added supplemental coverage to the SilverScript plans to more closely match the formulary drug lists of the non-Medicare plans.

MEDICARE RETIREES

Table Comparison of EUTF's Prescription Drug Plans vs. a Standard Medicare Part D Plan

PLAN FEATURE	EUTF MEDICARE PART D PLAN				KAISER SENIOR ADVANTAGE PLAN
ANNUAL DEDUCTIBLE:	$0				
COPAYMENTS:	GENERIC	PREFERRED	NON-PREFERRED	INJECTABLES AND SPECIALTY	ALL
RETAIL 30 DAYS	$5	$15	$30	20%	$15
RETAIL 90 DAYS	$10	$30	$60	20%	$45
MAIL ORDER 90 DAYS	$10	$30	$60	NOT A BENEFIT	$30
SPECIALTY:	$250 MAXIMUM COPAY PER FILL				
MAXIMUM ANNUAL OUT-OF-POCKET:	AFTER A PERSON HAS SPENT $4,950* IN ELIGIBLE OUT-OF-POCKET DRUG COSTS IN A YEAR, YOU QUALIFY FOR THE CATASTROPHIC COVERAGE. PLEASE REFER TO YOUR 2017 EVIDENCE OF COVERAGE BOOKLET.				

PLAN FEATURE	STANDARD CMS APPROVED MEDICARE PART D PLAN	
ANNUAL DEDUCTIBLE:	$400	
	COST OF COVERED DRUGS	
CO-INSURANCE:	YOU PAY:	MEDICARE PAYS:
UP TO $400	100%	0%
FROM $401 TO $3,699	25%	75%
FROM $3,700 TO $4,949	100%	0%
OVER $4,950	5%	95%
MAXIMUM ANNUAL OUT-OF-POCKET:	AFTER A PERSON HAS SPENT $4,950* IN ELIGIBLE OUT-OF-POCKET DRUG COSTS IN A YEAR, MEDICARE PAYS 95% OF THE DRUG COSTS FOR THE REMAINDER OF THE YEAR.	

*$4,950 subject to change annually per CMS

EUTF Medicare Part B Reimbursement

WHAT: When you become eligible for Medicare, **you must enroll in Medicare Part B** to continue your retiree medical and/or prescription drug benefits through the EUTF. The EUTF will reimburse you quarterly for the cost of the Medicare Part B premium. These payments do not include reimbursements for any penalties by Medicare. Note if your Medicare Part B premium is being paid for by the Medicare Savings Program or some other entity, you are not eligible for a reimbursement from the EUTF.

WHO: Applies to all retirees and their eligible spouse/DP/CUP who are eligible to enroll in Medicare Part B, and for whom their Medicare Part B premium is not being paid for by another entity such as the Medicare Savings Program or Medicaid. Spouses/DPs/CUPs who are still working but enrolled in an EUTF or HSTA VB retiree medical and/or prescription drug plan as a dependent are also required to enroll in Medicare Part B.

HOW: The following must be submitted to the EUTF to receive reimbursement of Medicare Part B premiums:

1) Copy of your Medicare card showing enrollment in Medicare Part B;
2) Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement (DDA) form; and,
3) Copy of the letter you receive from the Social Security Administration indicating the amount of your monthly Medicare Part B premium.

Your reimbursement will begin the later of the start date on your card or the 1st day of the month in which the EUTF receives a copy of your card. The DDA form can be found at the back of this Guide and on the EUTF website at eutf.hawaii.gov.

FREQUENTLY ASKED QUESTIONS:

Why am I required to enroll in Medicare Part B when I am eligible?

The requirement for all State and County retirees and dependents to enroll in Medicare Part B was set forth in Act 88, 2001 Session Laws of Hawaii. This Act created Chapter 87A, Hawaii Revised Statutes (HRS), which includes the following:

> Section 87A-23(4*): "All employee-beneficiaries or dependent-beneficiaries who are eligible to enroll in the Medicare Part B medical insurance plan shall enroll in that plan as a condition of receiving contributions and participating in benefits plans under this chapter. This paragraph shall apply to retired employees, their spouses, and the surviving spouses of deceased retirees and employees killed in the performance of duty;"*

Section 87A-23(5) allows the EUTF Board to determine which retirees and dependents may continue to participate in the EUTF or HSTA VB retiree medical and/or prescription drug plans even though they are not enrolled in Medicare Part B. Under this exception, the EUTF Board has allowed the following to continue to participate in EUTF or HSTA VB retiree medical and/or prescription drug plans even if they are not enrolled in Medicare Part B: (a) retirees that attained age 65 prior to the enactment of the law that required all eligible Medicare participants to enroll in Medicare Part B; and (b) retirees who are not citizens of the United States or lawfully admitted aliens who have not lived in the United States for at least five years and are ineligible to be enrolled in Medicare.

MEDICARE RETIREES

How and when will I be reimbursed for my Medicare Part B premiums?
Under current law, the amount of your Medicare Part B reimbursement is the amount you are charged by Medicare (minus any penalties). Generally, your reimbursement will be deposited quarterly during the first week of April, July, October and January for the prior quarter. If you became eligible for Medicare Part B after July 1, 2006, your reimbursements must be direct deposited into your financial institution account. A DDA form must be submitted to the EUTF in order to receive reimbursement.

Must I sign up for Medicare Part B if I am or my spouse or DP/CUP is still working and covered by another non-EUTF employer group health insurance?
Retirees and their eligible spouse or DP/CUP must be enrolled in Medicare Part B in order to be covered under EUTF or HSTA VB retiree medical and/or prescription drug plans, regardless of if they are still actively working or covered through another non-EUTF employer group health insurance.

What will happen if my spouse, DP/CUP or I fail to enroll in Medicare Part B when eligible?
EUTF Administrative Rule 5.04 (a) states;

> *"If an employee-beneficiary becomes eligible to enroll and fails to enroll in the federal Medicare Part B medical insurance plan, the employee-beneficiary's enrollment in the medical and prescription drug plans offered or sponsored by the Fund and the medical and prescription drug plan coverages for dependent-beneficiaries under that enrollment shall be cancelled."*

If the spouse or DP/CUP fails to enroll, then only the spouse or DP/CUP will be cancelled from medical and prescription drug plans offered by the EUTF. If your spouse or DP/CUP wants to continue coverage under your retiree plan, your spouse or DP/CUP is required to enroll in Medicare Part B even if he/she is still working. If you, the retiree, fail to enroll, you and any dependents covered under your plan will be canceled from the medical and/or prescription drug plans. Enrollment in Medicare Part B is required to be enrolled under the EUTF or HSTA VB retiree medical and/or prescription drug plans.

I didn't apply for Medicare when I turned 65 even though I did not have health coverage from my job or through my spouse's or DP's/CUP's employer. What should I do?
If you missed the initial enrollment (a seven-month period starting three months before your 65th birthday and ending three months after your birth month), you may be required to wait to apply for Medicare until the general enrollment period from January through March of each year for a start date of July 1. You should contact the Social Security Administration to apply for Medicare by calling 1-800-772-1213 or visit their website at SocialSecurity.gov. You will likely pay a 10 percent Medicare Part B premium penalty for each year you delayed signing up. Your EUTF Medicare Part B reimbursements will not include payment for any penalty amounts.

Will I be charged a higher Medicare B premium if I delay Medicare Part B enrollment due to being covered under an active employee plan as the subscriber or dependent?
No. If you don't enroll in Medicare Part B when you first become eligible because you or your spouse or DP/CUP were working and had group health plan coverage through that employer, you can sign up for Medicare Part B during a special enrollment period when that coverage ends. However, you will also need to waive enrolling in EUTF or HSTA VB retiree plans since Medicare Part B enrollment is required.

MEDICARE RETIREES

If my Medicare B premium is higher than the standard amount, will EUTF reimburse that amount?

If you are notified by Medicare that your Medicare Part B premium will have an income-related monthly adjustment amount, in other words your Medicare Part B premium is higher than the standard rate due to your higher income level, you will be reimbursed at the higher amount. However, you MUST promptly* send the EUTF a copy of the letter from the Social Security Administration informing you of the higher Medicare premium. *(Within 2 years)

EUTF automatically re-sets your Medicare Part B reimbursement to the Medicare standard rate every January 1st. Every year Medicare reviews your income and sets your Medicare B premium accordingly. So, every year you must notify EUTF of your higher than standard Medicare B premium in order to receive the full reimbursement.

Where is a retiree's spouse's or DP/CUP's Medicare reimbursement deposited?

Both the retiree and spouse's or DP's/CUP's Medicare reimbursement must be deposited in the same account at the financial institution designated. The retiree must be an account holder on the designated account.

ALL RETIREES

Dental Plan Benefits (Hawaii Dental Service [HDS]) – EUTF & HSTAVB

BENEFIT	PLAN COVERS
PLAN MAXIMUM per calendar year per member (Jan 1 – Dec 31)	$2,000
DIAGNOSTIC	
Examinations - twice per calendar year	100%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	100%
Other X-rays (full mouth X-rays limited to once every 5 years)	100%
PREVENTIVE	
Cleanings – twice per calendar year	100%
• Diabetic Patients – four Cleanings or *Periodontal Maintenance per calendar year	
• Expectant Mothers – three Cleanings or *Periodontal Maintenance per calendar year	
*Periodontal Maintenance benefit level	*60%
• Fluoride (twice per calendar year through age 19)	100%
• Fluoride – high risk – once per calendar year	100%
Space maintainers (through age 17)	100%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molars with no prior occlusal restorations, regardless of the number of surfaces sealed.	100%
RESTORATIVE	
Amalgam (silver-colored) fillings	60%
Composite (white-colored) fillings – limited to the anterior (front) teeth	60%
Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	60%
Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
ENDODONTICS	60%
Pulpal therapy	
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	60%
Periodontal scaling and root planing (once every two years)	
Gingivectomy, flap curettage and osseous surgery (once every three years)	
Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	
PROSTHODONTICS	60%
Fixed bridges (once every 5 years; ages 16 and older)	
Dentures (complete and partial – once every 5 years; ages 16 and older)	
Implants Services	
ORAL SURGERY	60%
ADJUNCTIVE GENERAL SERVICES	60%
Palliative treatment (for relief of pain but not to cure)	100%

The annual plan maximum is $2,000 per calendar year for EUTF & HSTA VB retirees enrolled in the dental plan provided by HDS.

The HDS public website at www.HawaiiDentalService.com includes a section exclusively for EUTF members. In this section, you will find valuable information on your HDS dental plan including your dental benefits and plan brochure.

Sign up for an online account today to check on your eligibility for services, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, rate your dentist, and receive paperless benefit statements from the convenience of your home computer or smartphone.

To sign up for an online account and paperless benefit statements:

1) Go to www.HawaiiDentalService.com
2) Click on **"New User?"** at the top left of the screen.
3) Complete the "Member Registration" form.
4) Select **"Yes"** to "Request electronic Explanation of Benefits."
5) Click on **"Register User"** button.

Vision Plan Benefits (Vision Service Plan [VSP]) – EUTF & HSTAVB

Your coverage with VSP Doctors and Affiliate Providers:

Exam covered in full ..... every calendar year, after $10 Copay

Prescription Glasses

Lenses covered in full..... every calendar year, after $25 Copay

- Single vision, lined bifocal and lined trifocal lenses
- Polycarbonate lenses for dependent children up to age 18

Frame..... every other calendar year

- $120 allowance, plus 20% off any out-of-pocket costs
- Or $65 allowance at Costco

~OR~

Contact Lenses ..... every calendar year

- $120 allowance (applies to cost of contacts and fitting & evaluation)

Extra Discounts and Savings from VSP Doctors*

Glasses & Sunglasses

- Average 35-40% savings on all non-covered lens options (such as tints, progressive lenses, anti-scratch coatings, etc.) UV coating is covered at no extra charge.
- 30% off additional glasses & sunglasses, including lens options, from the same VSP doctor on the same day as your Exam. Or 20% off from any VSP doctor within 12 months of your last Exam.

Retinal Screening

Guaranteed pricing on retinal screening as an enhancement to your Exam.

Contact Lenses

- 15% off cost of contact lens exam (fitting & evaluation)
- VSP has partnered with leading contact lens manufacturers to provide VSP members exclusive offers. Check out www.vsp.com for details.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price from VSP-contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

**Costco Pricing applies; there are no additional discounts. All other affiliate provider locations 20% off additional glasses and 15% off contact lens services within one year. Discounts available only through a VSP Preferred Provider: LVC discounts, Retinal screening not to exceed pricing, contact lens rebates.*

You get the best value from your VSP benefit when you visit a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 12 months to submit a claim to VSP for partial reimbursement, less copays according to the following schedule:

Out-of-Network Reimbursement Amounts

Exam..... Up to $45.00	Lined Trifocal Lenses..... Up to $85.00
Single Vision Lenses..... Up to $45.00	Frames..... Up to $47.00
Lined Bifocal Lenses..... Up to $65.00	Contacts..... Up to $105.00

Before seeing an out-of-network provider, call us at 1-866-240-8420, or go on-line at www.vsp.com to search for a VSP doctor near you!

Life Insurance (USAble Life) – EUTF & HSTAVB

Your retiree life insurance benefit is $2,235.

In addition, your retiree life insurance includes the following added benefits:

- Repatriation of remains benefit – this benefit reimburses an individual who incurs expensesrelated to transporting your remains back to a mortuary near your primary place of residence if you pass away 200 miles or more away from home. The reimbursement amount is 10% of your life insurance benefit or approximately $223.

Beneficiary changes: Contact USAble Life at 808-538-8920 or toll free at 1-855-207-2021 if you would like to change your beneficiary. Changes will be effective upon receipt by USAble Life. You may download the beneficiary designation form from their website at www.usablelife.com/portal/eutf. Their office is located at 999 Bishop Street, Suite #2701, Honolulu, Hawaii 96813 and opens from 7:45 am – 4:30 pm Hawaii Standard Time, Monday through Friday, except State observed holidays.

ALL RETIREES

Common Qualifying Events That Allow Enrollment Changes for Retirees

EVENT	WHEN EC-2/EC-2H MUST BE SUBMITTED TO EUTF	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-2/EC-2H	EFFECTIVE DATE (All plans except UnitedHealthcare's Medicare Advantage Plan)	EFFECTIVE DATE (UnitedHealthcare's Medicare Advantage Plan)	CAN I CHANGE PLANS (such as Kaiser to HMSA or UHC)?
Acquisition of Coverage (Retiree or dependent gets coverage from another plan and wishes to cancel EUTF or HSTA VB plans)	Within 30 days from effective date of acquiring coverage elsewhere.	Letter from carrier or employer detailing type of coverages enrolled in (i.e., medical, drug, dental, vision), effective date of coverage, and names of covered insured and/or dependents.	End of pay period in which retiree acquires coverage from a non-EUTF plan, except when the retiree acquires coverage from the non-EUTF plan on the first or 16th of the month, in which case coverage ends at the end of the prior pay period	Disenrollment is prospective and will be determined by UHC based on the date the member signs the EC-2 form and/or the effective date of his/her Medicare Part A & B	N/A
Birth (retiree wishes to add newborn to plans)	Within 180 days from date of birth.	Birth certificate only if child has a different last name from the retiree. Social Security Number within 60 days from date of submission of enrollment.	Retiree can choose: birth date, beginning of the next pay period after birth date, or beginning of 2nd pay period after birth date	Newborns are not eligible for enrollment in UHC.	No
Adoption	Within 30 days from date of adoption.	Adoption decree	Retiree can choose: date of adoption, beginning of the next pay period after adoption date, or beginning of 2nd pay period after adoption date	Children are not eligible for enrollment in UHC unless enrolled in Medicare Part A & B	N/A
Death	As soon as reasonably practical.	Death certificate or copy of obituary as soon as available	Date of death or last day of pay period in which death occurs for dependents	Date of death	N/A
Divorce (Retiree must terminate spouse or civil union partner's coverage)	Within 30 days of date of divorce. If EC-2/EC-2H is filed more than 30 days after date of divorce, retiree is responsible for claims incurred after the date of divorce.	Pages 1 and 2 of divorce decree, along with signature page. If children are involved, those pages that outline health benefits for children	First day of the first pay period in which divorce occurs.	Cancellation will be determined by UHC based on the date EUTF advises UHC of the cancellation	No

ALL RETIREES

EVENT	WHEN EC-2/EC-2H MUST BE SUBMITTED TO EUTF	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-2/EC-2H	EFFECTIVE DATE (All plans except UnitedHealthcare's Medicare Advantage Plan)	EFFECTIVE DATE (UnitedHealthcare's Medicare Advantage Plan)	CAN I CHANGE PLANS (such as Kaiser to HMSA or UHC)?
Failure to Enroll in Medicare Part B (Retirees and their dependents who are eligible to enroll in Medicare Part B must enroll)	N/A	None	Cancellation in the medical and prescription drug plan is effective the date the retiree or dependent first became eligible to enroll in Medicare Part B	Cancellation will be determined by UHC.	N/A
Failure to Pay (Retiree owes a shortage, but does not pay shortage by due date – enrollment will	N/A	None	If enrollment is cancelled, retiree may only re-enroll during the next open enrollment period	Cancellation will be determined by UHC based on the date EUTF advises UHC of the cancellation	No
Geographic Relocation (Retiree Enrolled in Kaiser and moves to an area where Kaiser is not available)	N/A	None	The date of the retiree's relocation.	Enrollment is prospective and will be determined by UHC based on the date the member signs the EC-2 form and/or the effective date of his/her Medicare Part A & B	Yes
Ineligible Student (Dependent child is no longer a full-time student and is age 19	As soon as the dependent child is no longer enrolled as a full-time student.	None	First day of the pay period following the date the child was no longer enrolled as a full- time student	N/A	No
Legal Separation (Retiree must terminate spouse's or civil union partner's EUTF or HSTA VB coverage)	Within 30 days of date of legal separation. If EC-2/EC-2H is filed more than 30 days after date of legal separation, retiree is responsible for paying claims incurred after the date of legal separation.	Court document establishing legal separation, including any pages regarding health benefits to children	First day of the pay period following the legal separation	Cancellation will be determined by UHC based on the date EUTF advises UHC of the cancellation	No

ALL RETIREES

EVENT	WHEN EC-2/EC-2H MUST BE SUBMITTED TO EUTF	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-2/EC-2H	EFFECTIVE DATE (All plans except UnitedHealthcare's Medicare Advantage Plan)	EFFECTIVE DATE (UnitedHealthcare's Medicare Advantage Plan)	CAN I CHANGE PLANS (such as Kaiser to HMSA or UHC)?
Loss of Coverage (Retiree and/or dependent lost coverage from a non-EUTF plan, wishes to enroll in EUTF or HSTA VB plans, and for dependents the retiree is currently enrolled in an	Within 30 days from loss of other coverage.	Loss of coverage letter from previous employer/ carrier detailing type of coverages lost (i.e., medical, drug, dental, vision), date of loss of coverage, and names of any covered dependents Copy of Dependent's Medicare Part B card, if eligible to enroll	Day following loss of coverage from other plan	Enrollment is prospective and will be determined by UHC based on the date the member signs the EC-2 form and/or the effective date of his/her Medicare Part A & B	No
Marriage (Retiree wishes to enroll new spouse in EUTF or HSTA VB plans)	Within 30 days from date of marriage.	Marriage Certificate within 60 days from date of marriage Copy of Spouse's Medicare Part B card, if eligible to enroll	The date of marriage, the first day of the first pay period after the date of marriage, or the first day of the 2nd pay period after the date of marriage	Enrollment is prospective and will be determined by UHC based on the date the member signs the EC-2 form and/or the effective date of his/her Medicare Part A & B	No
New Civil Union Partner (Retiree wishes to enroll new civil union partner in EUTF or HSTA VB plans)	Within 30 days from date of civil union.	Civil Union certification (on- line proof accepted) and Affidavit of Dependency within 60 days of civil union date. Copy of Partner's Medicare Part B card, if eligible to enroll	The date of the civil union, the first day of the first pay period after the date of the Civil Union, or the first day of the 2nd pay period after the date of the Civil Union	Enrollment is prospective and will be determined by UHC based on the date the member signs the EC-2 form and/or the effective date of his/her Medicare Part A & B	No
New Domestic Partner (Retiree wishes to enroll new domestic partner in EUTF or HSTA VB plans)	Within 30 days from date of notarized signature (event date is considered date of notarization).	Notarized Declaration of Domestic Partnership and Affidavit of Dependency (notarized if IRS qualified) with EC-2/EC-2H Copy of Partner's Medicare Part B card, if eligible to enroll	The date the notary signs the Declaration of Domestic Partnership, the first day of the first pay period after the notary signs, or the first day of the 2nd pay period after the notary signs	Enrollment is prospective and will be determined by UHC based on the date the member signs the EC-2 form and/or the effective date of his/her Medicare Part A & B	No

ALL RETIREES

EVENT	**WHEN EC-2/EC-2H MUST BE SUBMITTED TO EUTF**	**DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-2/EC-2H**	**EFFECTIVE DATE** (All plans except UnitedHealthcare's Medicare Advantage Plan)	**EFFECTIVE DATE** (UnitedHealthcare's Medicare Advantage Plan)	**CAN I CHANGE PLANS** (such as Kaiser to HMSA or UHC)?
Newly Eligible (retiree wishes to enroll child because child became full-time student and is between the ages of 19 through 23)	Within 30 days from date of School start date.	Student certification from an accredited College on school letterhead with registrar's signature confirming full-time status. Transcripts not acceptable	Date child becomes full time student, or the first day of the first pay period after becoming a full-time student, or the first day of the 2nd pay period after becoming a full-time student	Students are not eligible to enroll in UHC unless enrolled in Medicare Part A & B. Enrollment is prospective and will be determined by UHC based on the date the member signs the EC-2 form and/or the effective	No
Retirement	Within 60 days from the date of the Retirement.	EC-2 form, ERS Retirement Estimate Letter, and copy of Medicare Part B card (if eligible to enroll) within 60 days from the date of retirement	Date of the Retirement, first day of the pay period following the Retirement or first day of the 2nd pay period following the Retirement	Enrollment is prospective and will be determined by UHC based on the date the member signs the EC-2 form and/or the effective date of his/her Medicare Part A & B	N/A
Surviving Spouse/Domestic Partner Remarries or Enters Into Another Domestic Partnership (surviving spouse or domestic partner	Within 30 days from the remarriage or the new domestic partnership.	None	The first day of the pay period following the remarriage or new partnership	Cancellation will be determined by UHC based on the date EUTF advises UHC of the cancellation	N/A

ALL RETIREES

EVENT	WHEN EC-2/EC-2H MUST BE SUBMITTED TO EUTF	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-2/EC-2H	EFFECTIVE DATE (All plans except UnitedHealthcare's Medicare Advantage Plan)	EFFECTIVE DATE (UnitedHealthcare's Medicare Advantage Plan)	CAN I CHANGE PLANS (such as Kaiser to HMSA or UHC)?
Termination of Domestic Partnership (Retiree must terminate domestic partner from EUTF or HSTA VB plans)	Within 30 days of termination of domestic partnership. If EC-2/EC-2H is filed more than 30 days after date of termination of domestic partnership, retiree is responsible for claims incurred after the date of termination of domestic partnership.	Declaration of Termination of Domestic Partnership with EC-2/EC-2H (forms are available on the EUTF website)	First day of the pay period following the date of the termination of the domestic partnership	Cancellation will be determined by UHC based on the date EUTF advises UHC of the cancellation	No

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Required Notices

All of the following required notices are available for viewing at EUTF's website at eutf.hawaii.gov.

If you wish to have hard copies of any of the following notices, send EUTF an email at eutf@hawaii.gov. Indicate which notice(s) you want to receive and include your name and mailing address. Or, you may call our Customer Service Call Center at 808-586-7390 or toll free at 1-800-295-0089. All requested notices will be mailed to you free of charge.

- **Qualified Medical Child Support Order** – This is to notify participants that your health insurance plan honors qualified medical child support orders (QMCSOs), which means that if a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan.

- **National Medical Support Notices** – The EUTF also honors qualified National Medical Support Notices (NMSNs), which are similar to a QMCSO, but are issued by a state agency pursuant to a medical child support order.

- **Continuation of Group Health Coverage Under COBRA: Initial Notice** – This notice includes information on the federal law, commonly known as "COBRA," that requires most employers to offer employees and their covered dependents the opportunity to elect a temporary continuation of health coverage, at group rates, when coverage would otherwise be terminated, because of a "qualifying event".

For retirees enrolled in the CVS Caremark or SilverScript prescription drug plan:

- **HIPAA Notice: Notice of Privacy Rights** – This notice describes how your prescription drug information may be used and disclosed and how you can get access to this information.

- **Notice of Creditable Coverage** – This notice has information about your current prescription drug coverage with the EUTF and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you wish to have hard copies of any of the following notices, please contact Kaiser, UHC, or HMSA (contact information included at the end of this guide).

- **Women's Health & Cancer Rights Act** – This notice includes information regarding benefits that your health insurance plan is required to provide by the Women's Health and Cancer Rights Act of 1998 for mastectomy-related services.

- **Newborns' & Mothers' Health Protection Act** – This is to notify participants that group health plans and health insurance issuers who offer group insurance coverage may not (under federal law) restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section.

- **HIPAA Notice: Notice of Privacy Rights** – This notice describes how your medical information may be used and disclosed and how you can get access to this information.

- **Patient Protection Disclosure** – This notice provides individuals with information regarding their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires

designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization.

- **Massachusetts Health Care Reform Act (for Retirees residing in Massachusetts only)** – In order to help individuals determine if the health coverage they have or intend to purchase is sufficient to satisfy the individual mandate, carriers must disclose to insureds and potential insureds a health plan's Minimum Creditable Coverage status and whether the plan satisfiesthe individual coverage mandate of the Massachusetts Health Care Reform Law.

EUTF Important Notices

*This section contains **important retiree benefit program notices** of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time to time and some of the federal notices are updated each year.*

CHANGES DURING THE PLAN YEAR TO YOUR HEALTH CARE BENEFIT ELECTIONS

IMPORTANT: After this open enrollment period is completed, generally you **will not** be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment Event or a change in Status Event during the plan year as outlined below:

- *Special Enrollment Event:*

  If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30 days** after you or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

  In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

  You and your dependents may also **enroll in this plan** if you (or your dependents):

  - have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within **60 days** after the Medicaid or CHIP coverage ends.
  - become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within **60 days** after you (or your dependents) are determined to be eligible for such assistance.

  To request special enrollment or obtain more information, contact the EUTF Office at 808-586-7390 or toll-free at 1-800-295-0089.

- *Change in Status Event During the Plan Year:*

  For changes in status events during the plan year for retirees, EUTF follows the same change options that are available to active employees. This section outlines if and when benefits can be changed in the middle of a plan year (the plan year being the period January 1 through December 31). The following events **may** allow certain changes in benefits mid-year, **if** permitted by EUTF:

  - Change in legal marital status (e.g. marriage, divorce/legal separation, death).
  - Change in the number or status of dependents (birth, adoption, death)
  - Coverage of a child due to a QMCSO.
  - Entitlement or loss of entitlement to Medicare or Medicaid.
  - Changes consistent with Special Enrollment rights.

  You must notify EUTF in writing within **30 days** of the mid-year change in status at:

  Hawaii Employer-Union Health Benefits Trust Fund
  P.O. Box 2121
  Honolulu Hawaii 96805-2121

- ***Changes in Eligibility During the Plan Year:***

  You or your Dependents must promptly furnish to the EUTF Office (at 808-586-7390 or toll-free at 1-800-295-0089) information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth or change in status of a dependent child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

  Notify EUTF preferably within **30 days**, but no later than **60 days**, after any of the above noted events.

  Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility contact the EUTF Office at 808-586-7390 or toll-free at 1-800-295-0089.

EUTF will determine if your change request is permitted and the effective date.

Failure to give EUTF a timely notice (as noted above) may:

a. cause you, your spouse and/or dependent child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a dependent child to end when it otherwise might continue because of a disability,
c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid to an ineligible person.

For questions contact the EUTF Office at 808-586-7390 or toll-free at 1-800-295-0089.

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN

Plans are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Plans are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the EUTF Office at 808-586-7390 or toll-free at 1-800-295-0089.

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Medical Plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

The prescription drug coverage under the EUTF-sponsored medical plans and the CVS Caremark and SilverScript drug plans is creditable as explained in the Plan's Medicare Part D Notice of Creditable Coverage available at the end of this Important Notice section and also available from the EUTF Office at 808-586-7390 or toll-free at 1-800-295-0089.

PRIVACY NOTICE REMINDER FROM EUTF

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

The HIPAA Privacy Notice explains how the EUTF group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in EUTF group health plan benefits. A copy of the EUTF Privacy Notice is found in the Reference Guide (see the Guide's table of contents for the exact location of the Notice). You can get another copy of the EUTF HIPAA Privacy Notice from the EUTF Office at 808-586-7390 or toll-free at 1-800-295-0089. Also, the Privacy Notice for the various insured health plans is provided to you by the insurance companies and you can get another copy of their HIPAA Privacy Notice from the insurance company by contacting the phone number on your IDcard.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, medical plan coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact your medical plan insurance company (using the phone number on your medical plan ID card) or contact the EUTF Office at 808-586-7390 or toll-free at 1-800-295-0089.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact your medical plan (at the phone number on the ID card) to precertify the extended stay. If you have questions about this Notice contact your medical plan insurance company (using the phone number on your medical plan ID card) or the EUTF Office at 808-586-7390 or toll-free at 1-800-295-0089.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) AND NATIONAL MEDICAL SUPPORT NOTICE

Your medical insurance plans honor a valid qualified medical child support orders (QMCSO) in accordance with law. A Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the Plan recognize the child as a dependent even though the child may not meet the Plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by theQMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies;and
- Identifies each health care plan to which the QMCSO applies.

A QMCSO should be provided to the EUTF office. EUTF also honors a qualified National Medical Support Notice which is similar to a QMCSO but is issued by a state agency in accordance with a medical child support order. For additional QMCSO information (free of charge) and information regarding the procedures for administration of a QMCSO, contact the EUTF Office at 808-586-7390 or toll-free at 1-800-295-0089.

COBRA COVERAGE REMINDER

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees/retirees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee/retiree, divorce/legal separation, or a child ceasing to be an eligible dependent child.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. **You may want to look for coverage through the Health Care Marketplace. See https://www.healthcare.gov/.** In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The **maximum period of COBRA coverage** is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, **you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs**. That notice should be sent to the EUTF office via first class mail (address noted below) and is to include the retiree or qualified beneficiary's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
P.O. Box 2121 Honolulu Hawaii 96805-2121

When you elect EUTF-sponsored health coverage, EUTF will provide you with a COBRA Initial Notice. If you have questions about COBRA or would like another copy of a COBRA Initial Notice please contact the EUTF Office at 808-586-7390 or toll-free at1-800-295-0089.

CAUTION: IF YOU DECLINE MEDICAL PLAN COVERAGE OFFERED THROUGH THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

If you are in a benefits-eligible position and choose not to be covered by one of EUTF or HSTA VB's medical plan options, remember that you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace (www.healthcare.gov), typically at the Marketplace annual enrollment in the fall each year.

Americans without medical plan coverage could have to pay a penalty when they file their personal income taxes. Visit the Health Insurance Marketplace for detailed information on individual shared responsibility payment penalty. If you choose to not be covered by a medical plan at this enrollment time, your next opportunity to enroll for EUTF or HSTA VB's medical plan coverage is at the next annual EUTF open enrollment time, unless you have a change in status event during the plan year that allows you to add coverage during the plan year.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

The HMO medical plan options generally require the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your medical plan at the phone number on your ID card.

Direct Access to OB/GYN Providers:

You do not need prior authorization (pre-approval) from your medical plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical plan insurance company (using the phone number on your medical plan ID card).

IMPORTANT NOTICES ATTACHED

The following pages include important notices for you and your family:

- **Medicare Part D Notice**
- **Notice about Premium Assistance with Medicaid and CHIP**

The Plan's **HIPAA Privacy notice** is located inside your Retiree Reference Guide.

Important Notice from the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) about Prescription Drug Coverage for People with Medicare

This notice is for people with Medicare.
Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with the EUTF-sponsored outpatient prescription drug plans available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

EUTF has determined that the drug coverage is "creditable" under the following prescription drug plan options:

- **CVS Caremark,**
- **SilverScript,**
- **Kaiser.**

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the Caremark administered drug plans: HMSA PPO Plan, HSTA VB HMSA PPO Plan and UnitedHealthcare Medicare Advantage Plan, as well as the Kaiser HMO Plan (as administered by Kaiser) and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

> If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.
>
> For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

If you select or keep EUTF Retiree medical plan coverage with:	What you can do:	What this option means to you:
EUTF HMSA	Select or keep EUTF prescription drug coverage through CVS Caremark and **DO NOT ENROLL in a Medicare Part D prescription drug plan.**	You will continue to be able to use your EUTF Retiree medical plan and prescription drug benefits through CVS Caremark. As long as you are enrolled in creditable drug coverage (and the EUTF prescription drug coverage through CVS Caremark is creditable), you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare Part D prescription drug plan. **WARNING:** If you enroll in a Medicare Part D prescription drug plan while you are also enrolled in an EUTF prescription drug plan through CVS Caremark you will then have two prescription drug plans and this will make you **NO LONGER ELIGIBLE for EUTF prescription drug coverage**.
	Enroll in a Medicare Part D prescription drug plan and **DO NOT ENROLL in an EUTF prescription drug plan through CVS Caremark** If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D prescription drug plan premium out of your own pocket.	Without having EUTF prescription drug plan coverage through CVS Caremark (which is creditable coverage) **you will need to enroll in Medicare Part D prescription drug plan (PDP)** to avoid having to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts; • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

If you select or keep EUTF Retiree medical plan coverage with:	What you can do:	What this option means to you:
Kaiser and **HSTA VB HMSA**	**DO NOT ENROLL in a Medicare Part D prescription drug plan** Prescription drug coverage is automatically included with the Kaiser Senior Advantage medical plan and the HSTA VB HMSA plan.	You will continue to be able to use your Retiree medical plan and prescription drug benefits through EUTF Kaiser or HSTA VB HMSA. As long as you are enrolled in creditable drug coverage (and the prescription drug coverage through Kaiser or HSTA VB HMSA is creditable) you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare Part D prescription drug plan. **WARNING:** If you enroll in a Medicare Part D prescription drug plan while you are also enrolled in a Kaiser or HSTA VB HMSA prescription drug plan you will then have two prescription drug plans and this will make you **NO LONGER ELIGIBLE for Kaiser or HSTA VB HMSA medical and prescription drug plan**.
UHC	Select or keep EUTF prescription drug coverage through CVS Caremark and **DO NOT ENROLL in a Medicare Part D prescription drug plan**	The UHC plan **does not** include prescription drug coverage, so if you enroll in the UHC medical plan and want prescription drug coverage **you should also enroll** in the EUTF prescription drug plan through CVS Caremark. As long as you are enrolled in creditable drug coverage (and the EUTF prescription drug coverage through CVS Caremark is creditable) you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare Part D prescription drug plan. **WARNING:** If you enroll in more than one Medicare Advantage plan or enroll in more than one Medicare Part D prescription drug plan, you will be disenrolled in the other Medicare Advantage plan or other Medicare Part D prescription drug plan. If you are enrolled in a non-EUTF Medicare Part D prescription drug plan (not an EUTF prescription drug plan) and you enroll in the UHC plan, you may be disenrolled from the individual Medicare Part D prescription drug plan.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number), for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamaral 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
P. O. Box 2121
Honolulu, Hawaii 96805-2121
Phone Number: 808-586-7390 or toll-free at 1-800-295-0089

As in all cases, EUTF and, when applicable, the medical plan insurance companies, reserve the right to modify benefits at any time, in accordance with applicable law. This document (dated June 25, 2015) is intended to serve as your Medicare Part D Notice of Creditable Coverage, as required by law.

PREMIUM ASSISTANCE
UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0964
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss mo.gov/mhd/participants/pages/hipp h tm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/Access Nebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473

TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since **January 31, 2016**, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

HIPAA Notice: Notice of Privacy Rules

Effective date of this notice is December 16, 2014.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

A federal law, commonly known as HIPAA (the Health Insurance Portability and Accountability Act of 1996), governs all group health plans' use and disclosure of medical information. You may find HIPAA's privacy rules at 45 Code of Federal Regulations Parts 160 and 164.

This notice describes the EUTF's privacy practices and your rights regarding the uses and disclosures of your medical information as it relates to the EUTF group health plan. The EUTF self-funded group health plan includes the Outpatient Prescription Drug Program Benefits (hereafter referred to as the "Plan") and is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**) and to inform you about the Plan's legal duties and privacy practices with respect to protected health information.

You may receive a Privacy Notice from various insured group health benefit programs. Each of these notices will describe your rights as it pertains to that plan and in compliance with the Federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information related to the EUTF benefit plan (the "Plan") and outside companies contracted to help administer Plan benefits, also called "business associates."

The EUTF acknowledges that your medical and health information is personal – and is committed to protecting your privacy.

For administration purposes, the EUTF has access to a record of your claims reimbursed under your health insurance benefits plan. This notice applies to all of the medical records that the EUTF maintains or can access. Your personal doctor, health care provider, or health insurance carrier might have different policies or notices regarding their use and disclosure of medical information that they maintain or create. However, HIPAA applies to all organizations or persons that maintain personal health information, if they fall under HIPAA's definition of "Covered Entities."

By law, the EUTF MUST:

- Make sure that medical information that identifies you is kept private,
- Give you this notice of the EUTF's legal duties and privacy practices with respect to your medical information,
- Retain copies of the notices the EUTF issues to you,
- Retain any written acknowledgments that you received the notices, or document the EUTF's good faith efforts to obtain such written acknowledgments from you,
- Follow the terms of the notice that is currently in effect, and
- Notify affected individuals following a breach of unsecured protected health information.

HIPAA also requires the EUTF to tell you about:

- The EUTF's uses and disclosures of your medical information,
- Your privacy rights with respect to your medical information,
- Your right to file a complaint with the EUTF and with the Secretary of the Department of Health and Human Services, and
- The person or office at the EUTF whom you may contact for additional information about the EUTF's privacy practices.

How the EUTF May Use and Disclose Your Medical Information

The following categories describe the different ways the EUTF may use and disclose your medical information. Some uses and disclosures of your medical information require your authorization or the opportunity to agree or object to the use or disclosure. Other uses and disclosures do not. This notice clearly identifies whether or not the use or disclosure of your medical information requires your authorization or the opportunity to agree or object. Each category contains an explanation of what is meant by the "use and disclosure" of your medical information, and some examples. Not every use or disclosure in a category will be listed. However, the ways the EUTF is allowed to use and disclose your medical information will generally fall into one of the categories listed.

The following categories DO NOT REQUIRE the EUTF to obtain your consent, authorization, or to provide you the opportunity to agree or object to the use or disclosure.

- **For Treatment**: the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under the your insurance plan. For example, the EUTF might disclose the name of your child's dentist to your child's orthodontist so that the orthodontist may ask the dentist for your child's dental X-rays.

- **For Payment**: the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health plan to coordinate benefit payments.

- **For EUTF Operations**: the EUTF may use and disclose your medical information for health care operations and other EUTF operations. These uses and disclosures are necessary to administer the EUTF benefit plans. For example, the EUTF may use and disclose your medical information to conduct or facilitate quality assessments and improvement activities, patient safety activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, enrollment, premium rating and other activities related to creating, renewing or replacing insurance contracts or benefit plans, claims review and appeals, legal functions and services, business planning and development, and other activities related to business management and administration. In connection with the foregoing, the EUTF may disclose your medical information to third parties who perform various health care operations or EUTF operations on its behalf.

- **As Required By Law**: the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF's compliance with federal privacy regulations (this notice).

- **To Avert a Serious Threat to Health or Safety**: the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

Disclosure to Business Associates: the EUTF may disclose your medical information to business associates in carrying out treatment, payment, health care operations and EUTF operations. For example, the EUTF may disclose your medical information to a utilization management organization to review the appropriateness of a proposed treatment under your insurance plan.

Disclosure to Health Insurance Companies or Health Maintenance Organizations: In carrying out treatment, payment or health care operations, the EUTF may disclose your medical information to health insurance companies or health maintenance organizations (HMOs) that it contracts with to provide services or benefits under its health benefits plans. For example, the EUTF may disclose your medical information to the Hawaii Medical Service Association, Kaiser Permanente and Kaiser Health Plan, UnitedHealthcare, Hawaii Dental Service, Vision Service Plan, Royal State National and ChiroPlan Hawaii in order to verify your eligibility for benefits or services.

Disclosure to the Plan Sponsor and Its Representatives: the EUTF is sponsored by State, county and other public employers who are represented on the EUTF's Board of Trustees. The EUTF may disclose information to the EUTF's Board of Trustees, the sponsoring public employers, and the Employees Retirement System (ERS) for payment, health care operations, and EUTF operations. For example, the EUTF may disclose information to the sponsoring employers about whether you are participating in a group health plan that is offered by the EUTF, or whether you are enrolled or disenrolled in any such group health plan. Disclosure to the sponsoring employers may include disclosures to your departmental personnel officer (DPO) or any other person who functions as your employer's personnel officer. In the event you appeal a denied eligibility issue or other matter to the EUTF's Board of Trustees, the EUTF may disclose your medical information to the EUTF's Board of Trustees and its staff, consultant, and legal counsel as may be necessary to allow the EUTF's Board of Trustees to make a decision on your appeal. The EUTF may also disclose your medical information to the EUTF's Board of Trustees for plan administration functions, including such functions as quality assurance and auditing or monitoring the operations of group health plans that are part of the EUTF.

Public Health Activities: the EUTF may disclose your medical information to a public health authority for the purpose of preventing or controlling disease, injury or disability or to report child abuse or neglect.

Immunizations: To a school about an individual who is a student or prospective student of the school if the protected health information this is disclosed is limited to proof of immunization, the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis of the individual, if the individual is an emancipated minor; or the individual, if the individual is an adult or emancipated.

Organ and Tissue Donation: If you are an organ donor, the EUTF may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, the EUTF may release your medical information as required by military command authorities. The EUTF may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: the EUTF may release your medical information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health Oversight Activities: the EUTF may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the EUTF may disclose your medical information in response to a court order or administrative ruling. The EUTF may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the medical information requested.

Law Enforcement: the EUTF may release your medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About the victim of a crime if, under certain limited circumstances, the EUTF is able to obtain the person's agreement,
- About a death the EUTF believes might be the result of criminal conduct, and
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: the EUTF may release your medical information to a coroner or medical examiner. This might be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: the EUTF may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

The following category REQUIRES the EUTF to obtain your written authorization for the use or disclosure.

Generally, the Plan will require that you sign a valid authorization form in order to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operation. You have the right to revoke an authorization.

The Plan generally will require an authorization form for uses and disclosure of your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed. The Plan generally will require an authorization form for the sale of protected health information if the Plan receives direct or indirect financial remuneration (payment) from the entity to whom the PHI is sold. The Plan does not intend to engage in fundraising activities.

Psychotherapy Notes: Generally the EUTF must obtain your written authorization to use and disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the EUTF may use and disclose your psychotherapy notes when needed by the EUTF to defend against a lawsuit filed by you.

The following category REQUIRES that the EUTF gives you an opportunity to agree or disagree prior to the use or disclosure.

- **Family or Friends Involvement**: the EUTF may disclose your medical information to family members, other relatives, or your friends without your written consent or authorization if:
  - The medical information is directly relevant to the family or friend's involvement with your care or payment for that care, and
  - You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information maintained by the EUTF:

Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy (in hard copy or electronic form) of your PHI (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hard copy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

You have the right to inspect and obtain a copy of your medical information contained in a "designated record set," for as long as the EUTF maintains your medical information. The designated record set includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the EUTF to make decisions about people covered under the EUTF's health benefits plans. Information used for quality control or peer review analyses and not used to make decisions about people covered by the EUTF health benefits plans is not contained in the designated record set.

If you request a copy of your medical information, it will be provided to you in accordance with the time limits required under Part II of Chapter 92F, Hawaii Revised Statutes, and the rules enacted thereunder. Under those laws, the EUTF will generally provide a copy of your medical information to you within ten (10) business or working days. However, in certain circumstances, the EUTF may be entitled to additional time to respond to your request.

You or your personal representative must complete a form to request access to your medical information contained in the designated record set. You must submit the completed request form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

If you request a copy of the information, the EUTF may charge a fee for the costs of copying and mailing the information to you, for creating the PHI or preparing a summary of your PHI, or for other supplies associated with complying with your request.

The EUTF may deny your request to inspect and copy medical information in certain, very limited circumstances. If you are denied access to medical information, you may appeal.

If the EUTF denies your request to inspect or copy your medical information, the EUTF will provide you or your personal representative with a written denial identifying the reason(s) for the denial. The denial will also include a description of how you may exercise your appeal rights, and a description of how you may file a complaint with the Secretary of the Department of Health and Human Services.

Right to Amend Your Medical Information: If you think that your medical information is incorrect or incomplete, you may ask the EUTF to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the EUTF.

To request an amendment, you must submit your request, in writing, to the EUTF Privacy Officer. Your written request must include a reason that supports your request.

After you request that the EUTF amend your medical information, the EUTF must comply with your request within twenty (20) business or working days, or notify you that your request has been denied.

The EUTF may deny your request for an amendment to your medical information if your request is not in writing or does not include a reason to support the request. In addition, the EUTF may deny your request if you ask the EUTF to amend information that:

- Is not part of the medical information kept by or for the EUTF,
- Was not created by the EUTF, unless the person or entity that created the information is no longer available to make the amendment,
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete.

If the EUTF denies your request in the whole or in part, the EUTF must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial, and have that statement included with any future disclosure of your medical information.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" if a disclosure was made without your authorization for any purpose other than treatment, payment, or health care operations, or where the disclosure was to you about your own medical information.

To request this list of disclosures, you must submit a written request to the EUTF Privacy Officer. Your request must state a time period for which you are requesting the list of disclosures. This period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within any 12-month period will be provided free of charge. For additional lists, the EUTF may charge you for the costs

of providing the list. The EUTF will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any costs.

The EUTF has 60 days from the date it receives your request to provide you the list of disclosures, and is allowed an additional 30 days to comply, if it provides you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on your medical information uses or disclosures for treatment, payment or health care operations. You also have the right to request a limit on your medical information that the EUTF discloses to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that the EUTF not use or disclose information about a surgical procedure you had.

The EUTF is not required by law to agree to your request.

You or your personal representative must complete a form to request restrictions on the use or disclosure of your medical information. You must submit the completed form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice. In your request, you must indicate:

- What information you want to limit,
- Whether you want to limit the EUTF's use, disclosure, or both, and
- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that the EUTF communicate with you about your medical information or other medical matters in a certain way, or at a certain location. For example, you may ask that the EUTF contact you only at work or by mail.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask the EUTF to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to request a paper copy of this notice. To obtain a paper copy of this notice, submit a written request to the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

Breach Notification Right: If a breach of your unsecured protected health information occurs, the Plan will notify you.

A Note about Personal Representatives

You may exercise your privacy rights through a personal representative. Your personal representative will be required to provide evidence of his or her authority to act on your behalf before that person will be given access to your medical information or allowed to take any action on your behalf with respect to your medical information. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A court order appointing the person as the your conservator or guardian, or
- An individual who is the parent of a minor child.

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

However, state or other applicable law will govern whether the EUTF is permitted to disclose an unemancipated minor dependent child's medical information to the child's parent(s). State or other applicable law will also govern whether the EUTF is permitted to provide a parent's access to his or her child's medical information.

Changes to This Notice

The EUTF reserves the right to change this notice. The EUTF also reserves the right to make the revised or changed notice effective for medical information it already maintains, or has access to about you as well as any information the EUTF receives in the future. The EUTF will post a copy of the current notice on the EUTF's web site. This notice will contain the effective date of the current notice on the first page, in the top right-hand corner.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your rights, the duties of the EUTF or other privacy practices stated in this notice. Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice. Because our health plan posts its Notice on its web site, we will prominently post the revised Notice on that web site by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual Notice distribution to individuals covered by the Plan.

Minimum Necessary Standard

When the EUTF uses or discloses your medical information, or requests your medical information from another entity, the EUTF will make reasonable efforts not to use, disclose or request more than the minimum amount of your medical information needed to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply to:

- Disclosures to or requests by a health care provider for treatment,
- Uses by you or disclosures to you of your own medical information,
- Disclosures made to the Secretary of the Department of Health and Human Services,
- Uses or disclosures that may be required by law,
- Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- Uses and disclosures for which the EUTF has obtained your authorization.

The Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

This notice does not apply to medical information that has been "de-identified." De-identified information is medical information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the EUTF may use or disclose "summary health information" to obtain premium bids or to modify, amend or terminate the EUTF's health benefits plans. Summary health information is information

that summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom the EUTF has provided benefits, and from which identifying information has been deleted in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice. You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website (http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html) or this website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html or contact the Privacy Officer for more information about how to file a complaint. You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the EUTF will be made only with your written authorization. If you provide the EUTF with authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the EUTF will no longer use or disclose your medical information for the reasons covered by your written authorization.

You should understand that the EUTF is unable to take back any disclosures that have already been made with your authorization, and that the EUTF is required to retain any records regarding any care or services provided to you.

EUTF may not (and does not) use your genetic information that is PHI for underwriting purposes.

Questions?

If you have any questions about this notice, contact the EUTF Privacy Officer, at the address below.

Governing Law

If there is any discrepancy between the information in this notice and the actual HIPAA regulations, the regulations will prevail, and the EUTF will use and disclose your medical information in a manner consistent with the regulations.

You may contact the **EUTF Privacy Officer** at the following address:

Mailing Address: P.O. Box 2121, Honolulu, HI 96805
Physical Address: 201 Merchant Street, Suite 1700, Honolulu, HI 96813
Telephone number: 808-586-7390, Toll Free number: 1-800-295-0089

EUTF Monthly Retiree Rates
Effective January 1, 2017 through December 31, 2017

Benefit Plan	Type of Enrollment	Total Contribution Required[1]
MEDICAL PLANS - MEDICARE		
HMSA PPO Medicare	Self	$223.86
	Two-Party	$436.20
	Family	$646.64
UnitedHealthcare (UHC) Medicare Advantage PPO	Self	$57.30
	Two-Party (both Medicare)	$114.60
Medicare Prescription Drug – SilverScript	Self	$218.16
	Two-Party	$424.80
	Family	$629.84
Kaiser HMO Medicare Kaiser Prescription Drug	Self	$436.40
	Two-Party	$850.96
	Family	$1,261.16
MEDICAL PLANS – NON-MEDICARE		
HMSA PPO Non-Medicare	Self	$497.24
	Two-Party	$968.92
	Family	$1,436.40
Non-Medicare Prescription Drug – CVS Caremark	Self	$222.80
	Two-Party	$433.94
	Family	$643.38
Kaiser HMO Non Medicare Kaiser Prescription Drug	Self	$720.16
	Two-Party	$1,453.96
	Family	$2,144.72
DENTAL PLAN		
HDS Dental	Self	$37.40
	Two-Party	$72.88
	Family	$89.26
VISION PLAN		
VSP Vision	Self	$5.34
	Two-Party	$10.68
	Family	$14.34
LIFE INSURANCE		
USAble Life Insurance (Retiree only)	Self	$4.12

[1] The 2017 Retiree rates do not include an EUTF administrative fee.

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
EUTF RETIREES
EFFECTIVE JANUARY 1, 2017

1A MEDICAL/PRESCRIPTION DRUG

	Monthly Premium HMSA	Monthly Premium Kaiser	Monthly Premium UHC
A. Non-Medicare - Self	☐ $720 04	☐ $720.16	
B. Non-Medicare - 2-Party	☐ $1,402 86	☐ $1,453.96	
C. Non-Medicare - Family	☐ $2,079.78	☐ $2,144.72	
D. Medicare - Self	☐ $442 02	☐ $436.40	☐ $275.46
E. Medicare - 2-Party	☐ $861 00	☐ $850.96	☐ $539.40
F. Medicare - Family	☐ $1,276.48	☐ $1,261.16	

If you want medical and prescription drug, select one plan and enter premium amount (go to line 2) **1A** $ _____

If you want medical only, go to line 1B; If you want prescription drug only, go to line 1C

1B MEDICAL ONLY

	HMSA	UHC
A. Non-Medicare - Self	☐ $497 24	
B. Non-Medicare - 2-Party	☐ $968 92	
C. Non-Medicare - Family	☐ $1,436.40	
D. Medicare - Self	☐ $223 86	☐ $57.30
E. Medicare - 2-Party	☐ $436 20	☐ $114.60
F. Medicare - Family	☐ $646 64	

Select one plan and enter premium amount **1B** $ _____

If you selected a plan in 1A, do not complete this section

1C PRESCRIPTION DRUG ONLY

A. Non-Medicare - Self	☐ $222 80
B. Non-Medicare - 2-Party	☐ $433 94
C. Non-Medicare - Family	☐ $643 38
D. Medicare - Self	☐ $218.16
E. Medicare - 2-Party	☐ $424 80
F. Medicare - Family	☐ $629 84

Select one plan and enter premium amount **1C** $ _____

If you selected a plan in 1A, do not complete this section

2 DENTAL

	HDS
Non Medicare/Medicare	
Self	☐ $37.40
2-Party	☐ $72.88
Family	☐ $89.26

Select one plan and enter premium amount **2** $ _____

3 VISION

	VSP
Non Medicare/Medicare	
Self	☐ $5.34
2-Party	☐ $10.68
Family	☐ $14.34

Select one plan and enter premium amount **3** $ _____

4 Add lines 1A or 1B and 1C, 2, 3 (Medical, Prescription Drug, Dental, Vision) **4** $ _____

2017 Employer Contribution Amounts Not Available at Press Time
Go to *eutf.hawaii.gov* in December for the 2017 Amounts

5 EMPLOYER CONTRIBUTION

	0%	50%	75%	100%
A. Non Medicare - Self	☐ $0.00	☐	☐	☐
B. Non Medicare - 2-Party	☐ $0.00	☐	☐	☐
C. Non Medicare - Family	☐ $0.00	☐	☐	☐
D. Medicare - Self	☐ $0.00	☐	☐	☐
E. Medicare - 2-Party	☐ $0.00	☐	☐	☐
F. Medicare - Family	☐ $0.00	☐	☐	☐

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.

HSTA VB Monthly Retiree Rates

HSTA VB Monthly Retiree Rates
Effective January 1, 2017 through December 31, 2017

Benefit Plan	Type of Enrollment	Total Contribution Required[1]
MEDICAL PLANS - MEDICARE		
HSTA VB Retiree - HMSA PPO Medicare Medical, SilverScript Drug, RSN Chiropractic, VSP Vision	Self	$445.96
	Two-Party	$869.16
	Family	$1,285.82
HSTA VB Retiree - Kaiser HMO Medicare Medical and Drug, RSN Chiropractic, VSP Vision	Self	$450.16
	Two-Party	$878.14
	Family	$1,298.70
MEDICAL PLANS – NON-MEDICARE		
HSTA VB Retiree - HMSA PPO Non-Medicare Medical, CVS Caremark Drug, RSN Chiropractic, VSP Vision	Self	$683.42
	Two-Party	$1,331.74
	Family	$1,971.66
HSTA VB Retiree - Kaiser HMO Non-Medicare Medical and Drug, RSN Chiropractic, VSP Vision	Self	$713.20
	Two-Party	$1,439.70
	Family	$2,120.96
DENTAL PLAN		
HDS Dental	Self	$44.42
	Two-Party	$86.54
	Family	$105.94
VISION PLAN (Only for retirees enrolled in an out-of-state Kaiser Multi-Site or Sr. Advantage Plan)		
VSP Vision	Self	$5.34
	Two-Party	$10.68
	Family	$14.34
LIFE INSURANCE		
USAble Life Insurance (Retiree only)	Self	$4.12

[1] The 2017 Retiree rates do not include an EUTF administrative fee.

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
HSTA VB RETIREES
EFFECTIVE JANUARY 1, 2017

		Monthly Premium	Monthly Premium
1	**MEDICAL/PRESCRIPTION DRUG/CHIRO/VISION**	**HMSA**	**Kaiser**
A.	Non-Medicare - Self	☐ $683.42	☐ $713.20
B.	Non-Medicare - 2-Party	☐ $1,331.74	☐ $1,439.70
C.	Non-Medicare - Family	☐ $1,971.66	☐ $2,120.96
D.	Medicare - Self	☐ $445.96	☐ $450.16
E.	Medicare - 2-Party	☐ $869.16	☐ $878.14
F.	Medicare - Family	☐ $1,285.82	☐ $1,298.70

Select one plan and enter premium amount _____ | 1 | $

2	**DENTAL**	**HDS**
	Non Medicare/Medicare	
	Self	☐ $44.42
	2-Party	☐ $86.54
	Family	☐ $105.94

Select one plan and enter premium amount 2 $

3 Add lines 1 and 2 3 $

2017 Employer Amounts Not Available at Press Time
Go to *eutf.hawaii.gov in* December for the 2017 Amounts

	4 **EMPLOYER CONTRIBUTION MAXIMUM**	0%	50%	75%	100%
A.	Non Medicare - Self	☐ $0.00	☐	☐	☐
B.	Non Medicare - 2-Party	☐ $0.00	☐	☐	☐
C.	Non Medicare - Family	☐ $0.00	☐	☐	☐
D.	Medicare - Self	☐ $0.00	☐	☐	☐
E.	Medicare - 2-Party	☐ $0.00	☐	☐	☐
F.	Medicare - Family	☐ $0.00	☐	☐	☐

Check your medical selection on line 1. (For example, if you selected 1A, your employer contribution will be non Medicare self.) Enter your employer contribution amount (0% or 50% or75%). 4 $

5 Line 3 minus line 4, enter the AMOUNT YOU OWE monthly 5 $

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.

COBRA Retiree Open Enrollment

COBRA Retiree Open Enrollment

For members enrolled in the EUTF or HSTA VB COBRA Retiree health plans, your annual open enrollment coincides with the regular retiree open enrollment period beginning ***October 10, 2016*** through ***October 31, 2016.*** During open enrollment you can:

- Add a plan, change from one plan to another, or drop a plan
- Add a dependent or drop a dependent
- Change coverage tiers such as changing from single to family or family to 2-party
- Now is also a good time to tell us if you've had a change of address

A COBRA packet will be sent to your address on file with the EUTF COBRA OE Enrollment Form or HSTA VB COBRA OE Enrollment Form to provide you an opportunity to make changes to your COBRA health plans should you wish to do so. Plan changes properly submitted during this open enrollment period will be effective ***January 1, 2017***. Your completed EUTF COBRA OE Enrollment Form or HSTA VB COBRA OE Enrollment Form must be posted marked to EUTF **on or before *October 31, 2016*.** Enrollment forms submitted after ***October 31, 2016*** will **NOT be accepted**. Please note that if you do **NOT** want to make changes you do **NOT** need to complete the EUTF COBRA OE Enrollment Form or HSTA VB COBRA OE Enrollment Form if applicable, during open enrollment and make a selection.

IMPORTANT INFORMATION FOR EUTF COBRA RETIREES ONLY: THE MEDICARE PPO MEDICAL PLAN UNDER UNITEDHEALTHCARE IS NOT A MEDICAL PLAN OPTION FOR COBRA RETIREES.

COBRA Retiree Open Enrollment Rates for EUTF and HSTA VB

The following premium rates for EUTF and HSTA VB COBRA retirees are approved for the period of ***January 1, 2017*** through ***December 31, 2017***. Separate invoices will be billed by each carrier selected.

You may call the EUTF Customer Service Call Center at 808-586-7390 or toll free at 1-800-295-0089 if you have any questions or email your inquiry to eutf.cobra@hawaii.gov.

EUTF Monthly Retiree COBRA Rates

EUTF Monthly Retiree COBRA Rates

Benefit Plan	Type of Enrollment	Regular COBRA 1/1/2017 - 12/31/2017
MEDICAL PLANS - MEDICARE		
HMSA PPO Medicare	Self	$228.33
	Two Party	$444.92
	Family	$659.57
Medicare Prescription Drug – SilverScript	Self	$219.65
	Two-Party	$427.70
	Family	$634.14
Kaiser HMO Medicare Kaiser Prescription Drug	Self	$445.12
	Two-Party	$867.97
	Family	$1,286.38
MEDICAL PLANS - NON-MEDICARE		
HMSA PPO Non-Medicare	Self	$507.18
	Two-Party	$988.29
	Family	$1,465.12
Non-Medicare Prescription Drug – CVS Caremark	Self	$226.79
	Two-Party	$441.71
	Family	$654.90
Kaiser HMO Non-Medicare Kaiser Prescription Drug	Self	$734.56
	Two-Party	$1,483.03
	Family	$2,187.61
DENTAL PLAN		
HDS Dental	Self	$38.14
	Two-Party	$74.33
	Family	$91.04
VISION PLAN		
VSP Vision	Self	$5.44
	Two-Party	$10.89
	Family	$14.62

Note: These rates do not include an EUTF administrative fee.

HSTAVB Monthly Retiree COBRA Rates

HSTA VB Monthly Retiree COBRA Rates

Benefit Plan	Type of Enrollment	Regular COBRA 1/1/2017 - 12/31/2017
MEDICAL PLANS - MEDICARE		
HMSA PPO Medicare	Self	$193.96
	Two Party	$378.09
	Family	$560.49
Medicare Prescription Drug – SilverScript	Self	$250.59
	Two-Party	$487.96
	Family	$723.47
Kaiser HMO Medicare Kaiser Prescription Drug	Self	$452.20
	Two-Party	$881.76
	Family	$1,306.82
MEDICAL PLANS - NON-MEDICARE		
HMSA PPO Non-Medicare	Self	$415.67
	Two-Party	$809.88
	Family	$1,200.68
Non-Medicare Prescription Drug – CVS Caremark	Self	$273.56
	Two-Party	$532.81
	Family	$789.96
Kaiser HMO Non-Medicare Kaiser Prescription Drug	Self	$720.50
	Two-Party	$1,454.56
	Family	$2,145.52
DENTAL PLAN		
HDS Dental	Self	$45.30
	Two-Party	$88.27
	Family	$108.05
VISION PLAN		
VSP Vision	Self	$5.44
	Two-Party	$10.89
	Family	$14.62
CHIROPRACTIC PLAN		
Royal State Chiro	Self	$1.50
	Two-Party	$3.03
	Family	$3.22

Note: These rates do not include an EUTF administrative fee.

Definitions

Premiums – The semi-monthly or monthly amount paid for your health insurance. Premiums are primarily influenced by utilization of services by the members benefit plan design, and the cost of healthcare. For active employees under a collective bargaining agreement, the employer contribution to your premium is negotiated by your employee organization/union.

Eligible charge – The lower of the participating provider's actual charge or the amount the plan establishes as the maximum allowable fee (the maximum amount that the plan will pay for the covered services or supplies). This is the amount on which your coinsurance is based.

Copayment – A fixed amount (for example, $15) you pay for a covered service, usually when you receive the service. The amount can vary by plan and the type of covered service.

Coinsurance – Your share of the costs of a covered service, calculated as a percent (e.g. for most services under the HMSA 90/10 PPO medical plan, coinsurance is 10%) of the eligible charge. For example, if the plan's eligible charge for a primary care office visit is $100, your coinsurance payment of 10% would be $10. The plan pays the remainder of the eligible charge or $90 in this example.

Deductible – The amount you must pay for covered services before your plan begins to pay. The deductible does not apply to all services.

Out-of-Pocket Costs – Costs paid by the member related to deductibles, copayments and coinsurance for services. Out-of-pocket costs exclude premiums.

Maximum Out-of-Pocket Limits (MOOP) – The most you pay during a calendar year before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not include premiums, additional amounts for nonparticipating providers and other out-of-network charges, or spending for non-essential health benefits. The MOOP protects the members from catastrophic losses.

In-Network or Participating Provider – A physician, hospital, pharmacy, laboratory, or other healthcare provider your insurance carrier has contracted with to provide services at a negotiated fee or eligible charge rate. In most cases, participating providers are preferable to non-participating providers because of the lower out-of-pocket costs to the member.

Out-of-Network or Nonparticipating Provider – A physician, hospital, pharmacy, laboratory or other healthcare provider who has not contracted with your insurance carrier to provide services. When you receive services from a nonparticipating provider, you owe the plan's standard copayment or co-insurance plus the difference between the nonparticipating provider's charge for the services and your insurance carriers' eligible charge.

For example, if the nonparticipating provider's charge for a primary care office visit is $120, the plan's eligible charge is $100 and coinsurance is 10%, the plan will pay $90 ($100 * 90%) and you would pay $30 ($10 coinsurance plus $20 for the excess of the actual charge over the eligible charge). If the primary care provider was a participating provider, your total cost would be $10.

MEDICAL PLANS

Preferred Provider Organization (PPO) – A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network (participating providers). You can use doctors, hospitals, and providers outside of the network for an additional cost. Most of HMSA's EUTF and HSTA VB medical plans are PPO plans.

Health Maintenance Organization (HMO) – A type of health insurance plan that usually limits coverage to care from medical providers who work for or contract with the HMO. A HMO generally won't cover out-of-network care except in emergency situations. HMOs often provide integrated care and focus on prevention and wellness. Kaiser Permanente plans are HMO plans.

Primary Care Provider (PCP) – A provider (usually an internist, family/general practitioner or pediatrician) who provides a range of services such as prevention, wellness, and treatment for common illnesses. PCPs often maintain long-term relationships with you, and advise and treat you on a range of health related issues. PCPs may also coordinate your care with specialists.

Specialist – A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

PRESCRIPTION DRUG PLAN

Generics – A prescription drug that has the same active-ingredient formula as a brand-name drug. The color or shape may be different, but the active ingredients must be the same. Generic drugs usually cost significantly less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Brand Name – A prescription drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand prescription drugs are either preferred or non-preferred. You will pay more if you use non-preferred drugs than preferred or generic prescription drugs.

Formulary – A list of prescription drugs covered by a prescription drug plan. A formulary is also called a drug list. The formulary is normally updated quarterly for the non-Medicare retiree plans and annually for the Medicare retiree plans.

Print or type clearly. If this form is unreadable, incomplete, or does not contain all information required, it will be sent back to you without action.

SECTION 1 - RETIREE DATA

1. Enter your last name, first name, and middle initial.
2. Enter your contact information.
3. Enter your address information. If your residence address differs from your mailing address, you need to enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box **only** during the annual or limited Open Enrollment period.
5. If you are enrolling with the EUTF for the first time as a retiree, you are required to provide your full Social Security Number.
6. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your form without a birth date.
7. Mark the Qualifying Event box if you are making changes during the year when it is not Open Enrollment; and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
8. If you are married, or in a civil union or domestic partnership please be sure to check appropriate boxes and include date you were married or entered into a civil union or domestic partnership. You must attach a copy of required documents.
9. Special Note: If your Spouse, Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her name, date of birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND CONTRIBUTION START SELECTION

Complete this section only if you pay towards health plan benefits

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option used.
3. The event date for Marriage and Civil Union is the marriage date or civil union certification date, respectively. The event date to add a Domestic Partner (DP) is the date the Declaration of DP is notarized.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose ONE medical, ONE dental, and ONE vision plan. Your choice of the prescription drug plan will depend on the medical plan that you select. If you select Kaiser, your medical selection will include a prescription drug plan. If you select HMSA or UHC, you must select the prescription drug plan if you want prescription drug coverage. If you don't make a selection, you will not have any prescription drug coverage.
2. You may choose to elect only the medical PPO plan without the prescription drug plan or vice versa. If you want both the medical and prescription drug plans, please mark the appropriate boxes. If you do not want any plan coverage, mark the "Cancel/Waive" box.
3. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the "Cancel/Waive" box for each plan that you choose not to select.
4. Life Insurance is provided by the State/County for the retiree only.

Write your name in the top right corner of page 2.

SECTION 4 – DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. Social Security Number is not a required field when submitting an initial EC-2 for new birth. Please be sure to submit an EC-2 to update our records for your newborn once the information is received/issued by the Social Security Administration. If making changes to your dependent's data, enter the corrected item. If listing more than 3 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-2.

2. Use the following Relationship codes:

SP = Spouse	CH = Child√√√√√	GC = Guardianship or Foster Child √√
CU = Civil Union Partner √	CUCH = Civil Union Child √	SC = Step Child√√√√√
DP = Domestic Partner √√√	DPCH = Domestic Partner Child √√√	DC = Disabled Child √√√√

If you are adding an Adopted Child, Civil Union Partner and child, Domestic Partner and child or a Disabled Child, please contact the EUTF at 808-586-7390 or toll free, 1-800-295-0089 or visit our website at eutf.hawaii.gov for more information. Other EUTF forms to include with EC-2 (if applicable):

√ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes

√√ Legal documents for guardianship or foster child

√√√ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership, and Affidavit of "Dependency" for Tax Purposes

√√√√ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

√√√√√ Student Certification if enrolling dependent age 19-23

3. Gender – Write/type either M or F.
4. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
5. Dependent/Student certification. Your initials confirm that you are certifying that your spouse/partner and dependent children are eligible to be enrolled under your health plans. You also confirm that you will provide a copy of your child(ren)'s birth certificate and/or Social Security card if requested by the EUTF. If you have dependent children ages 19 through 23 who are full-time students, your initials confirm they are full-time students at an accredited college or school. You further confirm that you will provide a copy of your child(ren)'s student verification letters required by the EUTF.
6. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. You may add your Civil Union Partner or Domestic Partner at any time outside of Open Enrollment, provided all required documents have been received by EUTF within 30 days of the event date. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.

SECTION 5 – MEDICARE

IMPORTANT NOTICE: When you or your dependent(s) become eligible for Medicare Part B, you or your dependent(s) must enroll in Medicare Part B and forward proof of enrollment (Medicare card showing Medicare Part B effective date and Direct Deposit Authorization Form) to the EUTF. Failure to comply may result in loss of medical and prescription drug coverage.

SECTION 6 – UNITEDHEALTHCARE MEDICARE ADVANTAGE PLAN

IMPORTANT NOTICE: You must be enrolled in Medicare Part A and B in order to enroll in the UNTEDHEALTHCARE Medicare Advantage plan.

1. For retiree-beneficiary, enter your full name as it appears on your Medicare card. If you are enrolling your spouse/partner, they must also enter their full name as it appears on their Medicare card.
2. Enter your Medicare claim number as it appears on your Medicare card. If you are enrolling your spouse/partner, they must also enter their Medicare claim number as it appears on their Medicare card.
3. End-Stage Renal Disease information is required for enrollment into the UnitedHealthcare Medicare Advantage plan. Please mark the appropriate box.
4. You can receive a full pre-enrollment kit by calling UnitedHealthcare or by attending one of the open enrollment meetings

SECTION 7 – RETIREE AND SPOUSE/PARTNER SIGNATURE

Your signature certifies that the information provided in this application is true and complete and you agree to abide by the terms and conditions of the benefit plans selected. Retiree affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student and is also unmarried. Please enter date of Retiree's signature. If you are enrolling yourself **and your spouse/partner** in the UnitedHealthcare plan, your spouse/partner MUST provide a signature and date in section 7.

You must submit the EC-2 to the EUTF office within 60 days of the date of retirement. You may send it by mail or hand deliver. The addresses are printed at the bottom of page 2 of the enrollment form.

Print or type clearly. If this form is unreadable, incomplete, or does not contain all information required, it will be sent back to you without action.

SECTION 1 - RETIREE DATA

1. Enter your last name, first name, middle initial.
2. Enter your contact information.
3. Enter your address information. If your residence address differs from your mailing address, you need to enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box **only** during the annual or limited Open Enrollment period.
5. Enter your gender and birth date.
6. Mark the Qualifying Event box if you are making changes during the year when it is not Open Enrollment; and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
7. If you are Married, or in a Civil Union, or in a Domestic Partnership please be sure to check the appropriate boxes and include the date you were Married, or entered in a Civil Union, or entered in a Domestic Partnership. You must attach a copy of required documents.
8. Special Note: If your Spouse, Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her name, date of birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND CONTRIBUTION START SELECTION

Complete this section only if you pay towards health plan benefits

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option selected.
3. The event date for Marriage and Civil Union is the marriage date or civil union certification date, respectively. The event date to add a Domestic Partner (DP) is the date the Declaration of DP is notarized.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose ONE medical and ONE dental plan. Your choice of the prescription drug and vision plan will depend on the medical plan that you select.
2. If you have other health plan coverage and do not want to participate in the HSTA VB plans, mark the "Cancel/Waive" box for each plan that you choose not to select.
3. Life Insurance is provided by the state for the retiree only.

Write your name in the top right corner of page 2.

SECTION 4 – DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number. Social Security Number is <u>not</u> a required field when submitting an initial EC-2H for new birth. Please be sure to submit an EC-2H to update our records for your newborn once the information is received/issued by the Social Security Administration. If making changes to your dependent's data, enter the corrected item. If listing more than 3 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-2H.
2. Use the following Relationship codes:

SP = Spouse	CH = Child √√√√√	GC = Guardianship or Foster Child √√
CU = Civil Union Partner √	CUCH = Civil Union Child √	SC = Step Child √√√√√
DP = Domestic Partner √√√	DPCH = Domestic Partner Child √√√	DC = Disabled Child √√√√

If you are adding an Adopted Child, Civil Union Partner and child, Domestic Partner and child or a Disabled Child, please contact the EUTF at 808-586-7390 or toll free, 1-800-295-0089 or visit our website at eutf.hawaii.gov for more information. Other EUTF forms to include with EC-2 (if applicable):

√ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes

√√ Legal documents for guardianship or foster child

√√√ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership, and Affidavit of "Dependency" for Tax Purposes

√√√√ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

√√√√√ Student Certification if enrolling dependent age 19-23

3. Gender – Write/type either M or F.
4. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
5. Dependent/Student certification. Your initials confirm that you are certifying that your spouse/partner and dependent children are eligible to be enrolled under your health plans. You also confirm that you will provide a copy of your child(ren)'s birth certificate and/or Social Security card if requested by the EUTF. If you have dependent children ages 19 through 23 who are full-time students, your initials confirm they are full-time students at an accredited college or school. You further confirm that you will provide a copy of your child(ren)'s student verification letters required by the EUTF.
6. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. You may add your Civil Union Partner or Domestic Partner at any time outside of Open Enrollment, provided all required documents have been received by EUTF within 30 days of the event date. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.

SECTION 5 – MEDICARE

IMPORTANT NOTICE: When you or your dependent(s) become eligible for Medicare Part B, you or your dependent(s) must enroll in Medicare Part B and forward proof of enrollment (Medicare card showing Medicare Part B effective date and Direct Deposit Authorization Form) to the EUTF. Failure to comply may result in loss of medical and prescription drug coverage.

SECTION 6 – RETIREE SIGNATURE

Your signature certifies that the information provided in this application is true and complete. Retiree agrees to abide by the terms and conditions of the benefit plans selected. Retiree affirms that any listed dependent child, age 19 through 23, is attending a college, university or technical school as a full-time student and is also unmarried. Please enter date of Retiree's signature.

You must submit the EC-2H to the EUTF office. You may send it by mail or hand deliver. The addresses are printed at the bottom of page 2 of the enrollment form.

EC-2 Rev. Oct 2016	Hawaii Employer-Union Health Benefits Trust Fund	PLEASE SUBMIT THIS FORM EC-2 TO THE EUTF

EC-2: Enrollment Form for Retirees

SECTION 1: RETIREE DATA

Please complete all applicable fields below. Social Security numbers are required to process new retirees and dependent enrollments.**

Name (Last, First, Middle Initial)

_____

Home Phone ( )_____

Work Phone ( )_____

Mobile Phone ( )_____

Email_____

Mailing Address (☐ Check this box if your address has changed)

Street_____

Line 2 _____

City_____State_____Zip Code _____

Residence Address (if different from above)

Street _____

Line 2 _____

City_____State_____Zip Code _____

☐ Newly Retired
Date of Retirement (MM/DD/YYYY)

__/__/____

☐ Open Enrollment (effective 01/01/2017)

Retiree's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

__/__/____ Marital

Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
(☐ Check this box if status change)

__/__/____

☐ Qualifying Event (describe)

_____

Event Date: __/__/____

Civil Union Partner (Civil Union Status)
☐ IRS Qualified ☐ Not Qualified
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)

__/__/____

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)
(☐ Check this box if status change)

__/__/____

Special Note: If your Spouse/Civil Union or Domestic Partner is a State or County Employee or Retiree, please provide the following:
NAME: SSN: DOB:

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

Skip this section if RETIREE does NOT pay towards health plan benefits.

If events are filed within 30 days of the qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section
Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

Available Options for this Section

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

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If no selection is made, EUTF will assume no changes are being made.

Choose only one box in each plan selection

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family	
Medical	PPO-90/10 **HMSA** Medical No Prescription Drug Coverage	☐	☐	☐	☐	
PPO	**UnitedHealthcare** Medicare Advantage Grp. 13840-Medicare A&B required No Prescription Drug Coverage	☐	☐	☐	☐	(All enrollees must be enrolled in Medicare Part A & B)
Prescription Drug	**CVS Caremark** Prescription Drug (Not a valid selection with Kaiser)	☐	☐	☐	☐	
HMO	HMO-**Kaiser** Medical (Includes Kaiser Prescription Drug)	☐	☐	☐	☐	
Dental	Hawaii Dental Service	☐	☐	☐	☐	
Vision	Vision Service Plan	☐	☐	☐	☐	
Life	USAble Life	☐	☐	Not available to dependents		

Retiree's Name _____

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add/delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, CU=Civil Union Partner, DP=Domestic Partner, CH=your Child or your Spouse's Child, CUCH=Civil Union Partner's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-2 for new birth. Please be sure to submit an EC-2 to update our records for your newborn once the information is received/issued by SSA.

Continue Coverage	Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at http://eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.
Dependent Certification and Student Certification– See Section regarding Dependent and Student Certification on "Instructions for Completing Form EC-2" for more information.

I certify that my spouse/partner and/or dependent children meet eligibility requirements for enrollment in the EUTF plans. _____(initials)

I certify that my dependent child is a full-time student and have attached all documentation as required in Section 4 regarding dependent and student certification in the "Instructions for Completing Form EC-2". _____(initials)

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires all Medicare eligible retirees and their dependents to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF retiree benefit plans. If you or your dependent(s) are Medicare eligible and are not enrolled in Medicare Part B, you must enroll immediately and provide EUTF with a copy of your Medicare card. If you are already enrolled, be sure EUTF has a copy of your Medicare card.

SECTION 6: UNITEDHEALTHCARE MEDICARE ADVANTAGE PLAN (UHC)

If you or any of your dependents are enrolling in the UnitedHealthcare Medicare Advantage Plan, YOU MUST COMPLETE THE INFORMATION BELOW (the information is on your red, white and blue Medicare card):

Retiree – Name of Beneficiary:_____ **Medicare Claim #** __
Do you have End Stage Renal Disease (ESRD) ☐ Yes ☐ No

Spouse/Partner – Name of Beneficiary:_____ **Medicare Claim #** __
Do you have End Stage Renal Disease (ESRD) ☐ Yes ☐ No

If the above information is not completed, your enrollment into the UnitedHealthcare Medicare Advantage Plan may be rejected resulting in no medical coverage.

SECTION 7: RETIREE & SPOUSE/PARTNER 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 for 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 selected

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. This form supersedes all forms and submissions I 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 penalty for perjury.

Retiree Signature:_____ Date Signed:_____

Retiree Spouse/Partner Signature:_____ Date Signed:_____ (Signature & date required if enrolling in UHC)

Please submit your signed EC-2 form by mail to:

EUTF
P.O. Box 2121
Honolulu, HI 96805-2121

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite1700, Honolulu, HI 96813

Customer Service Call Center

Oahu (808) 586-7390
Toll Free 1(800) 295-0089

EC-2H
Rev. Oct 2016

Hawaii Employer-Union Health Benefits Trust Fund

EC-2H: Enrollment Form for HSTA VB Retirees

PLEASE SUBMIT THIS FORM EC-2H TO THE EUTF

SECTION 1: RETIREE DATA

Please complete all applicable fields below. Social Security numbers are required to process new retirees and dependent enrollments. **

Name (Last, First, Middle Initial) _____

☐ Open Enrollment (effective01/01/2017) ☐ Qualifying Event (describe)

Retiree's Social Security Number (SSN) or EUTF ID Number _____

Event Date: ____/____/____

Home Phone (_____) _____

Work Phone (_____) _____

Mobile Phone (_____) _____

Email _____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)
____/____/____

Civil Union Partner (Civil Union Status)
☐ IRS Qualified ☐ Not Qualified
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)
____/____/____

Mailing Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
(☐ Check this box if status change)
____/____/____

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)
(☐ Check this box if status change)
____/____/____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Special Note: If your Spouse/Civil Union or Domestic Partner is a State or County Employee or Retiree, please provide the following:
NAME: SSN: DOB:

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

Skip this section if RETIREE does NOT pay towards health plan benefits.

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section
Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

Available Options for this Section
☐ Coverage starts day of the event & premium contributions 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 contributions start 1st day of the **first** pay period√ following event
☐ Coverage and premium contributions start 1st day of the **second** pay period√ following event
√ (1st or 16th of the month)

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below.
Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If no selection is made, EUTF will assume no changes are being made.

Choose only one box in each plan selection

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
Medical PPO	HSTA VB - PPO-90/10 **HMSA** Medical, Prescription Drug Coverage, Vision, Chiro	☐	☐	☐	☐
HMO	HSTA VB - HMO-**Kaiser** Medical, (Includes Kaiser Prescription Drug), Vision, Chiro	☐	☐	☐	☐
Other Plans		**Cancel/Waive**	**Self**	**2-Party**	**Family**
Dental	HSTA VB - Hawaii Dental Service	☐	☐	☐	☐
Life	HSTA VB - USAble Life	☐	☐	Not available to dependents	

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Retiree's Name _____

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add or delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, CU=Civil Union Partner, DP=Domestic Partner, CH=your Child or your Spouse's Child, CUCH=Civil Union Partner's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-2H for new birth. Please be sure to submit an EC-2H to update our records for your newborn once the information received/issued by SSA.

Continue Coverage	Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at http://eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.
Dependent Certification and Student Certification– See Section regarding Dependent and Student Certification on "Instructions for Completing Form EC-2H" for more information.

I certify that my spouse and/or dependent children meet eligibility requirements for enrollment in the HSTAVB plans. _____**(initials)**

I certify that my dependent child is a full-time student and have attached all documentation as required in Section 4 regarding dependent and student certification in the "Instructions for Completing Form EC-2". _____**(initials)**

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires retirees and their dependents to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF retiree benefit plans. If you or your dependent(s) are Medicare eligible and are not enrolled in Medicare Part B, you must enroll immediately and provide EUTF with a copy of your Medicare card. If you are already enrolled, be sure EUTF has a copy of your Medicare card.

SECTION 6: RETIREE 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 for 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 selected

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. This form supersedes all forms and submissions I 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 penalty for perjury.

Retiree Signature:_____ Date Signed: _____

Please submit your signed EC-2H form by mail to:

EUTF
P.O. Box 2121
Honolulu, HI 96805-2121

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite 1700, Honolulu, HI 96813

Customer Service Call Center

Oahu (808) 586-7390
Toll Free 1(800) 295-0089

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND ("EUTF")

Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement

- ✓ I request reimbursement for my Medicare Part B Premium. A copy of my Medicare card and a copy of the letter from the Social Security Administration or Centers for Medicare & Medicaid Services showing the Medicare Part B Premium I pay are attached (for initial requests only). I understand that reimbursement of Medicare Part B Premiums will not begin until the EUTF receives a copy of the letter from the Social Security Administration or Centers of Medicare & Medicaid Services showing the Medicare Part B Premium I pay.
- ✓ I certify that my Medicare Part B premiums are not paid by any other entity, e.g. the Medicare Savings Program or Medicaid. Should my Part B premiums be paid by another entity in the future, I will notify the EUTF within 30 days of being notified by the other entity.
- ✓ If my enrollment in Medicare Part B stops I will notify the EUTF within 30 days. I understand that disenrollment from Medicare Part B means I will no longer be eligible for Part B premium reimbursement, as well as medical and prescription drug coverage.

Retiree's Name:		**SSN or EUTF ID Number:**
Retiree's Mailing Address:		**Phone:**

SECTION A – Deposit Authorization

Hawaii law (Act 039, SLH2006) requires all individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to designate a financial institution account into which the State of Hawaii EUTF shall be authorized to deposit their quarterly Medicare Part B reimbursements.

By signing in Section D, I/We hereby authorize the State of Hawaii EUTF to automatically and directly deposit my Medicare Part B premium reimbursements to my/our account at the financial institution named below:

SECTION B – Account Information (see your financial institution for help in completing this section)

Name of Account Holder(s):		
Name of Financial Institution:		
Routing Number:	**Account Number:**	**Δ Checking*** **Δ Savings**

Financial Institution Certification (Required for Savings; Optional for Checking):

Name of Agent:_____ Signature:_____ Date: _____

SECTION C – Agreements of All Account Holders

By signing in Section D, the Account Holder(s):

- Certify all information is accurate and authorize the EUTF to make withdrawals from my/our account in the event that the EUTF benefits have been deposited to the account in error, e.g., overpayments.
- Consent to the disclosure by the Financial Institution to the EUTF of any information that the EUTF requests to effectuate, administer, or enforce the transactions authorized in Sections A and C.
- Agree not to hold the EUTF responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me/us or by Financial Institution or due to an error on the part of Financial Institution in depositing funds to the account.

SECTION D – Signatures of All Account Holders

Authorized Signature (Primary):	**Date:**
Authorized Signature:	**Date:**

***Please attach a VOIDED check and return this form to the EUTF**

Instructions for Medicare Part B Reimbursement Request and Direct Deposit Agreement Form

The Social Security Administration or Centers for Medicare & Medicaid Services will periodically (when you begin receiving Social Security or enroll in Medicare and at least annually) mail you a letter showing the Medicare Part B Premium you pay. Additionally, you can print out a letter from the Social Security Administration showing the Medicare Part B Premium you pay by going to www.ssa.gov or you can request a letter from the Social Security Administration by calling 1-800-772-1213 (TTY 1-800-325-0778).

The 2006 State Legislature passed Act 39 which was signed into law by the Governor on April 27, 2006. The act establishes the requirement for all individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to designate a financial institution into which the EUTF shall be authorized to deposit their Medicare Part B reimbursements.

All portions of the Direct Deposit Agreement must be completed, except where optional, in order for the form to be valid. In addition, if there is any alteration of this form, a new form must be completed.

You must submit a new form if there are any changes to your account (i.e., account number, account holder, financial institution). The most recently dated form submitted to EUTF will apply.

Section B – Account Information
The name of the retiree or surviving spouse name must appear on the account. You may ask the representative of the financial institution to help complete this section. For deposits into a savings account, Financial Institution certification is required. For checking accounts, the certification is optional, but a voided check must be attached.

Section C – Agreements of All Account Holders
This section contains the agreements of everybody who is on the account, including the EUTF retiree or spouse or domestic partner or civil union partner. The agreements in Section C apply to all Account Holders even if they are not the retiree or spouse receiving Medicare Part B reimbursements.

Section D – Signatures of All Account Holders
By signing the Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement, the retiree, spouse, and/or surviving spouse certify the information is accurate and confirms that they understand and agree to the agreements in Section C.

The retiree or surviving spouse signs as primary account holder. If the account is a joint account, please have all account holder(s) sign the form. Use an additional sheet if necessary. If you are representing the retiree or surviving spouse or surviving domestic partner or civil union partner, please ensure that you have any authorizing document(s) attached to the Direct Deposit Agreement.

Please be sure to attach a VOIDED check if depositing into a checking account or have the financial institution complete Section B, if depositing into a savings account and return this form to the EUTF.

If you have any questions, please contact the EUTF customer service at:
Oahu: (808)586-7390
Toll-free: 1-800-295-0089
EUTF website: www.eutf.hawaii.gov
Mailing Address: EUTF
PO Box 2121
Honolulu, HI 96805
Street Address: EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

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For More Information

For Questions About…	Please Contact…
Eligibility & EUTF information	**eutf.hawaii.gov** EUTF Customer Service 808-586-7390 or Toll Free: 1-800-295-0089 (Monday through Friday, 7:45 a.m. – 4:30 p.m. HST)
Hawaii Medical Service Association (HMSA)	**www.hmsa.com** 808-948-6499 (Oahu) or Toll Free: 1-800-776-4672 (Neighbor Islands) (Monday through Friday, 7 a.m. – 7 p.m. HST) In person at the following locations: **HMSA EUTF Office** City Financial Tower 201 Merchant St., Suite 1840 Honolulu, HI 96813 (Hours of Operation: Monday – Friday, 7:45 a.m. – 4:30 p.m. HST) **HMSA Center @ Honolulu** HMSA Building 818 Keeaumoku St. Honolulu, HI 96814 (Hours of Operation: Monday through Friday, 8 a.m. – 6 p.m. HST Saturday: 9 a.m. – 2 p.m. HST) **HMSA Center @ Pearl City** Pearl City Gateway 1132 Kuala St., Suite 400 Pearl City, HI 96782 (Hours of Operation: Monday – Friday, 9 a.m. – 7 p.m. HST Saturday: 9 a.m. – 2 p.m. HST) **HMSA Center @ Hilo** Waiakea Center 303A E. Makaala St. (Hours of Operation: Monday – Friday, 9 a.m. – 7 p.m. HST Saturday: 9 a.m. – 2 p.m. HST) **Kailua-Kona Office** 75-1029 Henry St., Suite 301 Kailua-Kona, HI 96740 (Hours of Operation: Monday – Friday, 8 a.m. – 4 p.m. HST) **Kauai Office** 4366 Kukui Grove St., Suite 103 Lihue, HI 96766 (Hours of Operation: Monday – Friday, 8 a.m. – 4 p.m. HST) **Maui Office** 33 Lono Ave., Suite 350 Kahului, HI 96732 (Hours of Operation: Monday – Friday, 8 a.m. – 4 p.m. HST)
Kaiser Permanente (Kaiser)	**www.kp.org/eutf** 808-432-5250 (Oahu) or Toll Free: 1-800-966-5955 (Neighbor Islands) (Monday through Friday, 8:00 a.m. – 5:00 p.m. HST Saturdays 8:00 a.m. – 12:00 p.m. HST) Walk-in service: 711 Kapiolani Blvd. Honolulu, HI 96813 Monday through Friday, 8:00 a.m. – 4:30 p.m. excluding State observed holidays

UnitedHealthcare (UHC)	**www.uhcretiree.com** (866) 868-0324 (Monday through Friday 7am-8pm HST)
CVS Caremark (CVS) Non-Medicare Retirees: **SilverScript (SSI)** Medicare Retirees:	**caremark.com** 1-855-801-8263 **eutf.silverscript.com** **hstavb.silverscript.com** 1-877-878-5715 **CVS/Caremark Walk In Customer Service Center:** **Location: 1003 Bishop St, Pauahi Tower, Suite 704** **Hours of Operation:** Monday through Friday, 7:45 a.m. – 4:30 p.m. HST **except State observed holidays**
Vision Service Plan (VSP)	**www.vsp.com** Toll Free: 1-866-240-8420 (Monday through Friday, 5:00 a.m. – 8:00 p.m. PST Saturdays 7:00 a.m. – 8:00 p.m. PST) Oahu: 808-532-1600 or Toll Free: 1-800-522-5162 Office located: 1003 Bishop Street, Pauahi Tower, Suite 890, Honolulu, HI 96813 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST) – walk-in location
Hawaii Dental Service (HDS)	**www.HawaiiDentalService.com** 808-529-9310 or Toll Free: 1-866-702-3883 (Over the phone: Monday through Friday, 7:00 a.m. – 7:00 p.m. HST) Saturday 9:00 a.m. – 1:00 p.m., except Federal and State observed holidays) (Walk in hours: Monday through Friday, 8:00 a.m. – 4:30 p.m. HST, except Federal and State observed holidays) Office located: Topa Financial Center, Bishop Street Tower 700 Bishop Street, Suite 700
Royal State National (RSN)	**www.chiroplanhawaii.com** **Chiropractic Benefit (HSTA VB only)** 808-621-4774 or Toll Free: 1-800-414-8845 (Monday through Friday, 7:00 a.m. – 7:00 p.m. HST, Saturdays 9:00 a.m. – 1:00 p.m. HST, excluding State observed holidays) Walk-in Service: ChiroPlan Hawaii, Inc. 711 Kilani Avenue, Suite 3, Wahiawa, Hawaii, 96786 (Monday through Friday, 8:00 a.m. – 4:30 p.m. excluding State observed holidays.)
USAble Life (USA)	**www.usablelife.com/portal/eutf** 808-538-8920 or Toll Free: 1-855-207-2021 (Monday through Friday, 7:45 a.m. – 4:30 p.m. HST, except State observed holidays) USAble Life Full Service Walk In Office: First Hawaiian Center Building 999 Bishop St. Suite 2701 (Monday through Friday, 7:45 a.m. – 4:30 p.m. HST, except State observed holidays) Email: Service or General Inquiries: EUTF.CustServ@USAbleLife.com Claims Inquiries: EUTF>Claims@USAbleLife.com
CMS Centers for Medicare and Medicaid Services (CMS)	**cms.gov** 1-800-MEDICARE

Plan information can also be found online via the "Links to Carrier Web Sites" located on the EUTF website at eutf.hawaii.gov.

State of Hawaii
Department of Budget and Finance
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, Hawaii 96805-2121

Attention Retiree!!

IF MAKING CHANGES TO YOUR ENROLLMENT, THE DEADLINE FOR MAILING OR HAND DELIVERY OF THE ENROLLMENT FORM FOR RETIREES IS FRIDAY, OCTOBER 31, 2016. FORMS POSTMARKED OR SUBMITTED AFTER OCTOBER 31, 2016 WILL NOT BE PROCESSED.

Health Benefits Reference Guide

(EUTF and HSTA VB)

Active Employee Benefit Plans

Effective July 1, 2017 through June 30, 2018

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

April 2017

Aloha State and County Employees:

We are pleased to present the 2017 Reference Guide for Active Employee Benefit Plans. This Reference Guide provides information on the health benefit plans available to you for the fiscal year July 1, 2017 through June 30, 2018. You may make changes to your enrollment in these plans during the April 3 - 28, 2017 open enrollment period or if you have a qualifying event during the year. Any changes you make during open enrollment will take effect on July 1, 2017.

It is our vision to actively partner with you to improve your health. Our goal is to provide you with quality health benefit plan options. You earn these important benefits through the dedication and hard work you provide as a State or County employee. The information contained in this Reference Guide is intended to help you make good use of your benefits and make choices that best address your needs.

Please pay careful attention to the rates listed in this Reference Guide because significant changes have occurred that could affect the decisions you make. The EUTF Board of Trustees changed the method used to determine certain benefit plan rates. One result of the change is a significant reduction in the premiums for the PPO 75/25 Plan.

This Reference Guide and other useful information is also posted on the EUTF website at eutf.hawaii.gov. If you need any assistance, please call one of our helpful staff at 586-7390 or toll free at 1-800-295-0089.

Mahalo,

Roderick Becker, Chair
EUTF Board of Trustees

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Welcome to Open Enrollment for Active Employee Benefit Plans

The Open Enrollment period for Active Employee Health and Life insurance plans will be from April 3, 2017 through April 28, 2017.

Why is Open Enrollment special?
Now is the time when you should stop and think about health coverage for yourself and your family and determine which plan offered will best meet your needs for the new plan year (July 1, 2017 through June 30, 2018). During open enrollment, you can:

- Add a plan, change from one plan to another, or drop a plan
- Add an eligible dependent or drop a dependent
- Change coverage tiers such as changing from single to family or family to 2-party
- Now is also a good time to tell us if you've had a change of address

Open enrollment is generally your only opportunity to make changes without a qualifying event during the plan year such as needing to enroll a new dependent due to marriage or a birth. Paperwork must be submitted during the open enrollment period for changes to become effective for the plan year beginning July 1, 2017. So, now is the time to think about health benefits.

Here are the important dates:

- **Open Enrollment Election Period:** **April 3, 2017 through April 28, 2017**
- New coverage becomes effective: July 1, 2017
- Rates change effective: July 1, 2017
- New premiums deducted from paycheck: July 15, 2017 through June 30, 2018 (County Employees)
  July 20, 2017 through July 5, 2018 (State Employees)
- Plan Year Period: July 1, 2017 through June 30, 2018

Here's what you need to do now:

- **Know what you are enrolled in now:** What plans are you enrolled in? Who are the dependents enrolled on your plans? You may contact the EUTF at 586-7390 or toll-free at 1-800-295-0089, to inquire about which EUTF or HSTA VB plans you are enrolled in.
- **Learn what's being offered:** Read this Reference Guide to learn more about the plans and their cost. Attend an Open Enrollment informational session to get more details and talk to carrier representatives.
- **Make a decision about which plans best suit your needs**
- **Fill out the appropriate form:** Please refer to page 5 for complete enrollment instructions.

IF YOU DO NOT WANT TO MAKE ANY CHANGES, DO NOTHING. If you do not fill out a form, your current plan selections and eligible covered dependents will continue into the new plan year.

Plan Changes

Effective July 1, 2017 for Medical Plans:

I. For the EUTF and HSTA VB HMSA medical plans:
   1. Added coverage for gender identity services
   2. Removal of the age (under age 26) limit from the orthodontic services benefit for treatment of orofacial anomalies due to birth defects
   3. The benefit maximum of $25,000 per calendar year and the age limit (through age 13) for ABA services for the treatment of autism spectrum disorder will be removed
   4. Coverage clarification for newborns and adding coverage for the first 31 days of congenital defect and birth abnormalities even if the newborn is not added to the coverage

II. For the EUTF HMSA HMO medical plan:
   1. Removal of the limit (two per lifetime) on voluntary pregnancy terminations

III. For the EUTF HMSA (excluding HSTA VB) medical plans:
   1. Added coverage of supportive care benefit for seriously ill patients with congestive heart failure, chronic obstructive pulmonary diseases and liver failure
   2. Added coverage for counseling provided by a licensed dietitian

IV. For the EUTF Kaiser Comprehensive and Standard medical plans:
   1. Added coverage for gender reassignment surgery in accordance with federal law
   2. Removal of the dollar ($25,000) and age limit (under age 14) from the autism spectrum disorder benefit in accordance with federal law
   3. Removal of the age limit (under age 26) from the orthodontic services benefit for treatment of orofacial anomalies due to birth defects in accordance with federal law

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Open Enrollment Instructions

Step 1: **Review the choices available to you and decide whether you want to change** or keep your plans. If you decide to keep your current benefit plans, do nothing. You are not required to complete any forms to keep your current plans. See page 4 for plan changes.

Step 2: **Gather Information:** If you have questions about plan choices, please attend an Open Enrollment Informational Session. The schedule of sessions with location information is on page 7.

During Open Enrollment, all active employees are invited to explore health care and insurance options at the informational sessions. The following insurance carriers and administrator representatives will be on hand to answer your questions about their benefit plans.

Medical plans:	HMSA & Kaiser
Prescription Drug plans:	CVS/caremark & Kaiser
Supplemental Plan (Medical & Drug):	Royal State National
Dental plan:	HDS
Vision plan:	VSP
Life insurance:	USAble Life
Chiropractic plan:	Royal State National

If you are not sure which plan you're enrolled in now, please contact the EUTF at 808-586-7390 or toll-free at 1-800-295-0089, or you may call the carrier customer service numbers which are found on your ID cards. There are also links to the carrier websites on the EUTF website at eutf.hawaii.gov.

Step 3: **Which plans do you want to enroll in?** Review this Reference Guide and determine which health plans best meet your needs. The EUTF website includes links to insurance carriers' web pages along with the latest information regarding open enrollment. Questions regarding specific provisions for certain services should be directed to the carriers. Please refer to the back of this Guide for carrier contact information. The Summary of Benefits and Coverage for the medical and drug plans can be found at EUTF's website at eutf.hawaii.gov.

Step 4: **How much will it cost you**? Review the rates in the Premiums section of this Guide which show the employer/employee contributions for each employer and bargaining unit. (See pages 70-75)

Step 5: **Who do you need to cover?** You may add, or drop dependents from your plan, including a spouse, domestic partner (DP), civil union partner (CUP) or eligible children. Adding a spouse, domestic partner or civil union partner requires additional documentation. Refer to the Employee and Dependent Eligibility section beginning on page 12 of this Guide for details on who can be enrolled as an eligible dependent and visit the EUTF website at eutf.hawaii.gov to download forms.

Step 6: **Complete the Enrollment Form: Make your selections on the Form EC-1 for Active EUTF Employees, or EC-1H for those currently enrolled in HSTA VB plans. Please refer to the perforated pages at the end of this Guide or these forms can be downloaded from the EUTF website at eutf.hawaii.gov.**

A: To make changes to your personal information, such as your address, complete Section 1 and Section 6 on the Form EC-1 and EC-1H.

B: To change your plans, coverage selection or dependent information, including adding or dropping dependents or updating their data, complete Sections 1, 3, 4, 5 and 6 on the Form EC-1 and EC-1H. **Please mark all the coverages you want to be enrolled in, not just the ones you want to change.**

NOTE: If you are adding a new dependent, you are required to submit your dependent's Social Security Number (SSN) at the initial enrollment (except newborns, whose SSN must be submitted within 60 days from the date of the EUTF Confirmation Notice). If you are adding your spouse, you are required to submit a copy of your marriage certificate. If you are adding a dependent age 19-23 in dental and/or vision plans, you are required to submit your dependent's full-time student verification form or letter from the school's registrar's office or the National Clearinghouse.

C: Employees enrolled in the HSTA VB plans who change to the EUTF plans may NOT change back to HSTA VB plans in the future. Additionally, employees enrolled in the HSTA VB plans may not enroll in some HSTA VB plans and some EUTF plans – they must be enrolled in all HSTA VB plans or all EUTF plans.

Step 7: **THE MOST IMPORTANT STEP: REVIEW YOUR COMPLETED FORM.** Make sure these are the plans you want and the dependents you want to cover are eligible for coverage. You will not be able to change your selections after Open Enrollment ends, except as noted below, unless you experience a qualifying event during the plan year.

Last Step: **Submit the completed and signed form to your identified open enrollment designee no later than April 28, 2017.**

The designee may be your office secretary, financial officer, human resources personnel, etc.—find out who has been designated by your agency/department. It is very important that you submit your completed form on time.

FORMS SUBMITTED AFTER APRIL 28, 2017 WILL NOT BE PROCESSED.

The EUTF will send you an enrollment **Confirmation Notice** after processing is completed. The Confirmation Notice allows you to review the changes that were made to your coverages. If you note an error you will have a one-time opportunity to make corrections using the attached **Corrective Action Request Form (CAR)** within 15 calendar days from the date of the confirmation notice. County and Charter School employees **MUST** also notify their personnel if making changes to your EUTF enrollment using the CAR.

Although your coverage begins on July 1, 2017, your enrollment may not be processed right away. Therefore, if you need to fill a prescription or go to the doctor prior to receiving your ID cards you should email EUTF at eutf@hawaii.gov. In the email subject line type "URGENT – Confirmation of coverage needed". EUTF checks this email daily and will contact the carrier to rush your enrollment after it receives the EC-1 or EC-1H from your employer.

IMPORTANT: If any of your dependents are no longer eligible due to a divorce, reaching the limiting age or losing full-time student status (for dental and vision), they cannot continue to be covered under the EUTF plans. You are required to notify the EUTF and make these terminations when these events occur. Do not wait for open enrollment to submit these terminations.

ATTENTION: COBRA PARTICIPANTS

The COBRA Open Enrollment is also taking place April 3 – 28, 2017. Please refer to the EUTF website at eutf.hawaii.gov for more information.

2017 Schedule of Open Enrollment Informational Sessions for Active Employees

Date	Island	Locations	Time
Mar 30	Hawaii-Hilo	Aunty Sally Kaleohano's Luau Hale	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 3	Kauai	Kauai War Memorial Hall	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 4	Maui	UH Maui College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 5	Oahu	Mission Memorial Auditorium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 6	Online	Webinar	8:00-9:30am, 10:30am-12:00pm, 3:00-4:30pm
Apr 7	Oahu	UH West Oahu	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 10	Maui	UH Maui College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 10	Online	Webinar	8:00-9:30am, 10:30am-12:00pm, 3:00-4:30pm
Apr 11	Hawaii-Kona	West Hawaii Civic Center	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 12	Oahu	Windward Community College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 13	Oahu	Aloha Stadium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 17	Kauai	Kauai War Memorial Hall	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 18	Oahu	Mission Memorial Auditorium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 19	Lanai	Lanai Community Center	8:30-10:00am, 10:30am-12:00pm
Apr 19	Online	Webinar	8:00-9:30am, 10:30am-12:00pm, 3:00-4:30pm
Apr 20	Oahu	UH Manoa	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 21	Oahu	Leeward Community College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 24	Molokai	Kualapuu Park & Community Center	8:30-10:00am, 10:30am-12:00pm
Apr 25	Hawaii-Hilo	Aunty Sally Kaleohano's Luau Hale	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 26	Online	Webinar	8:30-10:00am, 1:30am-3:00pm
Apr 27	Oahu	Aloha Stadium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm

MAUI

UH Maui College
Pilina Multi-Purpose Room
310 Kaahumanu Avenue
Kahului, HI 96732

KAUAI

Kauai War Memorial Auditorium
4191 Hardy Street
Lihue, HI 96766

OAHU

Aloha Stadium
Hospitality Room
99-500 Salt Lake
Boulevard
Honolulu, HI 96818

Mission Memorial
Auditorium
550 South King Street
Honolulu , HI 96813

MOLOKAI

Kualapuu Park &
Community Center
1 Uwao Street
Kualapuu, HI 96757

LANAI

Lanai Community Center
8th Street
Lanai City, HI 96763

UH West Oahu
Campus Center C208
91-1001 Farrington Highway
Kapolei, HI 96707

Leeward Community
College
Education Building
96-045 Ala Ike Street
Pearl City, HI 96782

HAWAII

Aunty Sally Kaleohano's
Luau Hale
799 Piilani Street
Hilo, HI 96720

West Hawaii Civic Center
Community Meeting Hale
Bldg G
74-5044 Ane Keohokalole Highway
Kailua-Kona, HI 96740

Windward Community College
Hale Akoakoa Room 101-105
45-720 Keaahala Road
Kaneohe, HI 96744

UH Manoa
Kuykendall Auditorium
2445 Campus Road
Honolulu, HI 96822

How to Access the Webinar

1) Go to eutf hawaii.gov
2) In the top menu bar select "Learning Center" and click on "Webinars"
3) Select the desired webinar

MONEY SAVING TIPS

Properly using your EUTF health insurance coverage can save you and your family hundreds or even thousands of dollars. Making simple, cost effective decisions and being aware of how to effectively use your benefits will also keep you healthy while saving you $$. Start using the following information today:

Choose the Best Plan for Your Needs

Not all plans are created equal. Just because a plan has the highest monthly premium, does not mean it will be the most cost efficient.

Be sure to factor in your cost-share (deductibles, copayments and coinsurance), monthly premiums, calendar year out-of-pocket maximum and your expected usage for the year before making any plan decisions.

Every year open enrollment offers an opportunity to choose a plan that best suits your needs, which may change from year to year.

Pick the Right Facility

If you have a nagging cough, do not go the Emergency Room (ER). The ER should be reserved for emergency situations.

If you have a non-emergency illness or injury, go to your regular doctor or an urgent care clinic. For example, the total cost of a typical office visit would likely be less than $100 while an emergency room visit could cost upwards of $1,000. Other options include Kaiser or HMSA's online or telephonic care and clinics.

Use Participating Providers

Going to a non-participating doctor can be, in some cases, more than twice as expensive as going to a participating provider. Seeing doctors in your network is an easy way to keep your costs down.

Preventative Care

Preventing disease and detecting health concerns at an early state is key to living a healthy life. Getting regular preventative care may help you ward off potential serious health issues. It is much easier, and far less costly, to prevent an illness than it is to try to cure one. By following the guidelines for preventative care – and your doctor's advice – you are on your way to staying healthy.

Most preventative services are completely free of charge for you and your dependents when participating providers (in-network providers) are used. Examples include: immunizations, routine physical exams, mammograms, and well-baby care visits.

WHAT YOU CAN DO TO MAINTAIN GOOD HEALTH

HMSA Members

Staying healthy is the best way to control your health care costs. Take care of yourself all year long. See your provider early. Don't let a minor health problem become a major one. Take advantage of your many preventive care benefits, such as your annual physical exam—an annual checkup your doctor uses to assess your overall health. Talk to your doctor to learn about recommended preventive services and screening tests appropriate for your age and gender.

If you haven't seen your doctor in the last year, we encourage you to make an appointment for an annual visit. If you don't have a doctor visit hmsa.com, click on "Find a Doctor" in the top right corner. For help with finding a participating doctor, call 808-948-6499 or 1-800-776-4672 toll-free, Monday-Friday, 7 am – 7 pm HST.

Disease Management Services

Disease management is a no-cost service available to members with asthma, chronic obstructive pulmonary disease, coronary artery disease, heart failure, diabetes, or chronic kidney disease. Services are also available for members with behavioral health conditions. This program helps you and your doctor manage your care and make informed choices. For more information, call (855) 329-5461 toll-free, Monday – Friday 8am – 7pm and Saturday 8am – 5pm.

Health Coaching

Health coaching is a free service to help you reduce stress, manage your weight, develop a healthy eating plan, or manage chronic conditions. Call (855) 329-5461 toll-free to talk with a health coach, Monday – Friday 8am – 7pm and Saturday 8am – 5pm.

Dr. Ornish's Program for Reversing Heart Disease™ *

**Excludes HSTA VB Plans*

Members with heart disease or multiple cardiac risk factors may be eligible for Dr. Ornish's Program for Reversing Heart Disease®. This program can help reduce the amount of daily medication needed to manage heart disease and the risk of repeat procedures by improving key factors such as eating habits, stress management, and physical activity.

The program consists of eighteen, 4-hour sessions over nine weeks, at $20.00 per session. The program is available at three program delivery sites:

'Ekahi Healthcare Center at 500 Ala Moana Blvd., Honolulu 808-948-9500; **Hawaii Pacific Health** at 1100 Ward Ave., Honolulu 808-522-4114; and **Island Heart Care** at 75-1027 Henry St, Suite 110 Kailua Kona, 808-769-5225. To find out if you are eligible for this program, talk to your doctor or contact an Ornish care specialist at 1-877-888-3091 toll-free.

HMSA's Online Care®

See a doctor on your smartphone or tablet 24 hours a day, seven days a week, including holidays to answer questions or help with your concerns. No appointment or copayment is needed. Online Care doctors and specialists can diagnose conditions and prescribe medication when necessary. To learn more, go to hmsaonlinecare.com.

QuitNet® is a free tobacco cessation program. Quit smoking for good with the support of local coaches and the world's largest online quit-smoking community. To get started, call 1 (855) 329-5461 toll-free and talk to a health coach, Monday – Friday 8am – 7pm and Saturday 8am – 5pm.

DO YOU KNOW ABOUT THESE HEALTH PLAN BENEFITS?

Kaiser Permanente Members

Preventive Services. *Prevention makes good health possible!*

Many preventive screening tests are covered at no cost to you once per benefit year when you use participating providers. Depending on your age and gender some screenings may not be necessary. Screenings may include: Age-appropriate preventive medical examinations, preventive annual physical exam, blood pressure screening, colorectal cancer screening (for adults 50-75), cervical cancer screening, breast cancer screening, lipid evaluation, and much more. If you have questions about screenings recommended for you or what you are due for, please talk to your health care provider today.

Explore Healthy Resources. Kp.org *Online tools to help you thrive.*

Kp.org is your online gateway to great health. When you register, you can securely access many time-saving tools for managing the care you get at our facilities. Visit **kp.org** anytime, from anywhere to schedule and cancel routine appointments, view most lab results, refill most prescriptions, email your Kaiser Permanente doctor's office with non-urgent questions, print vaccinations records, manage a family member's health, take the total health assessment (*earn a $25 gift card by taking the total health assessment*), access to health lifestyle programs (*complete up to 3 healthy lifestyle program and earn an additional $25 gift card per program*), and so much more…..

Kaiser Permanente Fit Rewards. *Earn free gym membership!*

When you join, or are a current member of Kaiser Permanente (except those in Medicare and Medicaid/QUEST), you can earn free gym membership for up to a year. As a reward of making your health a priority, you will get reimbursed your $200 annual gym membership, after you go to the gym at least 45 days for a minimum of 30 minutes a session in 2017. For more information and to locate participating gyms in your area, visit **kp.org/fitrewards**.

Health Coaching. *Get the motivation and guidance you need!*

Take an active role in your health with our local health coaches. A personal coach can help you create and stick with a plan for reaching your goals, including: Getting more active, eating better, managing your weight, and reducing stress. There is no charge for telephonic health coaching. To schedule a convenient telephone session with your personal coach, call **808-432-2262,** Monday – Friday. We will call you back to schedule your wellness coaching sessions.

Tobacco Cessation. *Break the habit for good!*

The tobacco cessation program is provided free of charge to members. Trained counselors are available by phone to provide quit support and guidance. You may also be eligible to receive free tobacco cessation medications at no cost with a doctor's prescription. To talk to a counselor, call **808-643-4622**, Monday – Friday (appointments are available 8:30 am -2:30 pm).

DO YOU KNOW ABOUT THESE PHARMACY PLAN BENEFITS?

CVS/caremark Members

Diabetes Products

Regular blood glucose testing is essential for people with diabetes. One of the best ways to manage diabetes is to check blood sugar every day with a blood glucose meter. **The Diabetic Meter Program** provides eligible members with a no-cost blood glucose meter. The meters are funded by LifeScan Inc. the manufacturer of your prescription benefit plan's preferred glucose meters (One Touch).

To find out if you qualify for this benefit call the CVS/caremark Member Services Diabetic Meter Team toll-free at 1-800-588-4456.

Tobacco Cessation Products

Tobacco cessation products are provided as a plan benefit to support our members to quit smoking. CVS/caremark provides education and plan recommendations for certain products at no cost to members such as nicotine patches and other prescription medications.

To learn more about this program and covered medications call CVS/caremark customer service center 24/7 at 855-801-8263.

TIPS FOR USING YOUR PRESCRIPTION DRUG BENEFITS

All Plan Members

Ways to Save Money on Your Prescription Drug Costs

Ask your prescribing doctor if a generic medication is available and if you are able to make a switch to a generic drug. Taking a brand named drug over a generic drug can cost you 80% or more in copayments per prescription. Making a switch to a generic drug could save you hundreds of dollars annually. If we all make these changes, collectively we could potentially save the EUTF plan hundreds of thousands of dollars annually which would result in lower plan premiums.

Another way to save money is by using the mail-order program for 90-day supplies of prescription drugs. Mail order provides you with the lowest copayment and the convenience of free shipping to a location of your choice, and Mail order is also located locally so shipping will take only 2-3 days to be sent to a local address. The EUTF plan has the potential to save a significant amount of money since it cost less to fill prescriptions at a mail pharmacy versus a retail pharmacy. Those savings can help to lower future prescription drug premiums. Additionally, filling your prescriptions in a 90-day supply help to improve adherence. Members who fill prescriptions in a 90-day supply have a 10% improvement in optimal adherence to manage their health conditions. This also supports long-term savings to the EUTF plan. To start mail order, contact CVS/caremark at 1-855-801-8263.

For more information, visit caremark.com or call CVS Customer Care at 1-855-801-8263.

For Kaiser members, if you have not done so already, you'll need to register for a secure kp.org account in order to refill prescriptions online. You also can set up mail-order services when you visit your Kaiser Permanente or call the number on the prescription label.

Employee and Dependent Eligibility

Eligibility for coverage is determined by the Hawaii Revised Statutes and by the EUTF Administrative Rules adopted by the EUTF Board of Trustees. Requests for enrollments, terminations, and other changes must be submitted to the EUTF through your designated personnel officer. DOE employees please submit your changes to the DOE-EBU office. If you have any questions concerning eligibility provisions, please refer to the EUTF Administrative Rules posted on the EUTF website at eutf.hawaii.gov. You may also call the EUTF Member Services Branch at 808-586-7390 or toll free at 1-800-295-0089 or email your inquiry to eutf@hawaii.gov.

Health Plans

Employee Eligibility: The following persons are eligible to enroll as employee-beneficiaries in the benefit plans offered or sponsored by the EUTF for Active employees:

- An eligible employee, including an elective officer of the State, county or legislature
- The surviving spouse, Domestic Partner or Civil Union Partner (DP/CUP) of an employee killed in the performance of duty, provided the spouse or DP/CUP does not remarry or enter into another domestic or civil union partnership, shall be enrolled in Retiree plans
- The unmarried child of an employee killed in the performance of duty, provided the child is under the limiting age, as defined in the EUTF Administrative Rule 1.02 or is an adult disabled child in accordance with the EUTF Administrative Rule 3.01(b)(3) and does not have a surviving parent who is eligible to be an employee-beneficiary, shall be enrolled in Retiree plans

Dependent Eligibility: The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the EUTF for Active employees:

- The Employee's legal spouse, Domestic Partner or Civil Union Partner (DP/CUP).
- You or your spouse's/DP's/CUP's children under the age of 26 (for medical and prescription drug coverage). This includes children by birth, marriage (stepchild), or adoption or placement for adoption. For dental and vision coverage, dependent children under the age 19, and from age 19 through age 23 if they are full time students. For children covered under a legal guardianship or foster children, their coverage will terminate at age 18.
- 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 to the child reaching age 19.

Group Life Insurance

Only employees are eligible for the group life insurance plan offered by the EUTF.

Special Eligibility Requirements for Domestic and Civil Union Partners

Domestic Partner (DP): A person in a spouse-like relationship with an employee-beneficiary who meets the following requirements (you may also enroll a Domestic Partner's children as dependents so long as the children meet the EUTF eligibility requirements applicable to the enrollment of dependent children):

1. Intend to remain in a domestic partnership with each other indefinitely.
2. Have a common residence and intend to reside together indefinitely.
3. Jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care.
4. Neither are married or a member of another domestic partnership.
5. Not related by blood in a way that would prevent them from being married to each other in the State of Hawaii.
6. Both at least 18 years of age and mentally competent to contract.
7. Consent to the domestic partnership has not been obtained by force, duress or fraud.
8. Both sign and file a notarized declaration of domestic partnership (affidavit) with the EUTF.

Civil Union Partner (CUP): A person who has entered into a civil union under the rules established by the State of Hawaii Department of Health. You may also enroll a civil union partner's children as dependents so long as the children meet the EUTF eligibility requirements applicable to the enrollment of dependent children.

NOTE: There may be Federal and State Income Tax consequences with employer paid coverage for domestic partners. There may be Federal Income Tax consequences with employer paid coverage for civil union partners. If your domestic partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic partner will be deemed taxable income and reported to you on the appropriate federal or state tax form. If your civil union partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your civil union partner will be deemed taxable income and reported to you on the appropriate federal tax form. Consult your tax advisor to determine your domestic or civil union partner's status. If you determine that your domestic or civil union partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available along with information/instructions on the EUTF website at eutf.hawaii.gov) to the EUTF.

Enrollment

To enroll, you must complete a EUTF Enrollment Form for Active Employees (EC-1 or EC-1H [if you are already enrolled in the HSTA VB plans]) (see the perforated pages at the end of this Guide). If you do not enroll eligible members of your family within 30 days (180 days for newborns) of when you or they first become eligible, you must wait until the next Open Enrollment period to do so. The plan year for active employees begins July 1 and ends June 30 of the following year.

ID Cards

After you enroll for the first time, you will receive identification cards from the plans as follows:

- HMSA, CVS/caremark and HDS will issue two identical ID cards showing the name of the subscriber
- Kaiser will issue an ID card for each enrolled member of a family upon initial enrollment
- ChiroPlan Hawaii under Royal State National, USAble Life and VSP – ID cards are not required to obtain services.

Dual Enrollment Is Not Allowed

No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse/DP/CUP are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans.

Medicare Part B Premium Reimbursement

If you and your dependent are enrolled in a EUTF active employee medical plan, you and your dependent are not eligible for Medicare Part B reimbursement. However, if you are an active employee, enrolled in Medicare Part B and covered in the EUTF retiree medical plan as a spouse, surviving spouse, civil union or domestic partner, you are entitled to Medicare Part B reimbursement.

Change of Coverage – Special Enrollment Period due to a Qualifying Event

You are eligible to change coverage outside of the Open Enrollment period for the following reasons:

1. You marry and want to enroll your spouse and/or newly eligible dependent children. A copy of your marriage certificate is required.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide appropriate documents verifying the adoption in order to have the application accepted. To enroll a newborn, you do not need to attach a copy of the birth certificate or submit the social security number. A copy of the birth certificate is required only if

the child has a different last name from the employee. A social security number is required within 60 days from the date of the EUTF Confirmation Notice.

3. You have a change in family status involving the loss of eligibility of a family member (e.g., legal separation, divorce, death, child turns age 26 for medical and prescription drug, child age 19-23 is no longer a full-time student for dental & vision). See pages 19-22 for a list of the required documents.
4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage. A copy of the Loss of Coverage letter from your previous employer or insurance plan is required.
5. You move out of your plan's service area.

To change your coverage, you must complete Form EC-1 or EC-1H (if currently enrolled in the HSTA VB plans) and submit it through your employer representative within 30 days of the date of the event (180 days for newborns). Generally, removal of dependents is effective on a prospective basis, depending upon receipt of the enrollment form by the EUTF.

Dependent children are automatically terminated from the medical and prescription drug plans at the end of the month that they attain age 26 and do not require the completion of an enrollment form to terminate coverage.

Dental and vision coverage for the dependent automatically terminates at the age of 24 if the dependent is a full time student or 19 if not; and, does not require the completion of an enrollment form to terminate their coverage. If a dependent age 19-23 is no longer a full-time student, an enrollment form must be submitted to terminate their coverage.

If events are filed within 30 days of the qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. These events include: Adoption, Birth (filed within 180 days of the date of birth), Guardianship, Newly Eligible Student, Marriage, New Domestic Partner, New Civil Union Partner, Reinstatement in Employment, and Return from Authorized Leave of Absence (if not currently enrolled). See Common Qualifying Events That Allow Enrollment Changes for Active Employees on pages 19-22.

End of Coverage

Common situations resulting in loss of coverage for you and your dependents are:

1. You do not make required premium payments.
2. You die, subject to exceptions.
3. You fail to comply with the EUTF Administrative Rules.
4. You file fraudulent claims.
5. Your dependent reaches the limiting age or you divorce.
6. A surviving spouse, DP or CUP remarries or enters into another partnership.

Effective Dates of Coverage for New Hires and Employees Newly Eligible for EUTF Benefits

You have 3 choices of when you would like your coverage to begin:

1) Your date of hire or date you become newly eligible for EUTF benefits
2) First day of the first pay period from your date of hire or date you become newly eligible for EUTF benefits
3) First day of second pay period from your date of hire or date you become newly eligible for EUTF benefits

For example:

Date of hire or date you became newly eligible is January 3, 2017:

Option 1 effective date of coverage:	January 3, 2017
Option 2 effective date of coverage:	January 16, 2017
Option 3 effective date of coverage:	February 1, 2017

Although your coverage begins on the date you select, your enrollment may not be processed right away. Therefore, if you need to fill a prescription or go to the doctor prior to receiving your ID cards you should email EUTF at eutf@hawaii.gov. In the email subject line type "URGENT – Confirmation of coverage needed". EUTF checks this email daily and will contact the carrier to rush your enrollment after it receives the EC-1 or EC-1H from your employer.

If you were enrolled in the EUTF with your previous public employer and your coverage is still in effect on the day you begin work with your current public employer (COBRA coverage excluded), your coverage is continuous and you will experience no break in coverage. (See Transfer of Employment below.)

Transfer of Employment
If you terminate employment and are rehired by the same public employer within the same pay period or the next consecutive pay period, you are considered as having transferred employment and you shall be treated as if continuously enrolled in the EUTF benefit plans. If you terminate employment and are rehired by a different public employer (e.g., state to county or county to county) within the same pay period or the next consecutive pay period, you are allowed to change between plans, including adding or deleting dependents and changing coverage tiers. For purposes of this section only, the different public employers are: 1) State, including executive, legislative and judicial branches, Department of Education, University of Hawaii, Hawaii Health Systems Corporation, Office of Hawaiian Affairs, and all Charter Schools; 2) City and County of Honolulu; 3) County of Hawaii; 4) County of Kauai, and 5) County of Maui.

Effective Date of Termination
In general, when an event causes you or your dependent's coverage to terminate, such termination will be effective on the first day of the first pay period following the occurrence of the event, e.g., divorce, end of domestic or civil union partnership, death, surviving spouse/partner remarries, or child ceases to be eligible for coverage. There may be certain instances in which the effective date of termination is different, e.g. on the last day of the month in which a dependent reaches the limiting age. You may obtain additional information by referring to the EUTF Administrative Rules that are posted on the EUTF website at eutf.hawaii.gov.

Rejection of Enrollment
Enrollment in EUTF benefit plans is contingent on meeting all eligibility criteria detailed in the EUTF Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required.

An enrollment application shall be rejected if:
1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
2. The application is not filed within the time limitations prescribed by the EUTF Administrative Rules (see Common Qualifying Events That Allow Enrollment Changes During the Plan Year for Active Employees on pages 19-22);
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The employee-beneficiary owes past due contributions or other amounts to the EUTF; or
5. Acceptance of the application would violate applicable federal or state law or any other provision of the rules.

Employee-beneficiaries will be notified by mail of the rejection of any enrollment application.

Premium Conversion Plan – State of Hawaii Employees Only

Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to pay their health benefit plan

premiums on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://dhrd.hawaii.gov.

By electing to participate in the PCP, please note that:

1. Your authorization will automatically continue year-to-year for the duration of the plan until you change or cancel your participation in the PCP during the Open Enrollment period or as provided under number 2 below.
2. If you have an allowable change in status event (e.g., marriage, birth or adoption of children, divorce, etc.), you must complete/file all the required PCP forms within 90 days of the event, to change or cancel your reduction in pay (otherwise, changes can be made only during the Open Enrollment period). Please note that you must notify the EUTF within 30 days of the event in order to make the change in coverage.
3. Allowable changes/cancellations shall become effective as soon as administratively possible, on a **prospective** basis, after you file your forms (e.g. the beginning of the pay period following receipt of your form). To avoid the risk of losing money, you need to file the forms as soon as possible. Changes in pre-tax payroll deductions are always done after receipt of the PCP-2 forms; never retroactively.
4. Your PCP payroll deduction, in the absence of a PCP allowable change in status, cannot be changed for the current plan year.
5. If you change/cancel your health insurance plan coverage, but your PCP change/cancellation is not allowable, your PCP payroll deduction will remain in effect through the end of the plan year and your payments will be forfeited until PCP change/cancellation forms are filed and approved during the next Open Enrollment period.

PCP Example #1:

- Employee's divorce is effective August 2, 2017, and moves from a 2-party to self only plan.
- Employee has 30 days to submit an EC-1/EC-1H (if enrolled in HSTA VB plans) requesting to remove his/her ex-spouse.
- Employee submits an EC-1/EC-1H and DPO completes "Date EC-1/EC-1H Received in Employing Office" section on August 18, 2017.
- EUTF changes coverage effective August 15, 2017 (end of pay period in which event occurred)
- PCP allows payroll deduction change to occur on September 1, 2017 – prospective (next pay period) from the date the DPO receives the EC-1/EC-1H.
- Employee suffers one pay-period forfeiture (08/16/2017 – 08/31/2017).
- If employee had turned in EC-1 and the DPO completed the "Date EC-1 Received in Employing Office" section on or before August 15, 2017, there would be no forfeiture.

PCP Example #2:

- Employee acquires health coverage through spouse's plan, effective July 1, 2017.
- Employee has 30 days to submit EC-1/EC-1H (if enrolled in HSTA VB plans) form to terminate coverage.
- Employee submits an EC-1/EC-1H form and the DPO completes "Date EC-1/EC-1H Received in Employing Office" section on July 7, 2017.
- EUTF terminates coverage effective June 30, 2017.
- PCP allows payroll deduction change to become effective July 16, 2017, prospective (next pay period) from the date the DPO receives the EC-1/EC-1H.
- Employee suffers one pay period forfeiture (07/1/2017 – 07/15/2017).

- If employee had submitted their EC-1/EC-1H form and the DPO completed the "Date EC-1 Received in Employing Office" section on or before June 30, 2017, there would be no forfeiture.

Note: The PCP Election Change Form (PCP-2) must be submitted with the EC-1/EC-1H form. The date the DPO completes the "Date EC-1 Received in Employing Office" section is the key date used to determine the PCP effective date.

Premium Conversion Plan – County Employees Only

Please contact your county department personnel office for more information on available options.

Administrative Appeals Related to Eligibility (not related to claims filing)

Under EUTF Administrative Rule 2.04, a person aggrieved by one of the following eligibility decisions by the EUTF may appeal to the EUTF Board of Trustees (Board) for relief from that decision:

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF.

The first step in the appeal process is an appeal to the EUTF administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the EUTF's office within one hundred eighty (180) days of the date of the adverse decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the EUTF administrator nor the Board shall be required to hear any appeal that is filed after the one hundred eighty (180) day period has expired. The written appeal need not be in any particular form but should contain the following information:

1. The aggrieved person's name, address, and telephone number;
2. A description of the decision with respect to which relief is requested, including the date of the decision;
3. A statement of the relevant and material facts; and
4. A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.

If the aggrieved person is dissatisfied with the EUTF administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within thirty (30) days of its being filed in the EUTF's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the Board. A written appeal to the Board must be filed in duplicate in the EUTF's office within ninety (90) days of the administrator's action. If no action is taken by the administrator within thirty (30) days of the written appeal to the administrator being filed in the EUTF's office, then the written appeal to the Board must be filed in duplicate in the EUTF's office within one hundred twenty (120) days of the written appeal to the administrator being filed in the EUTF's office. The written appeal need not be in any particular form but shall contain the following information:

1. The aggrieved person's name, address and telephone number;
2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;
3. A description of the decision with respect to which relief is requested, including, the date of the decision;
4. A complete statement of the relevant and material facts;

5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Subject to applicable federal and state law, the Board may reject any appeal that does not contain the foregoing information.

The Board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.

The Board shall grant or deny the appeal within forty-five (45) days of the date of the postmark of a request for appeal. The Board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the Board may set such hearing before the Board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the Board to hear the matter in question. Please note that nothing in the EUTF Administrative Rules requires the Board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the EUTF Administrative Rules by submitting such a waiver in writing to the EUTF's office. The Board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

For Emergency Appeals of Eligibility, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

For Claim Filing and Appeals Information for Self-Insured Plan Administered Benefits, please refer to the EUTF Administrative Rule 2.06 for information on this appeal process.

The EUTF Administrative Rules can be found on the EUTF website at eutf.hawaii.gov.

Common Qualifying Events That Allow Enrollment Changes During the Plan Year for Active Employees

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Designated Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H*	EFFECTIVE DATE	CHANGES ALLOWED TO PLANS OR TO ENROLL IN PLANS OR ADD DEPENDENTS?
Acquisition of Coverage (employee gets coverage from another plan and wishes to cancel EUTF plans)	Within 30 days from effective date of gaining coverage elsewhere.	Letter from carrier or employer detailing type of coverages enrolled in (i.e., medical, drug, dental, vision) effective date and covered insured/ dependents, within 60 days from acquisition.	If coverage is gained 1st of month, EUTF coverage ends day before 1st. If coverage is gained 16th of month, EUTF coverage ends 15th.	N/A
Birth (employee wishes to add newborn to EUTF plans)	Within 180 days from date of birth.	Birth certificate only if child has a different last name from employee. Social Security Number within 60 days from the date of the EUTF Confirmation Notice.	Employee can choose: birth date, beginning of next pay period after birth date, or beginning of 2nd pay period after birth date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Child is No Longer a Full-time Student (employee must terminate dental and vision coverage for a child between ages 19 through 23)	Within 30 days of school end date.	None	Coverage ends the last pay period of school end date.	No
Court Order (to cover child)	EUTF receives the order directly from the Child Support Enforcement Agency (CSEA). No EC-1/ EC-1H is required if employee is already enrolled in EUTF plans.	CSEA notice	Effective date on CSEA notice.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Death	As soon as reasonably practical.	Death certificate or copy of obituary as soon as available.	Date of death or last day of pay period in which date of death occurs for dependents.	N/A
Divorce (employee must terminate spouse's or civil union partner's coverage)	Within 30 days of date of divorce If EC-1/EC-1H filed more than 30 days after date of divorce, employee shall be responsible for paying any claims incurred after the date of divorce.	Pages 1 and 2 of divorce decree, along with signature page. If children are involved, those pages that outline health benefits for children.	Coverage ends last day of pay period in which divorce date occurs.	No

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Designated Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H*	EFFECTIVE DATE	CHANGES ALLOWED TO PLANS OR TO ENROLL IN PLANS OR ADD DEPENDENTS?
Guardianship (employee wishes to add child to EUTF plans)	Within 30 days from date of guardianship.	Guardianship decree within 60 days.	Employee can choose: Date of guardianship, beginning of next pay period after date of guardianship, or beginning of 2nd pay period after date of guardianship.	No plan changes allowed if already in plan. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Legal Separation (employee must terminate spouse's EUTF coverage)	Within 30 days from date of legal separation If EC-1/EC-1H filed more than 30 days after date of legal separation, employee shall be responsible for paying any claims incurred after the date of legal separation.	Court document establishing legal separation, including any pages regarding health benefits for children.	Coverage ends last day of pay period of date of legal separation.	No
Leave of Absence Without Pay Lasting More than 30 Days (employee may waive all plans excluding life insurance or continue coverage by paying his/her share of premium or terminate coverage)	Within 30 days from beginning of LWOP to waive plans. To reenroll after LWOP EC-1/EC- 1H must be submitted within 30 days of return from LWOP.	Form L-1 completed by employer. Visit the EUTF website for this form as well as information about payment options available while on LWOP.	If employee cancels plans, last day of pay period in which LWOP begins.	No
Loss of Coverage (employee and/or dependent lost coverage from a non-EUTF plan, and wishes to enroll in EUTF plans)	Within 30 days from loss of other coverage.	Loss of coverage letter from previous employer/carrier detailing type of coverages lost (i.e., medical, dental, drug, vision), date of loss of coverage, and names of any covered dependents within 60 days.	Day following loss of coverage from other plan.	No plan changes allowed if already in plan. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Marriage (employee wishes to enroll new spouse in EUTF plans)	Within 30 days from date of marriage.	Marriage Certificate within 60 days of date of marriage.	Employee can choose: Date of marriage, beginning of next pay period after date of marriage or beginning of 2nd pay period after date of marriage.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Designated Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H*	EFFECTIVE DATE	CHANGES ALLOWED TO PLANS OR TO ENROLL IN PLANS OR ADD DEPENDENTS?
Newly Eligible Student (employee wishes to add child in dental or vision plan because child became a full time student and is between the ages of 19 through 23)	Within 30 days from school start date.	Student certification from an accredited college on school letterhead with registrar's signature confirming full time status within 60 days after becoming a full time student. Transcripts not acceptable.	Employee can choose: Date child becomes full time student, beginning of next pay period after becoming full time student, or beginning of 2nd pay period after becoming full time student.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
New Hire (new employee wishes to enroll in EUTF plans) Adult children under age 26 may be included in medical and prescription drug	Within 30 days of date of new hire.	1) Student Certificate if enrolling a dependent 19 through 23 in dental and/or vision (on school letterhead, signed by registrar) 2) Birth certificate if enrolling a dependent with a different last name and Social Security Number 3) Marriage certificate if married or civil union certificate Employees have 60 days from date of hire to turn in documents.	Employee can choose: New hire date, beginning of next pay period after new hire date, or beginning of 2nd pay period after new hire date.	N/A
New Domestic Partner (employee wishes to enroll new domestic partner in EUTF plans)	Within 30 days from date of notarized signature (event date is considered date of notarization).	Notarized Declaration of Domestic Partnership, and Affidavit of Dependency (notarized if IRS qualified) with EC-1 or EC-1H (forms available on the EUTF website).	Employee can choose: Date of notarization of Declaration of Domestic Partnership, beginning of next pay period after notary date, or beginning of 2nd pay period after notary date.	No plan changes allowed if already enrolled in plan. May enroll in plans if not already enrolled or may add dependents if already enrolled.
New Civil Union Partner (employee wishes to enroll new civil union partner in EUTF plans)	Within 30 days from date of civil union.	Civil union certification (on-line proof accepted), Affidavit of Dependency within 60 days of civil union date.	Employee can choose: Date of civil union, beginning of next pay period after date of civil union, or beginning of 2nd pay period after date of civil union.	No plan changes allowed if already in plan. May enroll in plans if not already enrolled or may add dependents if already enrolled.

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Designated Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H*	EFFECTIVE DATE	CHANGES ALLOWED TO PLANS OR TO ENROLL IN PLANS OR ADD DEPENDENTS?
Termination of Domestic Partnership (employee must terminate domestic partner and domestic partner's dependents)	Within 30 days of termination of partnership If EC-1/EC-1H is filed more than 30 days after date of termination of domestic partnership, employee shall be responsible for paying any claims incurred after the date of termination of domestic partnership.	Declaration of Termination of Domestic Partnership With EC-1 or EC-1H (forms are available on the EUTF website).	Coverage ends last day of pay period in which termination of domestic partnership occurred.	No

Note: For termination and transfer of employment, bargaining unit changes or death, the employer is required to notify EUTF immediately.

*Submit the EC-1/EC-1H form to your designated personnel office within 30 days of the event (excluding birth). Proof documents are required within 60 days of the event. If supporting documents are not received within 60 days of the event the event will be reversed retroactively.

The amended EUTF Administrative Rules were filed effective August 13, 2016. For a copy of the complete Administrative Rules please visit the EUTF website at eutf.hawaii.gov.

Rev. 02.13.17

Active Employee Benefit Plan Summaries

The following section provides condensed summaries of the health plans and life insurance coverage available for active employees. Remember that certain limitations and exclusions apply to all insurance plans. More complete information on the plans can be obtained directly from the carriers or from the EUTF website at eutf.hawaii.gov. If there should be any discrepancy between the information provided in this Reference Guide and that contained in the carrier's Guide to Benefits, the language in the carrier's Guide to Benefits will take precedence.

Medical and Prescription Drug Plan Options

Medical coverage is important to everyone. The Plans offered by the EUTF provide preventive care benefits to keep you healthy and many other benefits to help during those times when you are not. The EUTF offers the following Plan options, including prescription drug:

- Preferred Provider Organization (PPO) 90/10 Plan
- Preferred Provider Organization (PPO) 80/20 Plan
- Preferred Provider Organization (PPO) 75/25 Plan
- Health Maintenance Organization (HMO) Plans
- Supplemental Plan for those who are covered under another plan, such as a spouse's plan

The HSTA VB medical plan options, including prescription drug:

- Preferred Provider Organization (PPO) 90/10 Plan
- Preferred Provider Organization (PPO) 80/20 Plan
- Health Maintenance Organization (HMO) Plan

Understanding the Plan Designs

Preferred Provider Organization Plans (PPO) - EUTF 90/10, 80/20, and 75/25 and HSTA VB 90/10 and 80/20

A PPO plan is a medical plan that is based on a network of preferred medical providers who have contracts with the carrier. Coverage is also available if you go to a provider who is not in the network. A PPO gives you the flexibility to visit the providers you choose – inside or outside of the Plan's network. However, your out of pocket medical costs will be lower if you receive care from an in-network provider or facility. The numbers in the plan titles – 90/10, 80/20, or 75/25 – refer to the percent of eligible charges that the carrier pays for most network services – 90%, 80%, or 75% - and the amount the employee is responsible for, 10%, 20%, or 25%. It's important to note that when you participate in a PPO, you are responsible for asking if your medical provider is in the network or not. If you use an out-of-network provider, your out of pocket costs will be higher since most out-of-network expenses are paid at 60% or 70% and you would be responsible for 40% or 30% of the covered expense. Also, you'll often be responsible for submitting your own claims. Services provided by an out-of-network provider will impact your total cost. In addition to the higher coinsurance, you are responsible for the difference between the provider's billed charge and the Plan's eligible charge.

Health Maintenance Organization (HMO) - EUTF HMSA HMO and Kaiser Comprehensive and Standard HMO and HSTA VB Kaiser Comprehensive HMO

Under an HMO, you agree to use the health care professionals and facilities associated with that HMO. Except in emergencies, HMO's do not cover the cost of services you receive from doctors or other providers outside of the HMO's network. With an HMO, there are no deductibles or claim

forms. Generally, after a copayment for each office visit, most medical expenses are covered at 100%. You must select a Primary Care Provider to coordinate your care.

Supplemental Plan (Co-Payment Plan) - EUTF Royal State National Supplemental

If you have a primary medical plan through your non-State/County employed spouse/DP/CUP or another source, you can choose this plan. Covered medical expenses that are not covered by the other primary medical plan such as that plan's copays or coinsurance are paid under this plan. Covered expenses include copays for prescription drugs so there is not separate drug plan offered with the supplemental plan. You may enroll in the supplemental plan **only** if you have primary medical plan coverage not provided through the State or counties.

EUTF ACTIVES

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) - EUTF

Plan Design	EUTF 90/10 PPO Plan		EUTF 80/20 PPO Plan	
Carrier	**HMSA**		**HMSA**	
General	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Calendar Year Deductible Single/Family**	None	$100 per person; $300 per family	None	$250 per person; $750 per family
Calendar Year Maximum Out-of-Pocket Single/Family**	$2,000/$4,000		$2,500/$5,000	
Lifetime Benefit Maximum	None		None	
Plan Year Benefit Maximum	None		None	
Physician Services	**YOU PAY*:**		**YOU PAY*:**	
Primary Care Office Visit	10%	30%	20%	40%
Specialist Office Visit	10%	30%	20%	40%
Routine Physical Exams	No Charge	No Charge***	No Charge	No Charge***
Screening Mammography	No Charge	30%***	No Charge	40%**
Immunizations	No Charge	No Charge***	No Charge	No Charge***
Well Baby Care Visits	No Charge	30%***	No Charge	40%***
Maternity	10%	30%	10%	40%
Second opinion – surgery	10%	30%	20%	40%
Emergency Services				
Emergency Room (ER care)	10%	10%***	20%	20%***
Ambulance	10%	30%	20%	40%
Inpatient Hospital Services				
Room & Board	10%	30%	20%	40%
Ancillary Services	10%	30%	20%	40%
Physician Services	10%	30%	20%	40%
Surgery	10%	30%	20%	40%
Anesthesia	10%	30%	20%	40%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%	30%	20%	40%
Surgery	10%	30%	20%	40%
Diagnostic Lab	10%	30%	20%	40%
Diagnostic X-ray	10%	30%	20%	40%
Anesthesia	10%	30%	20%	40%
Mental Health Services				
Inpatient Care	10%	30%	20%, Facility Services	40%, Facility Services
Outpatient Care	10%	30%	20%, Facility Services	40%, Facility Services
Other Services				
Durable Medical Equipment	10%	30%	20%	40%
Home Health Care	No Charge	30%	20%	40%
Hospice Care	No Charge	Not Covered	No Charge	Not Covered
Nursing Facility - Skilled Care	10%, 120 days/CY	30%, 120 days/CY	20%, 120 days/CY	40%, 120 days/CY
Physical & Occupational Therapy	10%	30%	20%	40%
Notes:	*If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge. **Amounts paid toward the deduct ble and the maximum out-of-pocket limit are measured on a calendar year basis. However, if your new plan effective 7/1/17 is with the same carrier, the amounts paid from 1/1/17 – 6/30/17 will apply to your new plan deductible and maximum out-of-pocket limit. No refunds will be issued. ***Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 28.		*If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge. **Amounts paid toward the deductible and the maximum out-of-pocket limit are measured on a calendar year basis. However, if your new plan effective 7/1/17 is with the same carrier, the amounts paid from 1/1/17 – 6/30/17 will apply to your new plan deduct ble and maximum out-of-pocket limit. No refunds will be issued. ***Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 28.	

EUTF ACTIVES

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – EUTF continued

Plan Design	EUTF 75/25 PPO Plan		Supplemental
Carrier	**HMSA**		**Royal State**
General	In-Network	Out-of-Network*	
Calendar Year Deductible Single/Family**	$300/$900		None/None
Calendar Year Maximum Out-of-Pocket Single/Family**	$5,000/$10,000		None
Lifetime Benefit Maximum	None		None
Plan Year Benefit Maximum	None		All Services: $3,500 per person; Sublimit for Rx: $350/$700/$1,000
Physician Services	**YOU PAY*:**		**YOU PAY:**
Primary Care Office Visit	25%***	40%	Co-pay covered
Specialist Office Visit	25%***	40%	Co-pay covered
Routine Physical Exams	No Charge***	No Charge***	Co-pay covered
Screening Mammography	No Charge***	40%***	Co-pay covered
Immunizations	No Charge***	No Charge***	Co-pay covered
Well Baby Care Visits	No Charge***	40%***	Co-pay covered
Maternity	25%	40%	Co-pay covered
Second Opinion – Surgery	25%***	40%	Co-pay covered
Emergency Services			
Emergency Room (ER care)	25%	25%	Co-pay covered
Ambulance	25%	40%	Co-pay covered
Inpatient Hospital Services			
Room & Board	25%	40%	Co-pay covered
Ancillary Services	25%	40%	Co-pay covered
Physician Services	25%	40%	Co-pay covered
Surgery	25%	40%	Co-pay covered
Anesthesia	25%	40%	Co-pay covered
Outpatient Services			
Chemotherapy/ Radiation Therapy	25%	40%	Co-pay covered
Surgery	25%	40%	Co-pay covered
Diagnostic Lab	25%	40%	Co-pay covered
Diagnostic X-ray	25%	40%	Co-pay covered
Anesthesia	25%	40%	Co-pay covered
Mental Health Services			
Inpatient Care	25%, Facility Services	40%, Facility Services	Co-pay covered
Outpatient Care	25%, Facility Services	40%, Facility Services	Co-pay covered
Other Services			
Durable Medical Equipment	25%	40%	Co-pay covered
Home Health Care	25%	40%	Co-pay covered
Hospice Care	No Charge	Not Covered	Co-pay covered
Nursing Facility - Skilled Care	25%, 120 days/CY	40%, 120 days/CY	Co-pay covered
Physical & Occupational Therapy	25%	40%	Co-pay covered
Notes:	*If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the elig ble charge. **Amounts paid toward the deductible and the maximum out-of-pocket limit are measured on a calendar year basis. However, if your new plan effective 7/1/17 is with the same carrier, the amounts paid from 1/1/17 – 6/30/17 will apply to your new plan deductible and maximum out-of-pocket limit. No refunds will be issued. ***Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 28		For the Royal State Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed $20 per prescription drug (RX) up to $350 if enrolled in single coverage or $700 if enrolled in 2-party coverage and $1,000 if enrolled in family coverage per plan year. Reimbursement for prescription drugs co-payment count towards the Plan Year Maximum Benefit Payable.

EUTF ACTIVES

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – EUTF continued

Plan Design	HMO Comprehensive	HMO Standard	EUTF HMO
Carrier	**Kaiser***	**Kaiser***	**HMSA**
General			
Calendar Year Deductible Single/Family**	None/None	None/None	None/None
Calendar Year Out-of-pocket limit Single/Family**	$2,000/$6,000	$2,500/$7,500	$1,500/$3,000
Lifetime Benefit Maximum	None	None	None
Plan Year Benefit Maximum	None	None	None
Physician Services	**YOU PAY:**	**YOU PAY:**	**YOU PAY:**
Primary Care Office Visit	$15	$20	$15
Specialist Office Visit	$15	$20	$15
Routine Physical Exams	No Charge	No Charge	$15
Screening Mammography	No Charge	No Charge	No Charge
Immunizations	No Charge	No Charge	No Charge
Well Baby Care Visits	No Charge	No Charge	No Charge
Maternity	No charge for routine prenatal visits and one postpartum visit	No charge for routine prenatal visits and one postpartum visit	No Charge, Routine Pre/Post Natal Care & Delivery
Second Opinion – Surgery	$15	$20	$15
Emergency Services			
Emergency Room (ER care)	$50	$100	$25
Ambulance	20%	20%	20%
Inpatient Hospital Services			
Room & Board	No Charge	15%	No Charge
Ancillary Services	No Charge	15%	No Charge
Physician Services	No Charge	15%	No Charge
Surgery	No Charge	15%	No Charge
Anesthesia	No Charge	15%	No Charge
Outpatient Services			
Chemotherapy/ Radiation Therapy	$15	$20 for chemotherapy; 20% for radiation therapy	$15
Surgery	$15	15%	$15
Diagnostic Lab	$15/department/ day	$10/ department/ day for basic; 20% for specialty	No Charge
Diagnostic X-ray	$15/department/ day	$10/ department/ day for basic; 20% for specialty	$15 per X-ray
Anesthesia	$15	15%	$15
Mental Health Services			
Inpatient Care	No Charge	15%	No Charge, Facility Services
Outpatient Care	$15	$20	No Charge, Facility Services
Other Services			
Durable Medical Equipment	20%	50%	20%
Home Health Care	No Charge	No Charge	No Charge
Hospice Care	No Charge	No Charge	No Charge
Nursing Facility - Skilled Care	No Charge, 100 days/benefit period	15%, 60 days/benefit period	No Charge, 100 days/CY
Physical & Occupational Therapy	$15	$20	$15 (Outpatient)
Notes:	For prescription drug coverage, refer to the Kaiser HMO plan on page 29.		For prescription drug coverage, refer to the HMO plan on page 29.

*For Kaiser Members only:

1. Except for certain situations described in your *Group Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to your *Group Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement*.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

**Kaiser: Amounts paid toward the maximum out-of-pocket limit are measured on a calendar year basis. However, if your new plan effective 7/1/17 is with the same carrier through EUTF, the amounts paid from 1/1/17 – 6/30/17 will apply to your new plan maximum out-of-pocket limit. No refunds will be issued.

HMSA HMO: Amounts paid toward the maximum out-of-pocket limit are measured on a calendar year basis. However, if your new plan effective 7/1/17 is with the same carrier, the amounts paid from 1/1/17 – 6/30/17 will apply to your new plan maximum out-of-pocket limit. No refunds will be issued.

EUTF ACTIVES

PPO and HMO Prescription Drug Plans Coverage Chart (CVS/caremark & Kaiser) – EUTF

COVERAGE	PPO Prescription Drug Plan CVS/caremark*	
	Participating Pharmacy	**Nonparticipating Pharmacy****
Calendar Year Maximum Out-of-Pocket Single/Family	90/10 and 80/20 PPO Plan: $4,350/$8,700*** 75/25 PPO Plan:$1,850/$3,700***	None
RETAIL PRESCRIPTION PROGRAM (30/60/90 day supply)		
Generic	$5/$10/$15 copayment	$5/$10/$15 + 20% of eligible charges
Preferred Brand Name	$25/$50/$75 copayment	$25/$50/$75 + 20% of eligible charges
Other Brand Name	$50/$100/$150 copayment	$50/$100/$150 + 20% of eligible charges
Injectables and Specialty Drug	20% of eligible charges; Up to $250 maximum; $2,000 out-of-pocket maximum per calendar year; $30 copay oral oncology specialty medications	Not a benefit
Insulin		
Preferred Insulin	$5/$10/$15 copayment	$5/$10/$15 + 20% of eligible charges
Other Insulin	$25/$50/$75 copayment	$25/$50/$75 + 20% of eligible charges
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	20% of eligible charges
Other Diabetic Supplies	$25/$50/$75 copayment	$25/$50/$75 copayment + 20% of eligible charges
RETAIL 90 PHARMACY & MAIL ORDER PRESCRIPTION PROGRAM (30/60/90 day supply)		
	Retail 90 or Mail Pharmacy	**Non-Retail 90 Pharmacy**
Generic	$5/$10/$10 copayment	$5/$10/$15 copayment
Preferred Brand Name	$25/$50/$50 copayment	$25/$50/$75 copayment
Other Brand Name	$50/$100/$100 copayment	$50/$100/$150 copayment
Insulin		
Preferred Insulin	$5/$10/$10 copayment	$5/$10/$15 copayment
Other Insulin	$25/$50/$50 copayment	$25/$50/$75 copayment
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	No copayment
Other Diabetic Supplies	$25/$50/$50 copayment	$25/$50/$75 copayment

For the Royal State Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed $20 per prescription drug (RX) up to $350 if enrolled in single coverage, $700 if enrolled in 2-party coverage or $1,000 if enrolled in family coverage per policy year. Reimbursement for prescription drugs co-payment count towards the Plan Year Maximum Benefit Payable.

* This plan is the prescription drug coverage for the HMSA PPO medical options and is administered by CVS/caremark.

**If you receive services from a nonparticipating (out-of-network) pharmacy you are responsible for the copayment + coinsurance and any cost difference between the actual charge and the eligible charge.

***There is a prescription drug Maximum Out-of-Pocket (MOOP) limit of $4,350 per individual and $8,700 per family for the 90/10 PPO and 80/20 PPO plans and $1,850 per individual and $3,700 per family for the 75/25 PPO plan for the calendar year (1/1/17 – 12/31/17). Applicable copayments and caps for specialty medications apply and are counted towards the total annual out-of-pocket maximum for the 90/10 plan, the 80/20 plan, and the 75/25 plan.

The CVS/caremark prescription drug plan is bundled with the HMSA medical plan that you select. If you change from one HMSA medical plan to another during open enrollment your drug Maximum Out-of-Pocket (MOOP) may change on the effective date of your new plan selection. The new plan may have changes to the specialty drug cap, or a change to the prescription drug MOOP which may be of a higher or lower amount. All applicable drug copayments and co-insurance are accumulated on a calendar year basis towards an annual MOOP amount, and once the MOOP amount is met, you will no longer pay applicable copayments and coinsurance for the remainder of the calendar year while enrolled on that plan. If you change to a plan with a higher MOOP amount, you are responsible to meet the new MOOP level, but all prior applicable copayments and co-insurance paid towards one CVS/caremark plan can be credited towards the new MOOP amount for the new plan. If you change to a plan with a lower MOOP amount, there are no refunds for copayments or co-insurance that was paid towards the higher MOOP of the prior plan that are over the amounts of the new MOOP for the new plan.

All copayments and co-insurance paid are applied prospectively to the applicable MOOP amount based upon the plan the member is enrolled at the time.

Please note: Maintenance medications must be filled in a 90-day supply. Medications prescribed for treatment that are not approved by the Federal Drug Administration are excluded from the plan.

EUTF ACTIVES

PPO and HMO Prescription Drug Plans Coverage Chart (CVS/caremark & Kaiser) – EUTF continued

COVERAGE	HMO Prescription Drug Plan		
	Kaiser Comprehensive	Kaiser Standard	CVS/caremark*
	Copayment up to	**Copayment up to**	**In-Network**
Calendar Year Maximum Out-of-Pocket Single/Family	Applies towards the medical out of pocket supplemental charge maximum	Applies towards the medical out of pocket supplemental charge maximum	$4,350/$8,700**
RETAIL PRESCRIPTION PROGRAM (30/60/90 day supply)			
Generic	$5/$10/$15 – tier 1 $10/$20/$30 – tier 2	$5/$10/$15 – tier 1 $15/$30/$45 – tier 2	$5/$10/$15 copayment
Preferred Brand Name	$35/$70/$105	$50/$100/$150	$25/$50/$75 copayment
Other Brand Name	$35/$70/$105	$50/$100/$150	$50/$100/$150 copayment
Injectables and Specialty Drug	$75/$150/$225	$75/$150/$225	20% of eligible charges; Up to $250 maximum; $2,000 out-of-pocket maximum per calendar year; $30 copay oral oncology specialty medications
Insulin			
Preferred Insulin	$35/$70/$105 – brand insulin	$50/$100/$150 – brand insulin	$5/$10/$15 copayment
Other Insulin	$10/$20/$30 – generic insulin	$15/$30/$45 – generic insulin	$25/$50/$75 copayment
Diabetic Supplies			
Preferred Diabetic Supplies	$35/$70/$105	50% of applicable charges	No copayment
Other Diabetic Supplies	$35/$70/$105	50% of applicable charges	$25/$50/$75 copayment
MAIL ORDER PRESCRIPTION PROGRAM (30/60/90 day supply)			
			Mail or Retail 90 Pharmacy
Generic	$5/$10/$10 – tier 1 $10/$20/$20 – tier 2	$5/$10/$10 – tier 1 $15/$30/$30 – tier 2	$5/$10/$10 copayment
Preferred Brand Name	$35/$70/$70	$50/$100/$100	$25/$50/$50 copayment
Other Brand Name	$35/$70/$70	$50/$100/$100	$50/$100/$100 copayment
Insulin			
Preferred Insulin	Not Available through Mail Order	Not Available through Mail Order	$5/$10/$10 copayment
Other Insulin			$25/$50/$50 copayment
Diabetic Supplies			
Preferred Diabetic Supplies	$35/$70/$70	50% of applicable charges	No copayment
Other Diabetic Supplies	$35/$70/$70	50% of applicable charges	$25/$50/$50 copayment

For the Royal State Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed $20 per prescription drug (RX) up to $350 if enrolled in single coverage, $700 if enrolled in 2-party coverage or $1,000 if enrolled in family coverage per policy year. Reimbursement for prescription drugs co-payment count towards the Plan Year Maximum Benefit Payable.

* This plan is the prescription drug coverage for the HMSA HMO medical options and is administered by CVS/caremark.

**There is a prescription drug Maximum Out-of-Pocket (MOOP) limit of $4,350 per individual and $8,700 per family for the EUTF HMSA HMO plan for the calendar year (1/1/17 – 12/31/17). Applicable copayments and caps for specialty medications apply and are counted towards the total annual drug out-of-pocket maximum for the EUTF HMSA HMO plan.

For a summary of out-of-network benefits for the CVS/caremark plan, please refer to table on page 28.

The CVS/caremark prescription drug plan is bundled with the HMSA medical plan that you select. If you change from one HMSA medical plan to another during open enrollment your drug Maximum Out-of-Pocket (MOOP) may change on the effective date of your new plan selection. The new plan may have changes to the specialty drug cap, or a change to the prescription drug MOOP which may be of a higher or lower amount. All applicable drug copayments and co-insurance are accumulated on a calendar year basis towards an annual MOOP amount, and once the MOOP amount is met, you will no longer pay applicable copayments and coinsurance for the remainder of the calendar year while enrolled on that plan. If you change to a plan with a higher MOOP amount, you are responsible to meet the new MOOP level, but all prior applicable copayments and co-insurance paid towards one CVS/caremark plan can be credited towards the new MOOP amount for the new plan. If you change to a plan with a lower MOOP amount, there are no refunds for copayments or co-insurance that was paid towards the higher MOOP of the prior plan that are over the amounts of the new MOOP for the new plan.

All copayments and co-insurance paid are applied prospectively to the applicable MOOP amount based upon the plan the member is enrolled at the time.

Please note: Maintenance medications must be filled as a 90-day supply. Medications prescribed for treatment that are not approved by the Federal Drug Administration are excluded from the plan.

EUTF ACTIVES

Additional Information for EUTF PPO and HMO prescription drug plans

What's New

Effective 7/1/17, The CVS/caremark prescription drug plan will adopt the Advanced Controlled Specialty Formulary. There may be changes in coverage for some specialty medications and you may be required to use a preferred specialty drug for continued coverage. You and your doctor will receive a written notification approximately 30-60 days if you are impacted by this change. The notification will provide an alternate drug that you may want consult with your physician to determine if a change in your prescription would be in your best health interest.

General Information

The prescription drug plan includes programs that offer a financial incentive for participants to use the generic equivalent or Preferred Brand medication without compromising care as these medications have the same level of effectiveness. Preferred medications are usually priced lower than Other Brand name medications and have lower copayments.

To comply with the Affordable Care Act, generic forms of Tamoxifen and Raloxifene are covered with no copayment to the member when prescribed for primary prevention of breast cancer. If you are eligible for this benefit, please have your physician call 877-418-4130 to complete a copayment exception form on your behalf.

Web Service

Members can register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready. If you are not currently a member, please visit the CVS/caremark website at www.caremark.com/eutf for plan information.

Customer Care

For assistance with questions about your plan, finding a participating pharmacy, ordering a new ID card, refilling your mail order, etc. you may call CVS/caremark toll free 1-855-801-8263 to speak with a Hawaii representative 24 hours 7 days a week, or you may visit our customer service office in downtown Honolulu at the Pauahi Tower, 1003 Bishop Street, Suite 704, Monday through Friday from 7:45 am – 4:30pm.

Coordination of Benefits

Some participants may be enrolled in additional prescription coverage outside of their EUTF benefits. If this applies to you, please contact CVS/caremark Customer Care at 1-855-801-8263 to advise if your EUTF plan is secondary. When you go to the pharmacy, let them know that your EUTF plan is secondary and they will be able to coordinate benefits for you at the Point of Sale. You also have the option to send in a paper claim form for reimbursement. Below is a list of the required documentation to submit a paper claim for reimbursement. Please note that Coordination of Benefits does not guarantee 100% coverage of your medication. All EUTF plan parameters and guidelines will still apply and may conflict with your other benefits in some cases.

Required Documentation for Paper Claims:
Paper claims must be submitted to CVS/caremark within 1 year from the date of purchase

- Pharmacy receipt including:
  - Patient's name
  - Date of fill
  - Prescription number
  - Name of medication
  - Metric quantity
  - Day supply
  - Prescribing Dr's name or NPI number
  - Pharmacy name & address or pharmacy NABP number
- Completely filled out paper claim form with patient signature

EUTF ACTIVES

All paper claim reimbursement requests should be mailed to:
CVS/caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Pharmacy Network
The CVS/caremark prescription plan uses a Retail 90 network for EUTF plans. Members that fill a 90-day supply of medication at a Retail 90 network pharmacy or through the mail pharmacy will pay 2x the 30-day supply copayment. Members that fill a 90-day supply of medication at a non-Retail 90 pharmacy will pay 3x the 30-day supply copayment.

Utilization Management Programs
In an ongoing effort to effectively manage the prescription drug benefit, certain medications are subject to clinical guidelines as part of the prescription benefit plan design. The drug benefit includes the addition of the following three (3) clinical guidelines:

1. ***Quantity Limitations*** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies and input, review, and approval from the CVS/caremark National Pharmacy and Therapeutics (P&T) Committee.

2. ***Generic Step Therapy Program (GSTP)*** - Generic Step Therapy Program (GSTP) - The EUTF encourages the use of generic medications as an alternative to certain brand medications as an affordable and effective form of treatment to many health conditions. In an effort to promote use of generic medications, CVS/caremark has a generic step therapy program in place for all EUTF active employees. For certain non-preferred brand drugs, GSTP may require that you try a generic drug treatment prior to the use of a non-preferred brand drug. In some situations you may pay a higher copayment, please contact CVS/caremark Customer Care at 1-855-801-8263 for more information. Also see section labeled – Dispensed as Written (DAW 1 & 2) Program on page 32 of this guide.

3. ***Prior Authorization*** **(PA)** – Authorization process to ensure medical necessity of targeted drugs/classes before they are covered by the plan.

Specialty Drug Program
Specialty medications you receive at your doctor's office or specialty medication that is self-administered in a home setting are covered under the pharmacy drug benefit. Specialty medications you receive at an inpatient hospital setting or in a hospital based outpatient treatment center are covered under your medical plan. Specialty medications may be obtained from a specialty pharmacy or any retail pharmacy that participates in the CVS/caremark network that will supply the medication. CVS/caremark has a specialty pharmacy called CarePlus, located here in Hawaii. Members or physicians can contact CarePlus Pharmacy toll free at 1-800-896-1464 for assistance in ordering specialty medications. At your doctor's office visit, please present your drug card to your physician prior to treatment to ensure your medication is covered under the pharmacy drug benefit. Please refer to your medical plan description for additional information about coverage for specialty drugs.

EUTF participates in CVS/caremark's Specialty Guideline Management (SGM) Program and will adopt the Advanced Controlled Specialty Formulary (ACSF) effective 7/1/17.

SGM uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. All specialty medications require prior authorization. Physicians may call SGM at 808-254-4414 to obtain prior authorization.

SPDS requires the use of preferred specialty medications prescribed for the treatment of certain conditions. For coverage of non-preferred specialty medications, your physician may call 808-254-4414 to obtain a prior authorization.

EUTF ACTIVES

Most medications that fall within the Tier 4 (specialty drugs) will be subject to a 20% participant co-insurance up to a maximum $250 co-payment per fill. There is a $2,000 out-of-pocket maximum per person, per calendar year for specialty drug copayments. Exception: Oral oncology medications provided under the Specialty Drug Program will have a $30 copayment instead of a Tier 4 copayment.

If you have questions about your prescription drug benefits, call CVS/caremark at 1-855-801-8263. Representatives are available 24-hours a day to assist with your questions. You can also view the CVS/caremark Specialty Drug List found on caremark.com for a full listing of specialty therapeutic classes and medications.

Dispensed as Written (DAW 1&2) Program

The Dispensed as Written Program requires participants use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic co-payment will apply. However, if a participant or their physician chooses to use a brand medication rather than the generic equivalent, then the co-payment becomes the standard generic co-payment plus the difference in the cost of the generic and brand medication

Filling prescriptions at a Retail 90 Pharmacy or through the voluntary Mail Order Program for Maintenance Medications for EUTF Active Employee PPO or HMO Members

Maintenance medications are those prescriptions taken for an extended period of time to treat such chronic conditions as high blood pressure, diabetes, heart disease, or high cholesterol. Typically, your physician may write your prescription for these medications in a 90-day supply. The Mail Order Program is voluntary, but the requirement to fill maintenance medications in a 90-day supply is still required when you fill your prescription for maintenance medications at the CVS/caremark Mail Order Facility, or through any retail pharmacy in the CVS/caremark network. Participants are allowed (3) 30-day initial fills at the retail pharmacy for each new medication or new dosage amount in order to determine if the medication or dosage is correct. When you fill a prescription for a 90-day supply of a medication through either the mail order facility or through a Retail 90 pharmacy, you will pay two copayments for a three-month supply. If you fill a prescription for a 90-day supply of medication at a non-Retail 90 pharmacy, you will pay three copayments for a three-month supply. Overall, the cost to the plan is the lowest when you use the mail-pharmacy to fill your prescriptions for maintenance medications. You are encouraged to use mail order services to keep plan costs lower. To start mail order contact CVS/caremark at 1-855-801-8263.

HSTA VB ACTIVES

Medical Plan Coverage Chart (HMSA, Kaiser) – HSTA VB

Plan Design	HSTA VB 90/10 PPO Plan		HSTA VB 80/20 PPO Plan	
Carrier	**HMSA**		**HMSA**	
General	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Calendar Year Deductible Single/Family	None	$100 per person; $300 per family	None	
Calendar Year Maximum Out-of-Pocket Single/Family	$2,000/$4,000		$2,500/$5,000	
Lifetime Benefit Maximum	Unlimited		Unlimited	
Plan Year Benefit Maximum	None		None	
Physician Services	**YOU PAY*:**		**YOU PAY*:**	
Primary Care Office Visit	10%	30%	20%	20%
Specialist Office Visit	10%	30%	20%	20%
Routine Physical Exams	No Charge	No Charge**	No Charge	No Charge
Screening Mammography	No Charge	30%	No Charge	No Charge
Immunizations	No Charge	30%	No Charge	No Charge
Well Baby Care Visits	No Charge	30%**	No Charge	No Charge
Maternity	10%	30%	20%	20%
Second Opinion – Surgery	10%	30%	20%	20%
Emergency Services				
Emergency Room (ER care)	10%	10%**	20%	20%
Ambulance	10%	30%	20%	20%
Inpatient Hospital Services				
Room & Board	10%	30%	20%	20%
Ancillary Services	10%	30%	20%	20%
Physician Services	10%	30%	20%	20%
Surgery	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%	30%	20%	20%
Surgery	10%	30%	20%	20%
Diagnostic Lab	10%	30%	No Charge	No Charge
Diagnostic X-ray	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Mental Health Services				
Inpatient Care	10%	30%	20%	20%
Outpatient Care	10%	30%	20%	20%
Other Services				
Durable Medical Equipment	10%	30%	20%	20%
Home Health Care	No Charge	30%	No Charge	No Charge
Hospice Care	No Charge	Not Covered	No Charge	No Charge
Nursing Facility - Skilled Care	10%, 120 days/CY	30%, 120 days/CY	20%, 120 days/CY	20%, 120 days/CY
Physical & Occupational Therapy	10%	30%	20%	20%
Notes:	* If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge. **Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 35		* If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge. For prescription drug coverage, refer to the PPO plan on page 35	

HSTA VB ACTIVES

Medical Plan Coverage Chart (HMSA, Kaiser) – HSTA VB continued

Plan Design	HSTA VB HMO Comprehensive
Carrier	**Kaiser***
General	
Calendar Year Deductible Single/Family	None/None
Calendar Year Out-of-pocket limit Single/Family	$2,000/ $6,000
Lifetime Benefit Maximum	None
Plan Year Benefit Maximum	None
Physician Services	**YOU PAY:**
Primary Care Office Visit	$15
Specialist Office Visit	$15
Routine Physical Exams	No Charge
Screening Mammography	No Charge
Immunizations	No Charge
Well Baby Care Visits	No Charge
Maternity	No charge for routine prenatal visits and one postpartum visit
Second Opinion – Surgery	$15
Emergency Services	
Emergency Room (ER care)	$50
Ambulance	20%
Inpatient Hospital Services	
Room & Board	No Charge
Ancillary Services	No Charge
Physician Services	No Charge
Surgery	No Charge
Anesthesia	No Charge
Outpatient Services	
Chemotherapy/ Radiation Therapy	$15
Surgery	$15
Diagnostic Lab	$15/ department/ day
Diagnostic X-ray	$15/ department/ day
Anesthesia	$15
Mental Health Services	
Inpatient Care	No Charge
Outpatient Care	$15
Other Services	
Durable Medical Equipment	20%
Home Health Care	No Charge
Hospice Care	No Charge
Nursing Facility - Skilled Care	No Charge, 100 days / benefit period
Physical & Occupational Therapy	$15
Notes:	For prescription drug coverage, refer to the Kaiser HMO plan on page 35

*For Kaiser Members only:

1. Except for certain situations described in your *Group Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to your *Group Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement*.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

HSTA VB ACTIVES

PPO and HMO Prescription Drug Plans Coverage Chart (CVS/caremark & Kaiser) – HSTA VB

COVERAGE	HSTA VB PPO Prescription Drug Plan CVS/caremark		HMO Prescription Drug Plan Kaiser
	Participating Pharmacy*	**Non-Participating Pharmacy***	**Copayment**
Calendar Year Maximum Out-of-Pocket Single/Family	$4,350/$8,700**	None	Applies towards the medical out of pocket supplemental charge maximum
RETAIL PRESCRIPTION PROGRAM (30/60/90 day supply)			
Generic and Insulin	$5/$9/$9 copayment	$5/$9/$9 + 30% of eligible charges	$10/$20/$30
Brand Name	$15/$27/$27 copayment	$15/$27/$27 + 30% of eligible charges	$10/$20/$30
MAIL ORDER PRESCRIPTION PROGRAM (30/60/90 day supply)	**CVS/caremark**	**Vendor other than CVS/caremark**	**Kaiser**
Generic and Insulin	$5/$9/$9 copayment	Not a Benefit	Generic: $10/$20/$20 Insulin: Not Available through Mail Order
Preferred Brand Name	$15/$27/$27 copayment	Not a Benefit	$10/$20/$20

*If you receive services from a nonparticipating (out-of-network) pharmacy you are responsible for the copayment + coinsurance, and any difference between the actual charge and the eligible charge. Please note: Specialty medications and Injectables are covered under this plan and are subject to the applicable Generic or Brand Name copayment.

**There is a prescription drug Maximum Out-of-Pocket (MOOP) limit of $4,350 per individual and $8,700 per family, for the 2017 calendar year (1/1/17 – 12/31/17).

Medications prescribed for treatment that are not approved by the Federal Drug Administration are excluded from the plan.

Additional Information for the HSTA VB Prescription Drug Plan

General Information

The prescription drug plan includes programs that offer a financial incentive for participants to use the generic equivalent or Preferred Brand medication without compromising care as these medications have the same level of effectiveness. Preferred medications are usually priced lower than Non-Preferred Brand name medications and have lower copayments.

To comply with the Affordable Care Act, generic forms of Tamoxifen and Raloxifene are covered with no copayment to the member when prescribed for primary prevention of breast cancer. If you are eligible for this benefit, please have your physician call 877-418-4130 to complete a copayment exception form on your behalf.

HSTA VB ACTIVES

Web Service
Members can register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready. If you are not currently a member, please visit the CVS/caremark website at www.caremark.com/eutf for plan information.

Customer Care
For assistance with questions about your plan, finding a participating pharmacy, ordering a new ID card, refilling your mail order, etc. you may call CVS/caremark toll free 1-855-801-8263 to speak with a Hawaii representative, or you may visit our customer service office in downtown Honolulu at the Pauahi Tower, 1003 Bishop Street, Suite 704, Monday through Friday from 7:45 am – 4:30pm.

Coordination of Benefits
Some participants may be enrolled in additional prescription coverage outside of their EUTF benefits. If this applies to you, please contact CVS/caremark Customer Care at 1-855-801-8263 to advise if your EUTF plan is secondary. When you go to the pharmacy, let them know that your EUTF plan is secondary and they will be able to coordinate benefits for you at the Point of Sale. You also have the option to send in a paper claim form for reimbursement. Below is a list of the required documentation to submit a paper claim for reimbursement. Please note that Coordination of Benefits does not guarantee 100% coverage of your medication. All EUTF plan parameters and guidelines will still apply and may conflict with your other benefits in some cases.

Required Documentation for Paper Claims:
Paper claims must be submitted to CVS/Caremark within 1 year from the date of purchase

- Pharmacy receipt including:
  - Patient's name
  - Date of fill
  - Prescription number
  - Name of medication
  - Metric quantity
  - Day supply
  - Prescribing Dr's name or NPI
  - Pharmacy name & address or pharmacy NABP number
- Completely filled out paper claim form with patient signature

All paper claim reimbursement requests should be mailed to:
CVS/caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Utilization Management Programs
In an ongoing effort to effectively manage the prescription drug benefit, certain medications are subject to clinical guidelines as part of the prescription benefit plan design. The drug benefit includes the addition of the following three (3) clinical guidelines:

1. ***Quantity Limitations*** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies and input, review, and approval from the CVS/caremark National Pharmacy and Therapeutics (P&T) Committee.
2. ***Performance Generic Step Therapy Program (PGST)*** – Performance Generic Step Therapy Program (PGST) - The EUTF encourages the use of generic medications as an alternative to certain brand medications as an affordable and effective form of treatment of many health conditions. In an effort to promote use of generic medications, CVS/caremark has a generic step therapy program in place for HSTA VB active employees. For certain non-preferred brand drugs, PGST may require that you try a generic drug treatment prior to the use of a non-preferred brand drug for nasal steroids or for ulcer medications (proton pump inhibitors). In some situations you may pay a higher copayment,

please contact CVS/caremark Customer Care at 1-855-801-8263 for more information. Also see section labeled – Dispensed as Written (DAW 2) Program on page 37.

3. ***Prior Authorization*** **(PA)** – Authorization process to ensure medical necessity of targeted drugs/classes before they are covered by the plan.

Specialty Drug Program

Specialty medications you receive at your doctor's office or specialty medication that is self-administered in a home setting are covered under the pharmacy drug benefit. Specialty medications you receive at an inpatient hospital setting or in a hospital based outpatient treatment center are covered under your medical plan. Specialty medications may be obtained from a specialty pharmacy or any retail pharmacy that participates in the CVS/caremark network that will supply the medication. CVS/caremark has a specialty pharmacy called CarePlus, located here in Hawaii. Members or physicians can contact CarePlus Pharmacy toll free at 1-800-896-1464 for assistance in ordering specialty medications. At your doctor's office visit, please present your drug card to your physician prior to treatment to ensure your medication is covered under the pharmacy drug benefit. Please refer to your medical plan description for additional information about coverage for specialty drugs.

EUTF also participates in CVS/caremark's Specialty Guideline Management (SGM) Program. SGM uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. All specialty medications require prior authorization. Physicians may call SGM at 808-254-4414 to obtain prior authorization.

The copayments for specialty medications for HSTA VB members are based upon the applicable copayment which is usually a brand copayment.

If you have questions about your prescription drug benefits, call CVS/caremark at 1-855-801-8263. Representatives are available 24-hours a day to assist with your questions. You can also view the CVS/caremark Specialty Drug List found on caremark.com for a full listing of specialty therapeutic classes and medications.

Voluntary Mail Order Program for Maintenance Medications for HSTA VB Active Employee PPO or HMO Members

Maintenance medications are those prescriptions taken for an extended period of time to treat such chronic conditions as high blood pressure, diabetes, heart disease, or high cholesterol. When you fill a prescription for a 90-day supply of a maintenance medication through either the mail order facility or through a retail pharmacy, you will pay a lower copayment for a three-month supply. The cost to the plan is the lowest if you use the mail-order facility to fill your prescriptions for maintenance medications. You are encouraged to use mail order services to keep plan costs lower. To start mail order, contact CVS/caremark at 1-855-801-8263.

Dispensed as Written (DAW 2) Program

The Dispensed as Written Program requires participants use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic co-payment will apply. However, if a participant chooses to use a brand medication instead of the generic equivalent, the member is responsible for the standard generic co-payment plus the difference in the cost of the generic and brand medication.

HSTA VB ACTIVES

Dental Plan Benefits Coverage Chart (Hawaii Dental Service [HDS]) – HSTA VB Supplemental Plan

Your Plan provides:

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	$750
DIAGNOSTIC	
Examinations - twice per calendar year	50%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	50%
Other X-rays (full mouth X-rays limited to once every 5 years)	50%
PREVENTIVE	
Cleanings – twice per calendar year	50%
• Diabetic Patients – four cleanings or *periodontal maintenance	50%
• Expectant Mothers – three cleanings or *periodontal maintenance	
*Periodontal maintenance benefit level	*45%
Fluoride (once per calendar year through age 19)	50%
• Fluoride - high risk - once per calendar year	
Space maintainers (through age 17)	50%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molars with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	50%
RESTORATIVE	
Amalgam (silver-colored) fillings	45%
Composite (white-colored) fillings – limited to the anterior (front) teeth	45%
Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	45%
Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
ENDODONTICS	45%
Pulpal therapy	
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	45%
Periodontal scaling and root planing – once every two years	
Gingivectomy, flap curettage and osseous surgery – once every three years	
Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	
PROSTHODONTICS	
Fixed bridges (once every 5 years; ages 16 and older)	45%
Dentures (complete and partial – once every 5 years; ages 16 and older)	45%
Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth (ages 16 and older)	50%
ORAL SURGERY	50%
ADJUNCTIVE GENERAL SERVICES	45%
Palliative treatment (for relief of pain but not to cure)	50%
ORTHODONTICS	100%
Maximum amount payable by HDS for an eligible patient shall be $750 lifetime per case paid in eight quarterly payments of $93.75.	
Orthodontic services are not covered:	
*If services were started prior to the date the patient became eligible under this employer's plan.	
*If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue.	
*If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	

The HDS public website at www.hawaiidentalservice.com includes a section exclusively for EUTF members. In this section, you will find valuable information on your HDS dental plan including your dental benefits and plan brochure.
Sign up for an online account today to check on your eligibility for services, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, rate your dentist, and receive paperless benefit statements from the convenience of your home computer or smartphone.

To sign up for an online account and paperless benefit statements:

1) To go www.hawaiidentalservice.com
2) Click on "**New User?**" at the top left of the screen.
3) Complete the "Member Registration" form.
4) Select "**Yes**" to "Request electronic Explanation of Benefits."
5) Click on "**Register User**" button.

ALL ACTIVES

Dental Plan Benefits Coverage Chart (Hawaii Dental Service [HDS]) – EUTF and HSTA VB

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	$2,000
DEDUCTIBLE per plan year (July 1 – June 30) (does not apply to benefits covered at 100%)	$50/person
DIAGNOSTIC	
Examinations - twice per calendar year	100%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	100%
Other X-rays (full mouth X-rays limited to once every 5 years)	100%
PREVENTIVE	
Cleanings – twice per calendar year	100%
• Diabetic Patients – four Cleanings or *Periodontal Maintenance • Expectant Mothers – three Cleanings or *Periodontal Maintenance *Periodontal Maintenance benefit level	*80%
Fluoride (twice per calendar year through age 19)	
For HSTA VB Members: Fluoride (once per calendar year through age 19)	100%
Fluoride – high risk patients of any age - once per calendar year	
Space maintainers (through age 17)	100%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molars with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	100%
RESTORATIVE	
Amalgam (silver-colored) fillings	80%
Composite (white-colored) fillings – limited to the anterior (front) teeth	80%
Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	60%
Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
ENDODONTICS	80%
Pulpal therapy	
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	80%
Periodontal scaling and root planing – once every two years	
Gingivectomy, flap curettage and osseous surgery – once every three years	
Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	
PROSTHODONTICS	60%
Fixed bridges (once every 5 years; ages 16 and older)	
Dentures (complete and partial – once every 5 years; ages 16 and older)	
Implants: Surgical placement of endosteal implant and abutment, once per tooth, every five years (ages 19 and older)	
For HSTA VB Members: Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth. Once per tooth every 5 years (ages 16 and older).	
ORAL SURGERY	80%
ADJUNCTIVE GENERAL SERVICES	80%
Palliative treatment (for relief of pain but not to cure)	100%
ORTHODONTICS	50%
Maximum amount payable by HDS for an eligible patient shall be $1,000 lifetime per case paid in 8 quarterly payments of $125.	
Orthodontic services are not covered:	
*If services were started prior to the date the patient became eligible under this employer's plan.	
*If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue.	
*If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	

Shaded areas indicate coverage after a Wait Period of 12 months of continuous enrollment in the plan.

Visiting a Non-Participating Dentist

If you choose to have services performed by a dentist who is not an HDS or Delta Dental participating dentist, you are responsible for the difference between the amount that the non-participating dentist actually charges and the amount paid by HDS in accordance with your plan. In most cases you will need to pay in full at the time of service. The non-participating dentist will render services and may provide you with the completed claim form (universal ADA claim form) to submit to HDS. Mail the completed claim form for processing to: HDS – Dental Claims, 700 Bishop Street, Suite 700, Honolulu, HI 96813-4196. HDS payment will be based on the HDS non-participating dentist fee schedule and a reimbursement check will be sent to you along with your Explanation of Benefit (EOB) report.

ALL ACTIVES

Vision Plan Benefits (Vision Service Plan [VSP]) – EUTF and HSTA VB

Your coverage from a VSP Doctor:

Exam covered in full ..... every plan year*, after $10 Copay

Prescription Glasses

Lenses covered in full..... every plan year*, after $25 Copay

- Single vision, lined bifocal and lined trifocal lenses
- UV coating is covered
- Polycarbonate lenses covered for dependent children up to age 18

Frame..... every other plan year*

- $120 allowance, plus 20% off any out-of-pocket costs
- OR $65 allowance at COSTCO (no additional discounts)

~Instead of Glasses~

Contact Lenses ..... every plan year*

- $120 allowance (applies to cost of contacts and fitting & evaluation)

****plan year is July 1st – June 30th***

Extra Discounts and Savings

Glasses & Sunglasses

- Average 35-40% savings on all non-covered lens options (such as tints, progressive lenses, anti-scratch coatings, etc.)
- 30% off additional glasses & sunglasses, including lens options, from the same VSP doctor on the same day as your Exam. OR get 20% off from any VSP doctor within 12 months of your last Exam.

Contact Lenses

15% off cost of contact lens exam (fitting & evaluation)
VSP has partnered with leading contact lens manufacturers to provide VSP members exclusive offers. Check out www.vsp.com for details.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

You get the best value from your VSP benefit when you visit a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 12 months to submit a claim to VSP for partial reimbursement, less copays according to the following schedule:

Out-of-Network Reimbursement Amounts

Exam ..... Up to $45.00
Single Vision Lenses ..... Up to $45.00
Lined Bifocal Lenses ..... Up to $65.00
Lined Trifocal Lenses ..... Up to $85.00
Frame..... Up to $47.00
Contacts..... Up to $105.00

Before seeing an out-of-network provider, call VSP at 1-866-240-8420, or go on-line at www.vsp.com to search for a VSP doctor near you!

ALL ACTIVES

Chiropractic Plan Benefits (Royal State National [RSN]) – EUTF and HSTA VB

Royal State National Insurance Company, Ltd., through ChiroPlan Hawaii, Inc., is the provider of the chiropractic benefits. The chiropractic benefit is packaged with all active employee medical plans, including the Royal State National Supplemental Plan.

The plan benefits include the initial exam, any necessary x-rays (when taken in a ChiroPlan provider's office), therapeutically necessary chiropractic treatment and therapeutic modalities. For EUTF, the co-payment is $15 per visit up to 20 visits per calendar year. For HSTA VB, the co-payment is $12 per visit up to 20 visits per calendar year. Chiropractic services must be received by a credentialed ChiroPlan Provider. A complete list of ChiroPlan doctors and plan information may be obtained from the EUTF website at eutf.hawaii.gov. Please refer to the plan certificate for complete information on benefits, limitations and exclusions.

Life Insurance (USAble Life) – EUTF and HSTA VB

Your life insurance benefit will be $41,116, for active employees.

- Your benefit will be reduced once you reach age 65 and continue to be reduced as follows:
  - $26,725 for participants age 65 through 69
  - $18,502 for participants age 70 through 74
  - $12,335 for participants age 75 through 79
  - $8,223 for participants age 80 and over

In addition, your life insurance includes the following added benefits:

- Conversion – If your life insurance ceases because of termination of employment or is reduced due to age or retirement, you may convert to an individual whole life insurance policy within the first 30 days after termination. You do not need to provide evidence of good health.
- Portability - this provision allows a terminated participant to continue their life insurance at a group discounted rate instead of an individual rate, provided they meet the eligibility requirements.
- Accelerated Benefit – allows you to receive an early payment of a portion of your life insurance if you have a Qualified Medical Condition and meet certain requirements.
- Repatriation of Remains Benefit – this benefit reimburses an individual who incurs expenses related to transporting your remains back to a mortuary near your primary place of residence if you pass away 200 miles or more away from home.

Contact USAble Life at (808) 538-8920 or toll free at 1-855-207-2021 if you would like to change your beneficiary. You may download the beneficiary designation form from the USAble Life website at https://www.usablelife.com/portal/eutf.

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

- Providing current and accurate personal information as prescribed in this booklet
- Paying the employee's premium contributions in the amount or amounts provided by statute, or an applicable bargaining unit agreement;
- Paying the employee's premium contributions at the times and in the manner designated by the board; and
- Complying with the EUTF's Administrative Rules.

Employer Responsibilities

Any public employer whose current or former employees participate in EUTF benefit plans is responsible for:

- Providing information as requested by the EUTF under section 87A-24(9) of the HRS;
- Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;
- Assisting the EUTF in distributing information to and collecting information from the employee-beneficiaries;
- Complying with the EUTF's rules;
- Notifying EUTF immediately following termination, transfer, and bargaining unit changes or death.

Authorized Leave of Absence Without Pay (LWOP) and Other Contribution Shortages

If you are going on an Authorized Leave Without Pay (LWOP) lasting more than 30 days, please ask your personnel office for a completed Form L-1 – Authorized Leave of Absence Without Pay.

- You may voluntarily cancel your EUTF plans by submitting an EC-1/EC-1H form within 30 days of the beginning of the LWOP, and you may re-enroll in the same benefit plans upon return from LWOP by submitting an EC-1/EC-1H form within 30 days of your return from LWOP.
- Or, you may continue coverage while on a LWOP by timely paying the amounts listed on the Form L-1 directly to the EUTF.
- If any employee on LWOP does not cancel his or her plans by submitting an EC-1/EC-1H form and does not make payments to the EUTF, he or she will be cancelled for non-payment from all plans (except for the EUTF Life Insurance plan) and will not be able to re-enroll until the next open enrollment period.

If at any time the EUTF fails to receive an employee-beneficiary's premium deduction or receives only a partial deduction from his/her payroll, he/she will receive a Contribution Shortage Reminder Notice from the EUTF. ***If the employee-beneficiary fails to pay the premium shortage by the date specified in the contribution shortage notice, his/her plans will be cancelled retroactive to the date of the last paid premium. Reinstatement of the terminated employee-beneficiary and their dependent's health benefit coverage which was cancelled for non-payment, will be allowed if within 30 days from the date of the notice of cancellation, payment is made in full of past and currently due premiums. To be eligible for reinstatement, the terminated member must not have been terminated for non-payment of premiums within 12 months from the date of the notice of cancellation. Otherwise, he/she will NOT be able to re-enroll in any EUTF plans (medical, prescription drug, dental, and/or vision) until the next open enrollment.***

Future Retirees

Enrollment or Changes in Enrollment Upon Retirement

An employee-beneficiary may enroll or change coverages in the health benefit plans offered or sponsored by the EUTF and obtain coverage for eligible dependent-beneficiaries when they become a retired member of the Employees' Retirement System of the State of Hawaii (ERS) as defined in 87A-1.HRS. The effective date of the coverage shall be the first of the month on or after the employee-beneficiary's date of retirement provided a completed EC-2 enrollment application is received by the EUTF within sixty (60) days of retirement or within sixty (60) days of certification from the ERS if a disability retirement. Retired employee-beneficiaries shall be eligible to enroll in the EUTF benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the date of retirement.

Medicare Part B Enrollment for Medicare Eligible Employees (65+) Considering Retirement

The Hawaii Revised Statutes 87A-23(4) requires that State and County retirees and their dependents who are enrolled in EUTF retiree medical and/or prescription drug benefit plans, enroll in Medicare Part B. Active employees considering retirement who are eligible for Medicare should enroll in Medicare Part B prior to retirement in order to participate in any EUTF retiree medical and prescription drug benefit plans. At the time you complete your retiree (EC-2) enrollment form, provide EUTF with a copy of your Medicare Part B card as proof of enrollment. If no proof of enrollment is submitted to the EUTF within 60 days, your enrollment into the EUTF retiree medical and prescription drug benefit plans will be canceled back to your date of retirement.

In addition, as a retiree you and your dependent qualify for reimbursement of your Medicare Part B premiums. You must provide the EUTF with proof of your Medicare Part B enrollment and a copy of the letter from the Social Security Administration (SSA) or Centers for Medicare and Medicaid Services (CMS) showing the Medicare Part B Premium that you pay in order to receive the reimbursement. Reimbursement will be made beginning the effective date of your Medicare Part B or the first of the month in which EUTF receives proof of your Medicare Part B enrollment and a copy of the letter from SSA or CMS, whichever is later. Reimbursement is made via direct deposit into the checking or savings account of the retiree, and the EUTF must receive a completed Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement (DDA) form from the retiree in order to reimburse the Medicare Part B premium.

Employees should begin the Medicare Part B enrollment process at least 45 days prior to retirement, by contacting the Social Security Administration at 1-800-772-1213. For more information regarding Medicare, employees should contact Medicare directly at 1-800-633-4227.

If you or your dependent are currently Medicare eligible and you are not retired, EUTF does not require you or your dependent to enroll in Medicare.

In addition, if you are thinking about retirement during the upcoming plan year, you should consider the policies implemented by the providers regarding annual maximums and annual limits for medical, dental, vision and prescription drug benefits. Benefits that are paid under the Active employee plans are counted against the maximums and limitations of the Retiree Plans of the same carrier, if they occur within the same calendar year.

Medical Out-of-Pocket maximum example:

On January 1, 2017, Jane was an active employee enrolled in the EUTF HMSA 90/10 PPO Plan. By July 1, 2017 she had met her $2,000 calendar year out of pocket limit under that plan. She incurs additional medical expenses of $100 in August 2017, which are paid at 100% since her out of pocket limit was satisfied. She retires on September 1, 2017 and enrolls in the EUTF HMSA non-Medicare Retiree PPO plan. She proceeds to have additional medical services totaling $1,000 before the end of

2017. As an active employee, Jane's out-of-pocket limit was $2,000 per calendar year, but as a retiree her out-of-pocket limit is now $2,500 per calendar year. Therefore instead of 100% coverage for the additional $1,000 of medical expenses, she had to pay 10% of those expenses because she needed an additional $500 of out of pocket expenses to meet the out of pocket limit under her retiree plan.

Medical Deductible example:

On January 1, 2017, Jill was an active employee enrolled in the EUTF HMSA 90/10 PPO Plan. She met her individual non-network deductible of $100 in May 2017. She retires on June 1, 2017 and enrolls in the EUTF HMSA Retiree PPO plan. The $100 deductible she met under the Active employee plan will apply to the Retiree plan since it is within the same calendar year. She will not be subject to an additional deductible under the Retiree plan.

Attention: Medicare Eligible Members and/or Dependents Enrolling in EUTF

Attention: Medicare Eligible Members
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage through Medicare Part D. However, the EUTF active employee prescription drug plans offer benefits that are as good, or better, than the standard Medicare Part D plan coverage; therefore, you do not have to enroll in a Medicare Part D plan until you retire. For more information, a summary of your Notice of Creditable Coverage appears below.

Prescription Drug Benefits

The **Medicare Prescription Drug Program** (Medicare Part D) was established to provide prescription drug coverage for eligible Medicare individuals. Your employer is required to inform you whether or not your prescription drug plan is creditable or non-creditable.

Notice of Creditable Coverage (available at EUTF website at eutf.hawaii.gov)

Since you are or may become eligible for Medicare during the next year, the EUTF is required by law to notify you regarding your rights to the Medicare Part D prescription drug coverage. If you are enrolled in an EUTF plan, your prescription drug benefits are as good as or better than the standard Medicare Part D drug benefits. Although you have the right to join a Medicare Part D prescription drug plan, doing so may disrupt your regular medical coverage, and you do not have to do so at this time. Medicare will not penalize you if you decide to enroll in a Medicare Part D plan in the future, because the prescription drug coverage you now have through the EUTF is creditable coverage.

If you decide to join a Medicare Part D plan, you should compare the different drugs that are available under your current plan with EUTF and the alternative plans. Not all Medicare Part D plans cover the same drugs, nor provide the coverage at the same cost.

LATE ENROLLMENT PENALTY (LEP)

When you become eligible for Medicare, you must enroll in a Medicare Part D prescription drug plan if you are NOT enrolled in a creditable prescription drug plan. If you do not enroll in a Medicare Part D prescription drug plan, and you do not have creditable prescription drug coverage, Medicare may assess you a Late Enrollment Penalty (LEP). The LEP is a lifetime penalty and is not reimbursable by the EUTF. The LEP is assessed when you fail to enroll into a Medicare Part D prescription drug plan when you initially become eligible for enrollment, or you do not have creditable coverage and you have a gap of 63 continuous days without Medicare Part D coverage.

For your information, EUTF's prescription drug plans for active employees through CVS/caremark and Kaiser are considered creditable coverage and EUTF's prescription drug plans for retirees are considered a Medicare Part D prescription drug plan.

The cost of the LEP depends on how long you did not have creditable prescription drug coverage. Currently, the LEP is calculated by multiplying 1% of the "national base beneficiary premium" ($35.63 in 2017) times the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $.10 and added to your monthly premium. Since the "national base beneficiary premium" may increase each year, the penalty amount may also increase each year. You may have to pay this penalty for as long as you have a Medicare drug plan. This amount is billed separately by SilverScript and paid to Medicare and is not a part of any EUTF premium.

EUTF Important Notices

This section contains important employee benefit program notices of interest to you and your familyPlease share this information with your family members. Some of the notices in this document are required by law and other notices contain helpful information. These notices are updated from time to time and some of the federal notices are updated each year.

CHANGES DURING THE PLAN YEAR TO YOUR HEALTH CARE BENEFIT ELECTIONS

IMPORTANT: After this open enrollment period is completed, generally you **will not** be allowed to change your benefit elections or add/delete dependents until next years' open enrollment, unless you have a Special Enrollment Event or a Change in Status Event during the plan year as outlined below:

- ***Special Enrollment Event:***

  If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

  In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

  You and your dependents may also **enroll in this plan** if you (or your dependents):

  - have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within **60 days** after the Medicaid or CHIP coverage ends.
  - become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within **60 days** after you (or your dependents) are determined to be eligible for such assistance.

  To request special enrollment or obtain more information, contact the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

- ***Change in Status Event During the Plan Year:***

  EUTF follows the Internal Revenue Service (IRS) regulations on if and when benefits can be changed during the plan year (the plan year being the period July 1 through June 30). The following events **may** allow certain changes in benefits mid-year, **if** permitted by the IRS:

  - Change in legal marital status (e.g., marriage, divorce/legal separation, death).
  - Change in number or status of dependents (e.g., birth, adoption, death).
  - Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
  - Coverage of a child due to a QMCSO.
  - Entitlement or loss of entitlement to Medicare or Medicaid.
  - Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
  - Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify your Designated Personnel Office by submitting an EC-1/EC-1H Enrollment Change form within **30 days** of the mid-year change.

Failure to give EUTF a timely notice (as noted above) may:

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
d. result in your liability to repay the Plan if any benefits are paid to an ineligible person.

For questions contact the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323, Menu Option

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Medical Plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

The prescription drug coverage under the HMSA, HSTA VB and Kaiser medical plans is creditable as explained in the Plan's Medicare Part D Notice of Creditable Coverage available at the end of this Important Notice section and also available from the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

PRIVACY NOTICE REMINDER FROM EUTF

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

The HIPAA Privacy Notice explains how the EUTF group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in EUTF group health plan benefits. A copy of the EUTF Privacy Notice is found in the Reference Guide (see the Guide's table of contents for the exact location of the Notice). You can get another copy of the EUTF HIPAA Privacy Notice from the EUTF Office at 808-586-7390 or toll-free at 800-295-0089. Also, the Privacy Notice for the various insured health plans is provided to you by the insurance companies and you can get another copy of their HIPAA Privacy Notice from the insurance company by contacting the phone number on your ID card.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, medical plan coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact your medical plan insurance company (using the phone number on your medical plan ID card) or contact the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

AVAILABILITY OF SUMMARY HEALTH INFORMATION: THE SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical plan benefits.

Choosing a health coverage option is an important decision. To help you make an informed choice, the Summary of Benefits and Coverage (SBC), summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages long the SBC should be, the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our various medical plan options, go to the EUTF website at http://eutf.hawaii.gov/ or for a paper copy, contact the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact your medical plan (at the phone number on the ID card) to precertify the extended stay. If you have questions about this Notice contact your medical plan insurance company (using the phone number on your medical plan ID card) or the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) AND NATIONAL MEDICAL SUPPORT NOTICE

Your medical insurance plans honor a valid qualified medical child support orders (QMCSO) in accordance with law. A Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the Plan recognize the child as a dependent even though the child may not meet the Plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

A QMCSO should be provided to the EUTF office. EUTF also honors a qualified National Medical Support Notice which is similar to a QMCSO but is issued by a state agency in accordance with a medical child support order. For additional QMCSO information (free of charge) and information regarding the procedures for administration of a QMCSO, contact the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

COBRA COVERAGE REMINDER

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce/legal separation, or a child ceasing to be an eligible dependent child.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. **You may want to look for coverage through the Health Care Marketplace . See https://www.healthcare.gov/.** In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The **maximum period of COBRA coverage** is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, **you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs**. That notice should be sent to the EUTF office via first class mail (address noted below) and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
P.O. Box 2121 Honolulu Hawaii 96805-2121

When you elect EUTF-sponsored health coverage, EUTF will provide you with a COBRA Initial Notice. HMSA-CVS/caremark COBRA members: The COBRA medical and drug must be bundled to enroll in COBRA. You will need to set-up COBRA with HMSA and CVS/caremark separately and make separate COBRA payments to each carrier. If you have questions about COBRA or would like another copy of a COBRA Initial Notice please contact the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

CAUTION: IF YOU DECLINE MEDICAL PLAN COVERAGE OFFERED THROUGH THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

If you are in a benefits-eligible position and choose not to be covered by one of EUTF or HSTA VB's medical plan options, remember that you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace (www.healthcare.gov), typically at the Marketplace annual enrollment in the fall each year.

Americans without medical plan coverage could have to pay a penalty when they file their personal income taxes. Visit the Health Insurance Marketplace for detailed information on individual shared responsibility payment

penalty. If you choose to not be covered by a medical plan at this enrollment time, your next opportunity to enroll for EUTF or HSTA VB's medical plan coverage is at the next annual EUTF open enrollment time, unless you have a mid-year change event that allows you to add coverage in the middle of the plan year.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

The HMO medical plan options generally require the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your medical plan at the phone number on your ID card.

Direct Access to OB/GYN Providers:

You do not need prior authorization (pre-approval) from your medical plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical plan insurance company (using the phone number on your medical plan ID card).

GENERAL STATEMENT OF NONDISCRIMINATION (DISCRIMINATION IS AGAINST THE LAW)

Effective October 17, 2016, Hawaii Employer-Union Health Benefits Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Hawaii Employer-Union Health Benefits Trust Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Hawaii Employer-Union Health Benefits Trust Fund:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   - Qualified sign language interpreters
   - Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:
   - Qualified interpreters
   - Information written in other languages

If you need these services, contact the Fund's Civil Rights Coordinator.

If you believe that the Hawaii Employer-Union Health Benefits Trust Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator for EUTF
P O Box 2121, Honolulu, HI 96805-2121
Telephone: 1-808-586-7390, Toll-free: 1-800-295-0089, Fax: 808-586-2161, Email: eutf@hawaii.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Fund's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

Free Language Assistance: The following chart displays the top 15 languages spoken by individuals with limited English proficiency in the state of Hawaii:

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
1. Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-808-586-7390 (TTY: 1-808-587-5538).
2. Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-808-586-7390 (TTY: 1-808-587-5538)
3. French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-808-586-7390 (TTY: 1-808-587-5538).
4. German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-808-586-7390 (TTY: 1-808-587-5538).
5. Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-808-586-7390 (TTY: 1-808-587-5538).
6. Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-808-586-7390 (TTY: 1-808-587-5538).
7. Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-808-586-7390 (TTY: 1-808-587-5538)번으로 전화해 주십시오.
8. Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-808-586-7390 (TTY: 1-808-587-5538)まで、お電話にてご連絡ください。
9. Ilocano	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-808-586-7390 (TTY: 1-808-587-5538).
10. Samoan	MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-808-586-7390 (TTY: 1-808-587-5538).
11. Marshallese	LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-808-586-7390 (TTY: 1-808-587-5538).
12. Trukese	MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1-808-586-7390 (TTY: 1-808-587-5538).
13. Tongan	FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-808-586-7390 (TTY: 1-808-587-5538).
14. Hawaiian	E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe. E kelepona iā 1-808-586-7390 (TTY: 1-808-587-5538).
15. Pohnpeian	Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-808-586-7390 (TTY: 1-808-587-5538).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 2-28-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the **Hawaii Employer-Union Health Benefits Trust Fund (EUTF) office at 808-586-7390 or toll-free at 800-295-0089**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Hawaii Employer-Union Health Benefits Trust Fund		4. Employer Identification Number (EIN) 14-2014628
5. Employer address P.O. Box 2121		6. Employer phone number 808-586-7390 or toll-free at 800-295-0089
7. City Honolulu	8. State Hawaii	9. ZIP code 96805-2121
10. Who can we contact about employee health coverage at this job? EUTF Member Services Branch Manager		
11. Phone number (if different from above)	12. Email address eutf@hawaii.gov	

Here is some basic information about health coverage offered by this employer:

- **As your employer, we offer a health plan to:**

☐ All employees.

☒ Some employees. Eligible employees are:
Effective 2015, eligible employees are those defined in the Chapter 87A-1 of the Hawaii Revised Statutes.

- **With respect to dependents:**

☒ We do offer coverage. Eligible dependents are:
Effective 2015, eligible dependents include a legally married Spouse, or Civil Union Partner or Domestic Partner, and the following categories of children of the employee, Spouse, Civil Union Partner or Domestic Partner (with eligibility permitted to the last day of the month in which the married or unmarried child reaches age 26): natural child, stepchild, adopted child or child placed for adoption, or child under a Qualified Medical Child Support Order (QMCSO). Unmarried children age 26 and older may continue eligibility if disabled and that disability existed prior to age 19. A child under a legal guardianship order may continue eligibility to the last day of the month in which the child reaches age 18. Proof of dependent status is required by the Plan.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Important Notice from Hawaii Employer-Union Health Benefits Trust Fund (EUTF) about Prescription Drug Coverage for People with Medicare

This notice is for people with Medicare.
Please read this notice carefully and keep it where you can find it.

This Notice has information about your current prescription drug coverage with the HSTA VB, HMSA and Kaiser medical plans and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

EUTF has determined that the drug coverage is "creditable" under the following prescription drug plan options:

- **the HMSA 75/25 PPO Plan (as administered by CVS/caremark),**
- **HMSA 80/20 PPO Plan (as administered by CVS/caremark),**
- **HMSA 90/10 PPO Plan (as administered by CVS/caremark),**
- **HMSA HMO Plan (as administered by CVS/caremark),**
- **HSTA VB HMSA 90/10 PPO Plan (as administered by CVS/caremark),**
- **HSTA VB HMSA 80/20 PPO Plan (as administered by CVS/caremark),**
- **Kaiser HMO plans (as administered by Kaiser).**

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the CVS/caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser) you will not pay extra if you later decide to enroll in Medicare prescription drug**

coverage. You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from October 15th through December 7th); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a two-month Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

Your Choices:	What you can do:	What this option means to you:
Option 1	You can select or keep your current medical and prescription drug coverage under the CVS/caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser) and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through the CVS/caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser). • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th through December 7th of each year). • As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.

Your Choices:	What you can do:	What this option means to you:
Option 2	You can select or keep your current medical and prescription drug coverage with the CVS/caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser) **and also enroll in a Medicare prescription drug plan**. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.	Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows: • for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and the group health plan pays secondary. • for Medicare eligible Active Employees and their Medicare eligible Dependents, the group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under the CVS/caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser). That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts; • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number), for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

For people with limited income and resources , extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
P. O. Box 2121
Honolulu, Hawaii 96805-2121
Phone Number: 808-586-7390 or toll-free at 800-295-0089

As in all cases, EUTF and, when applicable, the medical plan insurance companies, reserve the right to modify benefits at any time, in accordance with applicable law. This document is intended to serve as your Medicare Part D Notice of Creditable Coverage, as required by law.

HIPAA Notice: Notice of Privacy Practices

Effective date of this notice is December 16, 2014.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

A federal law, commonly known as HIPAA (the Health Insurance Portability and Accountability Act of 1996), governs all group health plans' use and disclosure of medical information. You may find HIPAA's privacy rules at 45 Code of Federal Regulations Parts 160 and 164.

This notice describes the EUTF's privacy practices and your rights regarding the uses and disclosures of your medical information as it relates to the EUTF group health plan. The EUTF self-funded group health plan includes the Outpatient Prescription Drug Program Benefits (hereafter referred to as the "Plan") and is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**) and to inform you about the Plan's legal duties and privacy practices with respect to protected health information.

You may receive a Privacy Notice from various insured group health benefit programs. Each of these notices will describe your rights as it pertains to that plan and in compliance with the Federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information related to the EUTF benefit plan (the "Plan") and outside companies contracted to help administer Plan benefits, also called "business associates."

The EUTF acknowledges that your medical and health information is personal – and is committed to protecting your privacy.

For administration purposes, the EUTF has access to a record of your claims reimbursed under your health insurance benefits plan. This notice applies to all of the medical records that the EUTF maintains or can access. Your personal doctor, health care provider, or health insurance carrier might have different policies or notices regarding their use and disclosure of medical information that they maintain or create. However, HIPAA applies to all organizations or persons that maintain personal health information, if they fall under HIPAA's definition of "Covered Entities."

By law, the EUTF MUST:

- Make sure that medical information that identifies you is kept private,
- Give you this notice of the EUTF's legal duties and privacy practices with respect to your medical information,
- Retain copies of the notices the EUTF issues to you,
- Retain any written acknowledgments that you received the notices, or document the EUTF's good faith efforts to obtain such written acknowledgments from you,
- Follow the terms of the notice that is currently in effect, and
- Notify affected individuals following a breach of unsecured protected health information.

HIPAA also requires the EUTF to tell you about:

- The EUTF's uses and disclosures of your medical information,
- Your privacy rights with respect to your medical information,
- Your right to file a complaint with the EUTF and with the Secretary of the Department of Health and Human Services, and
- The person or office at the EUTF whom you may contact for additional information about the EUTF's privacy practices.

How the EUTF May Use and Disclose Your Medical Information

The following categories describe the different ways the EUTF may use and disclose your medical information. Some uses and disclosures of your medical information require your authorization or the opportunity to agree or object to the use or disclosure. Other uses and disclosures do not. This notice clearly identifies whether or not the use or disclosure of your medical information requires your authorization or the opportunity to agree or object. Each category contains an explanation of what is meant by the "use and disclosure" of your medical information, and some examples. Not every use or disclosure in a category will

be listed. However, the ways the EUTF is allowed to use and disclose your medical information will generally fall into one of the categories listed.

The following categories DO NOT REQUIRE the EUTF to obtain your consent, authorization, or to provide you the opportunity to agree or object to the use or disclosure.

- **For Treatment**: the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under the your insurance plan. For example, the EUTF might disclose the name of your child's dentist to your child's orthodontist so that the orthodontist may ask the dentist for your child's dental X-rays.

- **For Payment**: the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health plan to coordinate benefit payments.

- **For EUTF Operations**: the EUTF may use and disclose your medical information for health care operations and other EUTF operations. These uses and disclosures are necessary to administer the EUTF benefit plans. For example, the EUTF may use and disclose your medical information to conduct or facilitate quality assessments and improvement activities, patient safety activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, enrollment, premium rating and other activities related to creating, renewing or replacing insurance contracts or benefit plans, claims review and appeals, legal functions and services, business planning and development, and other activities related to business management and administration. In connection with the foregoing, the EUTF may disclose your medical information to third parties who perform various health care operations or EUTF operations on its behalf.

- **As Required By Law**: the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF's compliance with federal privacy regulations (this notice).

- **To Avert a Serious Threat to Health or Safety**: the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

Disclosure to Business Associates: the EUTF may disclose your medical information to business associates in carrying out treatment, payment, health care operations and EUTF operations. For example, the EUTF may disclose your medical information to a utilization management organization to review the appropriateness of a proposed treatment under your insurance plan.

Disclosure to Health Insurance Companies or Health Maintenance Organizations: In carrying out treatment, payment or health care operations, the EUTF may disclose your medical information to health insurance companies or health maintenance organizations (HMOs) that it contracts with to provide services or benefits under its health benefits plans. For example, the EUTF may disclose your medical information to the Hawaii Medical Service Association, Kaiser Permanente and Kaiser Health Plan, UnitedHealthcare, Hawaii Dental Service, Vision Service Plan, Royal State National and ChiroPlan Hawaii in order to verify your eligibility for benefits or services.

Disclosure to the Plan Sponsor and Its Representatives: the EUTF is sponsored by State, county and other public employers who are represented on the EUTF's Board of Trustees. The EUTF may disclose information to the EUTF's Board of Trustees, the sponsoring public employers, and the Employees Retirement System (ERS) for payment, health care operations, and EUTF operations. For example, the

EUTF may disclose information to the sponsoring employers about whether you are participating in a group health plan that is offered by the EUTF, or whether you are enrolled or disenrolled in any such group health plan. Disclosure to the sponsoring employers may include disclosures to your departmental personnel officer (DPO) or any other person who functions as your employer's personnel officer. In the event you appeal a denied eligibility issue or other matter to the EUTF's Board of Trustees, the EUTF may disclose your medical information to the EUTF's Board of Trustees and its staff, consultant, and legal counsel as may be necessary to allow the EUTF's Board of Trustees to make a decision on your appeal. The EUTF may also disclose your medical information to the EUTF's Board of Trustees for plan administration functions, including such functions as quality assurance and auditing or monitoring the operations of group health plans that are part of the EUTF.

Public Health Activities: the EUTF may disclose your medical information to a public health authority for the purpose of preventing or controlling disease, injury or disability or to report child abuse or neglect.

Immunizations: To a school about an individual who is a student or prospective student of the school if the protected health information this is disclosed is limited to proof of immunization, the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; or the individual, if the individual is an adult or emancipated.

Organ and Tissue Donation: If you are an organ donor, the EUTF may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, the EUTF may release your medical information as required by military command authorities. The EUTF may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: the EUTF may release your medical information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health Oversight Activities: the EUTF may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the EUTF may disclose your medical information in response to a court order or administrative ruling. The EUTF may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the medical information requested.

Law Enforcement: the EUTF may release your medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About the victim of a crime if, under certain limited circumstances, the EUTF is able to obtain the person's agreement,
- About a death the EUTF believes might be the result of criminal conduct, and
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: the EUTF may release your medical information to a coroner or medical examiner. This might be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: the EUTF may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

The following category REQUIRES the EUTF to obtain your written authorization for the use or disclosure.

Generally, the Plan will require that you sign a valid authorization form in order to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operation. You have the right to revoke an authorization.

The Plan generally will require an authorization form for uses and disclosure of your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed. The Plan generally will require an authorization form for the sale of protected health information if the Plan receives direct or indirect financial remuneration (payment) from the entity to whom the PHI is sold. The Plan does not intend to engage in fundraising activities.

Psychotherapy Notes: Generally the EUTF must obtain your written authorization to use and disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the EUTF may use and disclose your psychotherapy notes when needed by the EUTF to defend against a lawsuit filed by you.

The following category REQUIRES that the EUTF gives you an opportunity to agree or disagree prior to the use or disclosure.

- **Family or Friends Involvement**: the EUTF may disclose your medical information to family members, other relatives, or your friends without your written consent or authorization if:
  - The medical information is directly relevant to the family or friend's involvement with your care or payment for that care, and
  - You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information maintained by the EUTF:

Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy (in hard copy or electronic form) of your PHI (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hard copy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

You have the right to inspect and obtain a copy of your medical information contained in a "designated record set," for as long as the EUTF maintains your medical information. The designated record set includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the EUTF to make decisions about people covered under the EUTF's health benefits plans. Information used for quality control or peer review analyses and not used to make decisions about people covered by the EUTF health benefits plans is not contained in the designated record set.

If you request a copy of your medical information, it will be provided to you in accordance with the time limits required under Part II of Chapter 92F, Hawaii Revised Statutes, and the rules enacted thereunder. Under those laws, the EUTF will generally provide a copy of your medical information to you within ten (10) business or working days. However, in certain circumstances, the EUTF may be entitled to additional time to respond to your request.

You or your personal representative must complete a form to request access to your medical information contained in the designated record set. You must submit the completed request form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

If you request a copy of the information, the EUTF may charge a fee for the costs of copying and mailing the information to you, for creating the PHI or preparing a summary of your PHI, or for other supplies associated with complying with your request.

The EUTF may deny your request to inspect and copy medical information in certain, very limited circumstances. If you are denied access to medical information, you may appeal.

If the EUTF denies your request to inspect or copy your medical information, the EUTF will provide you or your personal representative with a written denial identifying the reason(s) for the denial. The denial will also include a description of how you may exercise your appeal rights, and a description of how you may file a complaint with the Secretary of the Department of Health and Human Services.

Right to Amend Your Medical Information: If you think that your medical information is incorrect or incomplete, you may ask the EUTF to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the EUTF.

To request an amendment, you must submit your request, in writing, to the EUTF Privacy Officer. Your written request must include a reason that supports your request.

After you request that the EUTF amend your medical information, the EUTF must comply with your request within twenty (20) business or working days, or notify you that your request has been denied.

The EUTF may deny your request for an amendment to your medical information if your request is not in writing or does not include a reason to support the request. In addition, the EUTF may deny your request if you ask the EUTF to amend information that:

- Is not part of the medical information kept by or for the EUTF,
- Was not created by the EUTF, unless the person or entity that created the information is no longer available to make the amendment,
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete.

If the EUTF denies your request in the whole or in part, the EUTF must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial, and have that statement included with any future disclosure of your medical information.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" if a disclosure was made without your authorization for any purpose other than treatment, payment, or health care operations, or where the disclosure was to you about your own medical information.

To request this list of disclosures, you must submit a written request to the EUTF Privacy Officer. Your request must state a time period for which you are requesting the list of disclosures. This period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within any 12-month period will be provided free of charge. For additional lists, the EUTF may charge you for the costs of providing the list. The EUTF will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any costs.

The EUTF has 60 days from the date it receives your request to provide you the list of disclosures, and is allowed an additional 30 days to comply, if it provides you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on your medical information uses or disclosures for treatment, payment or health care operations. You also have the right to request a limit on your medical information that the EUTF discloses to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that the EUTF not use or disclose information about a surgical procedure you had.

The EUTF is not required by law to agree to your request.

You or your personal representative must complete a form to request restrictions on the use or disclosure of your medical information. You must submit the completed form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice. In your request, you must indicate:

- What information you want to limit,
- Whether you want to limit the EUTF's use, disclosure, or both, and
- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that the EUTF communicate with you about your medical information or other medical matters in a certain way, or at a certain location. For example, you may ask that the EUTF contact you only at work or by mail.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask the EUTF to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to request a paper copy of this notice. To obtain a paper copy of this notice, submit a written request to the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

Breach Notification Right: If a breach of your unsecured protected health information occurs, the Plan will notify you.

A Note about Personal Representatives

You may exercise your privacy rights through a personal representative. Your personal representative will be required to provide evidence of his or her authority to act on your behalf before that person will be given access to your medical information or allowed to take any action on your behalf with respect to your medical information. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A court order appointing the person as the your conservator or guardian, or
- An individual who is the parent of a minor child.

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

However, state or other applicable law will govern whether the EUTF is permitted to disclose an unemancipated minor dependent child's medical information to the child's parent(s). State or other applicable law will also govern whether the EUTF is permitted to provide a parent's access to his or her child's medical information.

Changes to This Notice

The EUTF reserves the right to change this notice. The EUTF also reserves the right to make the revised or changed notice effective for medical information it already maintains, or has access to about you as well as any information the EUTF receives in the future. The EUTF will post a copy of the current notice on the EUTF's web site. This notice will contain the effective date of the current notice on the first page, in the top right-hand corner.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your rights, the duties of the EUTF or other privacy practices stated in this notice. Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice. Because our health plan posts its Notice on its web site, we will prominently post the revised Notice on that web site by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual Notice distribution to individuals covered by the Plan.

Minimum Necessary Standard

When the EUTF uses or discloses your medical information, or requests your medical information from another entity, the EUTF will make reasonable efforts not to use, disclose or request more than the minimum amount of your medical information needed to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply to:

- Disclosures to or requests by a health care provider for treatment,
- Uses by you or disclosures to you of your own medical information,
- Disclosures made to the Secretary of the Department of Health and Human Services,

- Uses or disclosures that may be required by law,
- Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- Uses and disclosures for which the EUTF has obtained your authorization.

The Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

This notice does not apply to medical information that has been "de-identified." De-identified information is medical information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the EUTF may use or disclose "summary health information" to obtain premium bids or to modify, amend or terminate the EUTF's health benefits plans. Summary health information is information that summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom the EUTF has provided benefits, and from which identifying information has been deleted in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice. You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website (http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html) or this website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html or contact the Privacy Officer for more information about how to file a complaint. You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the EUTF will be made only with your written authorization. If you provide the EUTF with authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the EUTF will no longer use or disclose your medical information for the reasons covered by your written authorization.

You should understand that the EUTF is unable to take back any disclosures that have already been made with your authorization, and that the EUTF is required to retain any records regarding any care or services provided to you.

EUTF may not (and does not) use your genetic information that is PHI for underwriting purposes.

Questions?

If you have any questions about this notice, contact the EUTF Privacy Officer, at the address below.

Governing Law

If there is any discrepancy between the information in this notice and the actual HIPAA regulations, the regulations will prevail, and the EUTF will use and disclose your medical information in a manner consistent with the regulations.

You may contact the **EUTF Privacy Officer** at the following address:

Mailing Address: P.O. Box 2121, Honolulu, HI 96805

Physical Address: 201 Merchant Street, Suite 1520, Honolulu, HI 96813

Telephone number: 808-586-7390, Toll Free number: 1-800-295-0089

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

EFFECTIVE JULY 1, 2017

BU'S 00, 01, 02, 03, 04, 06, 08, 09, 10, 11, 13, 14: FOR ALL EMPLOYERS EXCEPT COUNTY OF MAUI

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	Self	$186.29	$372.58	$307.06	45.2%	$679.64
Prescription Drug - CVS Caremark	Two-Party	$458.72	$917.44	$731.96	44.4%	$1,649.40
RSN Chiropractic	Family	$577.79	$1,155.58	$946.90	45.0%	$2,102.48
PPO - 80/20 Plan - HMSA Medical	Self	$131.05	$262.10	$307.06	53.9%	$569.16
Prescription Drug - CVS Caremark	Two-Party	$324.65	$649.30	$731.96	53.0%	$1,381.26
RSN Chiropractic	Family	$406.82	$813.64	$946.90	53.8%	$1,760.54
PPO - 75/25 Plan - HMSA Medical	Self	$27.12	$54.24	$292.34	84.3%	$346.58
Prescription Drug - CVS Caremark	Two-Party	$72.30	$144.60	$696.20	82.8%	$840.80
RSN Chiropractic	Family	$85.11	$170.22	$901.34	84.1%	$1,071.56
HMSA HMO	Self	$235.65	$471.30	$307.06	39.4%	$778.36
Prescription Drug - CVS Caremark	Two-Party	$578.62	$1,157.24	$731.96	38.7%	$1,889.20
RSN Chiropractic	Family	$730.71	$1,461.42	$946.90	39.3%	$2,408.32
HMO - Kaiser Comprehensive Medical	Self	$137.58	$275.16	$307.06	52.7%	$582.22
Kaiser Prescription Drug	Two-Party	$341.34	$682.68	$731.96	51.7%	$1,414.64
RSN Chiropractic	Family	$428.62	$857.24	$946.90	52.5%	$1,804.14
HMO - Kaiser Standard Medical	Self	$35.46	$70.92	$307.06	81.2%	$377.98
Kaiser Prescription Drug	Two-Party	$93.15	$186.30	$731.96	79.7%	$918.26
RSN Chiropractic	Family	$112.00	$224.00	$946.90	80.9%	$1,170.90
Supplemental - Royal State National	Self	$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party	$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family	$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN						
HDS Dental	Self	$6.79	$13.58	$18.82	58.1%	$32.40
	Two-Party	$13.59	$27.18	$37.62	58.1%	$64.80
	Family	$22.37	$44.74	$61.88	58.0%	$106.62
VISION PLAN						
VSP Vision	Self	$1.30	$2.60	$3.90	60.0%	$6.50
	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the prescription drug plan actual premium until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
BU 07

EFFECTIVE JULY 1, 2017

BU 07: FOR STATE OF HAWAII

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	Self	$175.98	$351.96	$327.68	48.2%	$679.64
Prescription Drug - CVS Caremark	Two-Party	$429.77	$859.54	$789.86	47.9%	$1,649.40
RSN Chiropractic	Family	$544.93	$1,089.86	$1,012.62	48.2%	$2,102.48
PPO - 80/20 Plan - HMSA Medical	Self	$120.74	$241.48	$327.68	57.6%	$569.16
Prescription Drug - CVS Caremark	Two-Party	$295.70	$591.40	$789.86	57.2%	$1,381.26
RSN Chiropractic	Family	$373.96	$747.92	$1,012.62	57.5%	$1,760.54
PPO - 75/25 Plan - HMSA Medical	Self	$16.81	$33.62	$312.96	90.3%	$346.58
Prescription Drug - CVS Caremark	Two-Party	$43.35	$86.70	$754.10	89.7%	$840.80
RSN Chiropractic	Family	$52.25	$104.50	$967.06	90.2%	$1,071.56
HMSA HMO	Self	$225.34	$450.68	$327.68	42.1%	$778.36
Prescription Drug - CVS Caremark	Two-Party	$549.67	$1,099.34	$789.86	41.8%	$1,889.20
RSN Chiropractic	Family	$697.85	$1,395.70	$1,012.62	42.0%	$2,408.32
HMO - Kaiser Comprehensive Medical	Self	$127.27	$254.54	$327.68	56.3%	$582.22
Kaiser Prescription Drug	Two-Party	$312.39	$624.78	$789.86	55.8%	$1,414.64
RSN Chiropractic	Family	$395.76	$791.52	$1,012.62	56.1%	$1,804.14
HMO - Kaiser Standard Medical	Self	$25.15	$50.30	$327.68	86.7%	$377.98
Kaiser Prescription Drug	Two-Party	$64.20	$128.40	$789.86	86.0%	$918.26
RSN Chiropractic	Family	$79.14	$158.28	$1,012.62	86.5%	$1,170.90
Supplemental - Royal State National	Self	$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party	$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family	$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN						
HDS Dental	Self	$6.79	$13.58	$18.82	58.1%	$32.40
	Two-Party	$13.59	$27.18	$37.62	58.1%	$64.80
	Family	$22.37	$44.74	$61.88	58.0%	$106.62
VISION PLAN						
VSP Vision	Self	$1.30	$2.60	$3.90	60.0%	$6.50
	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the prescription drug plan actual premium until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
BU 12

EFFECTIVE JULY 1, 2017:

BU12: FOR CITY AND COUNTY OF HONOLULU, COUNTY OF KAUAI, COUNTY OF HAWAII

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	Self		$148.56	$297.12	$252.84	46.0%	$549.96
Prescription Drug - CVS Caremark	Two-Party		$379.11	$758.22	$616.42	44.8%	$1,374.64
RSN Chiropractic	Family		$484.91	$969.82	$811.20	45.5%	$1,781.02
PPO - 80/20 Plan - HMSA Medical	Self		$102.82	$205.64	$252.84	55.1%	$458.48
Prescription Drug - CVS Caremark	Two-Party		$264.73	$529.46	$616.42	53.8%	$1,145.88
RSN Chiropractic	Family		$336.61	$673.22	$811.20	54.6%	$1,484.42
PPO - 75/25 Plan - HMSA Medical	Self		$20.22	$40.44	$244.32	85.8%	$284.76
Prescription Drug - CVS Caremark	Two-Party		$58.16	$116.32	$595.10	83.6%	$711.42
RSN Chiropractic	Family		$68.91	$137.82	$783.58	85.0%	$921.40
HMSA HMO	Self		$195.30	$390.60	$252.84	39.3%	$643.44
Prescription Drug - CVS Caremark	Two-Party		$496.22	$992.44	$616.42	38.3%	$1,608.86
RSN Chiropractic	Family		$636.80	$1,273.60	$811.20	38.9%	$2,084.80
HMO - Kaiser Comprehensive Medical	Self		$122.85	$245.70	$252.84	50.7%	$498.54
Kaiser Prescription Drug	Two-Party		$314.97	$629.94	$616.42	49.5%	$1,246.36
RSN Chiropractic	Family		$401.75	$803.50	$811.20	50.2%	$1,614.70
HMO - Kaiser Standard Medical	Self		$30.62	$61.24	$252.84	80.5%	$314.08
Kaiser Prescription Drug	Two-Party		$84.27	$168.54	$616.42	78.5%	$784.96
RSN Chiropractic	Family		$102.75	$205.50	$811.20	79.8%	$1,016.70
Supplemental - Royal State National	Self		$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party		$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family		$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN							
HDS Dental	Self		$6.79	$13.58	$18.82	58.1%	$32.40
	Two-Party		$13.59	$27.18	$37.62	58.1%	$64.80
	Family		$22.37	$44.74	$61.88	62.8%	$106.62
VISION PLAN							
VSP Vision	Self		$1.30	$2.60	$3.90	60.0%	$6.50
	Two-Party		$2.41	$4.82	$7.20	59.9%	$12.02
	Family		$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE							
USAble Life Insurance	Employee		$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the prescription drug plan actual premium until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
FOR ACTIVE EMPLOYEES FORMERLY UNDER THE HSTA VEBA
BU 05

EFFECTIVE JULY 1, 2017

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution *	Percent Employer	Total
MEDICAL PLANS						
HSTA VB HMSA 90/10 PPO	Self	$168.37	$336.74	$273.44	44.8%	$610.18
Prescription Drug, RSN Chiropractic,	Two-Party	$407.80	$815.60	$661.24	44.8%	$1,476.84
VSP Vision	Family	$519.97	$1,039.94	$842.98	44.8%	$1,882.92
HSTA VB HMSA 80/20 PPO	Self	$117.90	$235.80	$273.44	53.7%	$509.24
Prescription Drug, RSN Chiropractic,	Two-Party	$285.34	$570.68	$661.24	53.7%	$1,231.92
VSP Vision	Family	$363.74	$727.48	$842.98	53.7%	$1,570.46
HSTA VB Kaiser Comprehensive	Self	$120.96	$241.92	$273.44	53.1%	$515.36
Prescription Drug, RSN Chiropractic,	Two-Party	$293.61	$587.22	$661.24	53.0%	$1,248.46
VSP Vision	Family	$374.74	$749.48	$842.98	52.9%	$1,592.46
DENTAL PLAN						
HSTA VB HDS Dental	Self	$7.50	$15.00	$20.04	57.2%	$35.04
	Two-Party	$14.98	$29.96	$40.10	57.2%	$70.06
	Family	$24.66	$49.32	$65.98	57.2%	$115.30
HSTA VB HDS Supplemental Dental	Self	$4.15	$8.30	$10.98	57.0%	$19.28
	Two-Party	$8.30	$16.60	$21.96	57.0%	$38.56
	Family	$12.45	$24.90	$32.94	57.0%	$57.84
VISION PLAN						
HSTA VB VSP Vision	Self	$1.30	$2.60	$3.90	60.0%	$6.50
	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
HSTA VB USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
MAUI COUNTY
ALL BU's EXCEPT BU 12

EFFECTIVE JULY 1, 2017

ALL BU's EXCEPT BU 12: FOR COUNTY OF MAUI

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	Self	$183.34	$366.68	$312.96	46.0%	$679.64
Prescription Drug - CVS Caremark	Two-Party	$444.97	$889.94	$759.46	46.0%	$1,649.40
RSN Chiropractic	Family	$567.24	$1,134.48	$968.00	46.0%	$2,102.48
PPO - 80/20 Plan - HMSA Medical	Self	$128.10	$256.20	$312.96	55.0%	$569.16
Prescription Drug - CVS Caremark	Two-Party	$310.90	$621.80	$759.46	55.0%	$1,381.26
RSN Chiropractic	Family	$396.27	$792.54	$968.00	55.0%	$1,760.54
PPO - 75/25 Plan - HMSA Medical	Self	$24.17	$48.34	$298.24	84.3%	$346.58
Prescription Drug - CVS Caremark	Two-Party	$58.55	$117.10	$723.70	82.8%	$840.80
RSN Chiropractic	Family	$74.56	$149.12	$922.44	84.1%	$1,071.56
HMSA HMO	Self	$232.70	$465.40	$312.96	40.2%	$778.36
Prescription Drug - CVS Caremark	Two-Party	$564.87	$1,129.74	$759.46	40.2%	$1,889.20
RSN Chiropractic	Family	$720.16	$1,440.32	$968.00	40.2%	$2,408.32
HMO - Kaiser Comprehensive Medical	Self	$134.63	$269.26	$312.96	53.8%	$582.22
Kaiser Prescription Drug	Two-Party	$327.59	$655.18	$759.46	53.7%	$1,414.64
RSN Chiropractic	Family	$418.07	$836.14	$968.00	53.7%	$1,804.14
HMO - Kaiser Standard Medical	Self	$32.51	$65.02	$312.96	82.8%	$377.98
Kaiser Prescription Drug	Two-Party	$79.40	$158.80	$759.46	82.7%	$918.26
RSN Chiropractic	Family	$101.45	$202.90	$968.00	82.7%	$1,170.90
Supplemental - Royal State National	Self	$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party	$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family	$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN						
	Self	$6.79	$13.58	$18.82	58.1%	$32.40
HDS Dental	Two-Party	$13.59	$27.18	$37.62	58.1%	$64.80
	Family	$14.29	$28.58	$78.04	73.2%	$106.62
VISION PLAN						
	Self	$1.30	$2.60	$3.90	60.0%	$6.50
VSP Vision	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the prescription drug plan actual premium until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
MAUI COUNTY
BU 12

EFFECTIVE JULY 1, 2017:

BU12: FOR COUNTY OF MAUI

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	Self	$148.56	$297.12	$252.84	46.0%	$549.96
Prescription Drug - CVS Caremark	Two-Party	$371.39	$742.78	$631.86	46.0%	$1,374.64
RSN Chiropractic	Family	$481.24	$962.48	$818.54	46.0%	$1,781.02
PPO - 80/20 Plan - HMSA Medical	Self	$102.82	$205.64	$252.84	55.1%	$458.48
Prescription Drug - CVS Caremark	Two-Party	$257.01	$514.02	$631.86	55.1%	$1,145.88
RSN Chiropractic	Family	$332.94	$665.88	$818.54	55.1%	$1,484.42
PPO - 75/25 Plan - HMSA Medical	Self	$20.22	$40.44	$244.32	85.8%	$284.76
Prescription Drug - CVS Caremark	Two-Party	$50.44	$100.88	$610.54	85.8%	$711.42
RSN Chiropractic	Family	$65.24	$130.48	$790.92	85.8%	$921.40
HMSA HMO	Self	$195.30	$390.60	$252.84	39.3%	$643.44
Prescription Drug - CVS Caremark	Two-Party	$488.50	$977.00	$631.86	39.3%	$1,608.86
RSN Chiropractic	Family	$633.13	$1,266.26	$818.54	39.3%	$2,084.80
HMO - Kaiser Comprehensive Medical	Self	$122.85	$245.70	$252.84	50.7%	$498.54
Kaiser Prescription Drug	Two-Party	$307.25	$614.50	$631.86	50.7%	$1,246.36
RSN Chiropractic	Family	$398.08	$796.16	$818.54	50.7%	$1,614.70
HMO - Kaiser Standard Medical	Self	$30.62	$61.24	$252.84	80.5%	$314.08
Kaiser Prescription Drug	Two-Party	$76.55	$153.10	$631.86	80.5%	$784.96
RSN Chiropractic	Family	$99.08	$198.16	$818.54	80.5%	$1,016.70
Supplemental - Royal State National	Self	$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party	$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family	$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN						
HDS Dental	Self	$6.79	$13.58	$18.82	58.1%	$32.40
	Two-Party	$13.59	$27.18	$37.62	58.1%	$64.80
	Family	$14.29	$28.58	$78.04	73.2%	$106.62
VISION PLAN						
VSP Vision	Self	$1.30	$2.60	$3.90	60.0%	$6.50
	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the prescription drug plan actual premium until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

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Definitions

Premiums The semi monthly or monthly amount paid for your health insurance Premiums are primarily influenced by utilization of services by the members, benefit plan design, and the cost of healthcare. For active employees under a collective bargaining agreement, the employer contribution to your premium is negotiated by your employee organization/union.

Eligible charge – The lower of the participating provider's actual charge or the amount the plan establishes as the maximum allowable fee (the maximum amount that the plan will pay for the covered services or supplies). This is the amount on which your coinsurance is based.

Copayment – A fixed amount (for example, $15) you pay for a covered service, usually when you receive the service. The amount can vary by plan and the type of covered service.

Coinsurance – Your share of the costs of a covered service, calculated as a percent (e.g. for most services under the HMSA 90/10 PPO medical plan, coinsurance is 10%) of the eligible charge. For example, if the plan's eligible charge for a primary care office visit is $100, your coinsurance payment of 10% would be $10. The plan pays the remainder of the eligible charge or $90 in this example.

Deductible – The amount you must pay for covered services before your plan begins to pay. For example, if you select the self EUTF HMSA 75/25 PPO medical plan your deductible is $300. For services that the deductible applies to (e.g. inpatient hospital services), you must pay the first $300 in eligible charges. Once the $300 deductible is met, the plan benefits begin (e.g. for eligible charges, you will pay your copayment or coinsurance and the plan will pay the remainder). The deductible does not apply to all services.

Out-of-Pocket Costs – Costs paid by the member related to deductibles, copayments and coinsurance for services. Out-of-pocket costs exclude premiums.

Maximum Out-of-Pocket Limits (MOOP) – The most you pay during a calendar year before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not include premiums, additional amounts for nonparticipating providers and other out-of-network charges, or spending for non-essential health benefits. The MOOP protects the members from catastrophic losses.

In-Network or Participating Provider – A physician, hospital, pharmacy, laboratory, or other healthcare provider your insurance carrier has contracted with to provide services at a negotiated fee or eligible charge rate. In most cases, participating providers are preferable to non-participating providers because of the lower out-of-pocket costs to the member.

Out-of-Network or Nonparticipating Provider – A physician, hospital, pharmacy, laboratory or other healthcare provider who has not contracted with your insurance carrier to provide services. When you receive services from a nonparticipating provider, you owe the plan's standard copayment or co-insurance plus the difference between the nonparticipating provider's charge for the services and your insurance carriers' eligible charge.

For example, if the nonparticipating provider's charge for a primary care office visit is $120, the plan's eligible charge is $100 and coinsurance is 10%, the plan will pay $90 ($100 * 90%) and you would pay $30 ($10 coinsurance plus $20 for the excess of the actual charge over the eligible charge). If the primary care provider was a participating provider, your total cost would be $10

MEDICAL PLANS

Preferred Provider Organization (PPO) – A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network (participating providers). You can use doctors, hospitals, and providers outside of the network for an additional cost. Most of HMSA's EUTF and HSTA VB medical plans are PPO plans.

Health Maintenance Organization (HMO) – A type of health insurance plan that usually limits coverage to care from medical providers who work for or contract with the HMO. A HMO generally won't cover out-of-network care except in emergency situations. HMOs often provide integrated care and focus on prevention and wellness. Kaiser Permanente and one EUTF active employee medical plans are HMO plans.

Primary Care Provider (PCP) – A provider (usually an internist, family/general practitioner or pediatrician) who provides a range of services such as prevention, wellness, and treatment for common illnesses. PCPs often maintain long-term relationships with you, and advise and treat you on a range of health related issues. PCPs may also coordinate your care with specialists.

Specialist – A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

PRESCRIPTION DRUG PLAN

Generics – A prescription drug that has the same active-ingredient formula as a brand-name drug. The color or shape may be different, but the active ingredients must be the same. Generic drugs usually cost significantly less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

For prescription drug coverage under Kaiser Comprehensive and Standard plans:

1) Tier 1 Generic - Generic drugs for chronic conditions - Not all generic drugs used for the treatment of chronic conditions are considered generic maintenance drugs.

2) Tier 2 Generic - Generic drugs not covered in Tier 1

Brand Name – A prescription drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand prescription drugs are either preferred or other brand/non-preferred. You will pay more if you use other brand/non-preferred drugs than preferred or generic prescription drugs.

Formulary – A list of prescription drugs covered by a prescription drug plan. A formulary is also called a drug list. The formulary is normally updated quarterly for the active employee and the non-Medicare retiree plans and annually for the Medicare retiree plans.

INSTRUCTIONS FOR COMPLETING FORM EC-1

Please print clearly or type. If the Form EC-1 is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the Form EC-1 to your Personnel Office or Department Personnel Officer (DPO) for verification, signature, and routing to EUTF within 30 days (180 days for newborns) of the event date. For DOE Employees: You must submit your EC-1 form to the DOE-EBU Office at PO Box 2360, Honolulu, HI 96804.

SECTION 1 - EMPLOYEE DATA

1. Enter your Last Name, First Name, and Middle Initial.
2. Enter your contact information.
3. Enter your address information. If your **residence** address differs from your **mailing** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the New Hire/Newly Eligible box if:
   A) You are a new employee; and enter the effective date you were hired, or
   B) Your employment status is changing from part time (25% FTE) to full time (50% -100% FTE) employment; and enter the effective date you will become full time.
5. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
6. Mark the Termination box if you are terminating your employment, and enter your last day of employment.
7. If you are enrolling with the EUTF for the first time, you are required to provide your Social Security Number and your dependent(s) Social Security Number.
8. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a gender and a birth date.
9. Mark the Qualifying Event During the Plan Year box if you have made any changes during the year, and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Change in Public Employer, Transfer In/Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
10. If you are Married, in a Civil Union, or Domestic Partnership, please be sure to check the appropriate boxes and include the date you were Married, entered into a Civil Union, or entered into a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health or your marriage certificate. If you do not receive the certificate within 60 days of the date of the event, contact the EUTF. A notarized Declaration of Domestic Partnership form is required (form is available on the EUTF website).
11. Special Note: If you have a Spouse, Civil Union Partner or Domestic Partner please provide his/her Name, Date of Birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 - COVERAGE AND CONTRIBUTION START SELECTION

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contributions start 1st day of the pay period in which the effective date of coverage occurs) will be the default option selected.

SECTION 3 - PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the "Cancel/Waive" box for each plan that you choose not to select. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.
3. To be eligible for the Royal State Supplemental plan coverage, you must have other medical coverage from another source, not including this employer.
4. The RSN ChiroPlan is included with all medical plans, including the Royal State Supplemental plan.
5. Life insurance is provided for the employee only.
6. FOR STATE EMPLOYEES ONLY*: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://dhrd.hawaii.gov. Please inquire with your DPO or DHRD on completing a PCP-2 form.
   -Mark one of the following boxes: ☐ Enroll or ☐ Do NOT Enroll.
   *The State allows its employees to pay for health premiums on a pre-tax basis. For more information please visit www.dhrd.hawaii.gov

   FOR COUNTY EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is administered by the Budget and Fiscal Services Department. Please contact your Department Personnel Office for more information on available options.

INSTRUCTIONS FOR COMPLETING FORM EC-1 (continued)

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number (SSN). Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the SSN blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1.
2. Use the following Relationship codes:

SP Spouse √	CH = Child √√√√	SC = Step Child √√√√
DP Domestic Partner √√√	DPCH Domestic Partner's Child √√√	GC Guardianship or Foster Child √√
CU Civil Union Partner √	CUCH = Civil Union Partner's Child √	DC Disabled Child √√√√

3. For Relationship codes with a √ or √√ or √√√ or √√√√, please see below for other required forms.
4. Other EUTF and/or DRHD forms to include with EC-1 (if applicable):
   - √ Marriage or Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes for Civil Unions
   - √√ Legal documents for guardianship or foster child
   - √√√ EUTF Declaration of Domestic Partnership and Affidavit of "Dependency" for Tax Purposes
   - √√√√ Disability Certification for Dependent Children (Form D-1) for enrolling a disabled child
   - √√√√√ Student certification if enrolling dependent age 19-23 in dental and/or vision plans
5. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF through your employer within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. Additions of a Civil Union Partner or a Domestic Partner are permitted outside of Open Enrollment. For a New Civil Union submitted within 30 days from the date of the civil union, the effective date of coverage is based on the event date. For a New Domestic Partner submitted within 30 days from the date of notarized signature, the effective date of coverage is based on the date of the notary. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
6. Gender – Write/type either M or F.
7. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
8. Dependent and Student certification. You must provide a copy of your child(ren)'s birth certificate and/or social security card if requested by the EUTF. You also must provide a copy of your child(ren)'s student verification letter on school letterhead, signed by the registrar, as required by the EUTF.

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you or your dependents are covered under another health plan, or if you selected the Royal State Supplemental plan, you are required to complete this section.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).
3. If you have ever been or are currently covered as a dependent under a state or county employee or retiree plan, please provide the state or county employee or retiree's Name, Date of Birth and Social Security Number, (SSN optional) on the corresponding line.

Note: To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must have health coverage through another source, not including this employer.

SECTION 6 - EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from your salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

You must submit the EC-1 through your personnel office. Your personnel office confirms that you are a current employee and are eligible for health benefits through the EUTF. Your personnel office will forward your EC-1 to EUTF.

For DOE Employees: You must submit your EC-1 form to the DOE-EBU Office at PO Box 2360, Honolulu, HI 96804.

EMPLOYER VALIDATION **[for EMPLOYER USE ONLY]**

1. Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education, 010022 for University of Hawaii, 010053 for Budget and Finance, etc.
2. Department and Division/School - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. Enter the date the EC-1 was received from the employee. The date recorded should be the date that the **employer** received the Form EC-1, not the date the DPO / employer designee received it.
5. Please provide contact phone and fax numbers.
6. DPO / employer designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1 was signed by the DPO / employer designee.

INSTRUCTIONS FOR COMPLETING FORM EC-1H

Use of this form is for members currently enrolled in the HSTA VB plans. If you are not currently enrolled in the HSTA VB plans, please use the EC-1 form.

Please print clearly or type. If the Form EC-1H is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the completed Form EC-1H to your Personnel Office (DOE-EBU) at PO Box 2360, Honolulu HI 96804) or your Charter School Personnel Office for verification, signature, and routing to EUTF within 30 days (180 days for newborns) of the event date.

SECTION 1 - EMPLOYEE DATA

1. Enter your Last Name, First Name, and Middle Initial.
2. Enter your contact information.
3. Enter your address information. If your **residence** address differs from your **mailing** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
5. Mark the Termination box if you are terminating your employment, and enter your last day of employment.
6. Enter your gender and birth date. EUTF is unable to process your paperwork without a gender and a birth date.
7. Mark the Qualifying Event During the Plan Year box if you have made any changes during the year, and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Change in Public Employer, Transfer In/Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
8. If you are Married, in a Civil Union, or Domestic Partnership, please be sure to check the appropriate boxes and include the date you were Married, entered into a Civil Union, or entered into a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health or your marriage certificate. If you do not receive the certificate within 60 days of the date of the event, contact the EUTF. A notarized Declaration of Domestic Partnership form is required (form is available on the EUTF website).
9. Special Note: If you have a Spouse, Civil Union Partner or Domestic Partner please provide his/her Name, Date of Birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 - COVERAGE AND CONTRIBUTION START SELECTION

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contributions start 1st day of the pay period in which the effective date of coverage occurs) will be the default option selected.

SECTION 3 - PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the "Cancel/Waive" box for each plan that you choose not to select. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.
3. The RSN ChiroPlan and Vision Service Plan (VSP) for vision are included with all medical plans.
4. Life insurance is provided for the employee only.
5. FOR STATE EMPLOYEES ONLY*: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://dhrd.hawaii.gov. Please inquire with your Personnel Office (DOE-EBU), Charter School or DHRD on completing a PCP-2 form.

   -Mark one of the following boxes: ☐ Enroll or ☐ Do NOT Enroll.

   *The State allows its employees to pay for health premiums on a pre-tax basis. For more information please visit www.dhrd.hawaii.gov

INSTRUCTIONS FOR COMPLETING FORM EC-1H (continued)

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number (SSN). Social Security Number is not a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the SSN blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1H.
2. Use the following Relationship codes:

SP Spouse √	CH = Child √√√√	SC = Step Child √√√√
DP Domestic Partner √√√	DPCH Domestic Partner's Child √√√	GC Guardianship or Foster Child √√
CU Civil Union Partner √	CUCH = Civil Union Partner's Child √	DC Disabled Child √√√√

3. For Relationship codes with a √ or √√ or √√√ or √√√√, please see below for other required forms.
4. Other EUTF and/or DRHD forms to include with EC-1H (if applicable):
   - √ Marriage or Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes for Civil Unions
   - √√ Legal documents for guardianship or foster child
   - √√√ EUTF Declaration of Domestic Partnership and Affidavit of "Dependency" for Tax Purposes
   - √√√√ Disability Certification for Dependent Children (Form D-1) for enrolling a disabled child
   - √√√√√ Student certification if enrolling dependent age 19-23 in dental and/or vision plans
5. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF through your employer within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. Additions of a Civil Union Partner or a Domestic Partner are permitted outside of Open Enrollment. For a New Civil Union submitted within 30 days from the date of the civil union, the effective date of coverage is based on the event date. For a New Domestic Partner submitted within 30 days from the date of notarized signature, the effective date of coverage is based on the date of the notary. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
6. Gender – Write/type either M or F.
7. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
8. Dependent and Student certification. You must provide a copy of your child(ren)'s birth certificate and/or social security card if requested by the EUTF. You also must provide a copy of your child(ren)'s student verification letter on school letterhead, signed by the registrar, as required by the EUTF.

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you or your dependents are covered under another health plan, you are required to complete this section.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).
3. If you have ever been or are currently covered as a dependent under a state or county employee or retiree plan, please provide the state or county employee or retiree's Name, Date of Birth and Social Security Number, (SSN optional) on the corresponding line.

SECTION 6 – EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from your salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

For Charter School Employees: You must submit the EC-1H through your personnel office. Your personnel office confirms that you are a current employee and are eligible for health benefits through the EUTF. Your personnel office will forward your EC-1H to EUTF.

For DOE Employees: You must submit your EC-1H to the DOE-EBU Office at P O Box 2360, Honolulu, HI 96804.

EMPLOYER VALIDATION **[for EMPLOYER USE ONLY]**

1. Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education.
2. Department and School/Office - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. Enter the date the EC-1H was received from the employee. The date recorded should be the date that the **employer** received the Form EC-1H, not the date the Personnel Office (DOE-EBU) or Charter School / employer designee received it.
5. Please provide contact phone and fax numbers.
6. Personnel Office (DOE-HBAU) or Charter School / employer designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1H was signed by the Personnel Office (DOE-EBU) or Charter School / employer designee.

EC-1
Rev. 04/2017

Hawaii Employer-Union Health Benefits Trust Fund

EC-1: Enrollment Form for Active Employees

DUE DATE: This form must be submitted to your Personnel Officer or Departmental Personnel Office within 30 days (180 days for newborns) of the event date.

Please submit this form to your personnel office.
DOE employees submit to:
DOE-EBU
P O Box 2360
Honolulu HI 96804

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social security numbers are required to process new hires.

Name (Last Name, First Name, Middle Initial)

_____

Home Phone (____) _____
Mobile Phone (____) _____
Work Phone (____) _____
Email _____

Mailing Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip code _____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip code _____

☐ New Hire/Newly Eligible
Date of Hire/Newly Eligible: (MM/DD/YYYY)

_____/_____/ _____

☐ Open Enrollment (effective 07/01/2017)

☐ Termination of Employment
Date of Termination: (MM/DD/YYYY)

_____/_____/ _____

Employee's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/ _____

☐ Mid-Year Qualifying Event (describe)

Mid-Year Qualifying Event Date:

_____/_____/_____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)

_____/_____/_____

☐ **Civil Union**
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)

_____/_____/_____

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
Notary Date: (MM/DD/YYYY)

_____/_____/_____

Special Note: If you are married, in a civil union or domestic partnership, please provide your spouse/partner's Name, Date of Birth, SSN:

Name: _____ DOB: _____/_____/_____ SSN: _____

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

If your event is listed below, please select one of the three options, otherwise skip this section.

Some events allow for a selection of the Coverage and Premium Contribution Start Dates.

Qualifying Events for this Section
Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section
☐ Coverage starts day of the event & premium contributions 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 contributions start 1st day of the **first** pay period following event
☐ Coverage and premium contributions start 1st day of the **second** pay period following event

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If no selection is made, EUTF will assume no changes are being made.

Medical/Prescription Drug Plan Type	Carrier Selection	You may only choose one medical/prescription drug plan: Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	PPO-80/20 **HMSA** Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	PPO-75/25 **HMSA** Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
HMO	HMO-**HMSA** CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	HMO-**Kaiser** Standard Prescription Drug, RSN Chiro	☐	☐	☐	☐
	HMO-**Kaiser** Comprehensive Prescription Drug, RSN Chiro	☐	☐	☐	☐
Supplemental	Supplemental- Royal State National Insurance Company (Includes Supplemental Drug Coverage), Chiro *** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under a non- EUTF health plan. See Section 5 on "Instructions for Completing Form EC-1"	☐	☐	☐	☐

Other Plans			Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Vision	Vision Service Plan	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Life	USAble Life		☐	☐		

For STATE Employees ONLY*	Do NOT Enroll	Enroll
Premium Conversion Plan	☐	☐

*The State allows its employees to pay for health premiums on a pre-tax basis. For more information please visit www.dhrd.hawaii.gov
For County Employees: Please contact your DPO for more information on Premium Conversion or Flex Plan options.

Employee's Name:

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH=Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information received/issued by the SSA.

Continue Coverage	Add	Delete	Dependent Last Name, First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐

Detailed eligibility information is available at http://eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.
Dependent Certification and Student Certification – See Section 4 item 8 on "Instructions for Completing Form EC-1" for more information.

SECTION 5: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide the type of plan, name of the plan, subscriber's name, and dependents on the plan.

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Are you on this Plan?	Are all dependents listed in Section 4 on this Plan? If no, list below which dependents are on this plan.
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Have you ever been or are you currently covered as a dependent under a state or county employee or retiree plan? ☐ Yes ☐ No
If "Yes", please provide the information as requested below of the state or county employee or retiree:
Name: (Last Name, First Name, Middle Initial) _____ DOB: ____/____/_____ SSN: (Optional) _____

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form also meet the eligibility requirements for enrollment in the EUTF plans. I understand that the benefit elections made on this application are in effect for 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 selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

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. This form supersedes all forms and submissions I 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 penalty for perjury.

Employee: Signature: _____ Date Signed: _____

Department ID#	Department	Division/School	Bargaining Unit
Date EC-1 Received in Employing Office / /		DPO Phone Number	DPO Fax Number
DPO (or employer designee's) Printed Name: DPO (or employer designee's) 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.			Date of DPO (or employer designee's) Signature / /
Remarks:			

EC-1H
Rev. 04/2017

Hawaii Employer-Union Health Benefits Trust Fund

EC-1H: Enrollment Form for HSTA VB Active BU 05/45 Employees

DUE DATE: This form must be submitted to DOE-EBU within 30 days (180 days for newborns) of the event date.

DOE employees please submit this form to:
DOE-EBU
P O Box 2360
Honolulu HI 96804

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social security numbers are required to process new hires.

Name (Last Name, First Name, Middle Initial)

_____

Home Phone (____) _____
Mobile Phone (____) _____
Work Phone (____) _____

Email _____

Mailing Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip code _____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip code _____

☐ Open Enrollment (effective 07/01/2017)

☐ Termination of Employment
Date of Termination: (MM/DD/YYYY)

_____/_____/ _____

Employee's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/ _____

☐ Mid-Year Qualifying Event (describe)

Mid-Year Qualifying Event Date:

_____/_____/_____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)

_____/_____/_____

☐ **Civil Union**
Civil Union Date: (MM/DD/YYYY)

_____/_____/_____

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
Notary Date: (MM/DD/YYYY)

_____/_____/_____

Special Note: If you are married, in a civil union or domestic partnership, please provide your spouse/partner's Name, Date of Birth, SSN:

Name: _____ DOB: _____/_____/_____ SSN: _____

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

If your event is listed below, please select one of the three options, otherwise skip this section.

Some events allow for a selection of the Coverage and Premium Contribution Start Dates.

Qualifying Events for this Section
Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section
- ☐ Coverage starts day of the event & premium contributions 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 contributions start 1st day of the **first** pay period following event
- ☐ Coverage and premium contributions start 1st day of the **second** pay period following event

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If no selection is made, EUTF will assume no changes are being made.

Medical/Prescription Drug Plan Type	Carrier Selection	You may only choose one medical/prescription drug plan: Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical, CVS Prescription Drug, Vision, RSN Chiro	☐	☐	☐	☐
PPO	PPO-80/20 **HMSA** Medical, CVS Prescription Drug, Vision, RSN Chiro	☐	☐	☐	☐
HMO	HMO-**Kaiser** Comprehensive Medical, Prescription Drug, Vision, RSN Chiro	☐	☐	☐	☐

Other Plans			Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Supplemental Dental	Supplemental Hawaii Dental Service	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Vision	Vision Service Plan	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Life	USAble Life		☐	☐		

For STATE Employees ONLY*	Do NOT Enroll	Enroll
Premium Conversion Plan	☐	☐

*The State allows its employees to pay for health premiums on a pre-tax basis. For more information please visit www.dhrd.hawaii.gov

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Employee's Name:

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH=Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H to update our records for your newborn once the information received/issued by the SSA.

Continue Coverage	Add	Delete	Dependent Last Name, First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐

Detailed eligibility information is available at http://eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.
Dependent Certification and Student Certification – See Section 4 item 8 on "Instructions for Completing Form EC-1H" for more information.

SECTION 5: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide the type of plan, name of the plan, subscriber's name, and dependents on the plan.

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Are you on this Plan?	Are all dependents listed in Section 4 on this Plan? If no, list below which dependents are on this plan.
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Have you ever been or are you currently covered as a dependent under a state or county employee or retiree plan? ☐ Yes ☐ No
If "Yes", please provide the information as requested below of the state or county employee or retiree:
Name: (Last Name, First Name, Middle Initial) _____ DOB: ____/____/_____ SSN: (Optional) _____

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form also meet the eligibility requirements for enrollment in the EUTF plans. I understand that the benefit elections made on this application are in effect for 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 selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

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. This form supersedes all forms and submissions I 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 penalty for perjury.

Employee: Signature: _____ Date Signed: _____

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

FORMS SUBMITTED TO YOUR EMPLOYER'S OPEN ENROLLMENT DESIGNEE AFTER FRIDAY, APRIL 28, 2017 WILL NOT BE PROCESSED

Contact Information

For Questions About	Please Contact
Eligibility & EUTF Information	**eutf@hawaii.gov** EUTF Customer Service Call Center 808-586-7390 or Toll Free: 1-800-295-0089 Monday through Friday, 7:45 a.m. – 4:30 p.m. HST
CVS/caremark (CVS)	**www.caremark.com/** **www caremark com/eutf/** 1-855-801-8263 TTY - 711 (24 hour a day, 7 day a week) Walk-in Service: Pauahi Tower 1003 Bishop Street, Suite 704 Hours of Operation: Monday – Friday 7:45 a.m. – 4:30 p.m. HST
Hawaii Dental Service (HDS)	**www.hawaiidentalservice.com** 808-529-9310 or Toll Free: 1-866-702-3883 Over the phone: Monday through Friday, 7:00 a.m. – 7:00 p.m. HST, Saturday 9:00 a.m. – 1:00 p.m., except Federal and State observed holidays Walk In Hours Monday through Friday, 8:00 a.m. – 4:30 p.m., except Federal and State observed holidays Office located: Topa Financial Center, Bishop Street Tower, 700 Bishop Street, Suite 700
Hawaii Medical Service Association (HMSA)	**www.hmsa.com/eutf** **On Oahu** Walk in ervice at our Downtown office (City Financial Tower, 18th floor) Monday through Friday, 8 a.m. – 4 p.m. HMSA Center @ Honolulu is open Monday through Friday, 8 a m 6 p m and on Saturday from 9 a m 2 p m HMSA Center @ Pearl City is open Monday through Friday, 9 a.m. – 7 p.m. and Saturday from 9 a.m. – 2 p.m. Or call customer service at 808-948-6499 Monday through Friday, 7 a.m. – 7 p.m. HMSA Center @ Honolulu - 818 Keeaumoku St. HMSA Center @ Pearl City - Pearl City Gateway 1132 Kuala St., Suite 400 **On Hawaii Island:** Walk in service at our HMSA Center @ Hilo, Monday through Saturday, 9 a.m. – 7 p.m., and Saturday, 9 a.m. – 2 p.m. Our Kailua Kona office is open Monday through Friday from 8 a.m. – 4 p.m. Or call our Kona office at 808-329-5291 during those hours. HMSA Center @ Hilo - Waiakea Center 303A E. Makaala St. Kailua Kona office - 75-1029 Henry St., Suite 301 **On Maui:** Walk in service at our Kahului office, Monday through Friday from 8 a.m. – 4 p.m. Or call our Kahului office at 808-871-6295 during those hours. Kahului office - 33 Lono Ave., Suite 350 **On Kauai:** Walk in service at our Lihue office, Monday through Friday from 8 a.m. – 4 p.m. Or call our Lihue office at 808-245-3393 during those hours. Lihue office - 4366 Kukui Grove St., Suite 103 **From any island:** Call Toll Free 1-800-776-4672, Monday through Friday from 7 a.m. – 7 p.m.

For Questions About	Please Contact
Kaiser Permanente (Kaiser)	**www.kp.org/eutf** 808-432-5955 (Oahu) or Toll Free: 1-800-966-5955 (Neighbor Islands) Monday through Friday, 7:00 a.m. – 7:00 p.m. HST Saturdays 8:00 a.m. – 1:00 p.m. HST Walk-in Service: 711 Kapiolani Blvd Honolulu, HI 96813 Monday through Friday, 8:00 a.m.– 4:30 p.m. excluding State observed holidays.
Royal State National (RSN)	**Chiropractic Benefit** 808-621-4774 or Toll Free: 1-800-414-8845 **www.chiroplanhawaii.com** Monday through Friday, 7:00 a.m. – 7:00 p.m. HST; Saturdays 9:00 a.m. – 1:00 p.m. HST, excluding State observed holidays Walk-in Service: ChiroPlan Hawaii, Inc. 711 Kilani Avenue, Suite 3 Wahiawa, HI 96786 **Monday through Friday, 8:00 a.m. – 4:30 p.m. excluding State observed holidays.** **Supplemental Plan** 808-539-1621 or Toll Free: 1-888-942-2447 **www.royalstate.com** Monday through Friday, 7:00 a.m. – 7:00 p.m. HST Saturdays 9:00 a.m. – 1:00 p.m. HST, excluding State observed holidays. Walk-in Service: Royal State Insurance 819 S. Beretania Street Honolulu, HI 96813 **Monday through Friday, 8:00 a.m. – 4:30 p.m. excluding State observed holidays.**
USAble Life	**www.usablelife.com/portal/eutf** 808-538-8920 or Toll Free 1-855-207-2021 (Monday through Friday, 7:45 a.m. – 4:30 p.m. except State observed holidays) Walk-in Service: First Hawaiian Bank Building 999 Bishop St. Suite 2701 Honolulu, HI 96813 Questions may be sent to us via email. General Customer Service inquiries - EUTF.custserv@usablelife.com Claims Inquiries – EUTF.claims@usablelife.com

For Questions About	Please Contact
Vision Service Plan (VSP)	**www.vsp.com** Toll Free: 1-866-240-8420 As of Sunday 3/12/17 – Daylight Savings BEGINS: (Monday through Friday, 2:00 a.m. – 5:00 p.m. HST Saturdays 4:00 a.m. – 5:00 p.m. HST Sundays 4:00 a.m. – 4:00 p.m. HST) Effective Sunday 11/5/17 – Daylight Savings ENDS: (Monday through Friday, 3:00 a.m. – 6:00 p.m. HST Saturdays 5:00 a.m. – 6:00 p.m. HST Sundays 5:00 a.m. – 5:00 p.m. HST) Oahu: 808-532-1600 or Toll Free: 1-800-522-5162 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST) Walk-in Service: 1003 Bishop St., #890 Honolulu, HI 96813

Plan information can also be found online via the “Links to Carrier Web Sites” located on the EUTF website at eutf.hawaii.gov.

INSTRUCTIONS FOR COMPLETING FORM EC-2

Print or type clearly. If this form is unreadable, incomplete, or does not contain all information required, it will be sent back to you without action.

SECTION 1 - RETIREE DATA

1. Enter your last name, first name, and middle initial.
2. Enter your contact information.
3. Enter your address information. If your residence address differs from your mailing address, you need to enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box **only** during the annual or limited Open Enrollment period.
5. If you are enrolling with the EUTF for the first time as a retiree, you are required to provide your full Social Security Number.
6. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your form without a birth date.
7. Mark the Qualifying Event box if you are making changes during the year when it is not Open Enrollment; and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
8. If you are married, or in a civil union or domestic partnership please be sure to check appropriate boxes and include date you were married or entered into a civil union or domestic partnership. You must attach a copy of required documents.
9. Special Note: If your Spouse, Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her name, date of birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND CONTRIBUTION START SELECTION

Complete this section only if you pay towards health plan benefits

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option used.
3. The event date for Marriage and Civil Union is the marriage date or civil union certification date, respectively. The event date to add a Domestic Partner (DP) is the date the Declaration of DP is notarized.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose ONE medical, ONE dental, and ONE vision plan. Your choice of the prescription drug plan will depend on the medical plan that you select. If you select Kaiser, your medical selection will include a prescription drug plan. If you select HMSA or UHC, you must select the prescription drug plan if you want prescription drug coverage. If you don't make a selection, you will not have any prescription drug coverage.
2. You may choose to elect only the medical PPO plan without the prescription drug plan or vice versa. If you want both the medical and prescription drug plans, please mark the appropriate boxes. If you do not want any plan coverage, mark the "Cancel/Waive" box.
3. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the "Cancel/Waive" box for each plan that you choose not to select.
4. Life Insurance is provided by the State/County for the retiree only.

Write your name in the top right corner of page 2.

SECTION 4 – DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. Social Security Number is <u>not</u> a required field when submitting an initial EC-2 for new birth. Please be sure to submit an EC-2 to update our records for your newborn once the information is received/issued by the Social Security Administration. If making changes to your dependent's data, enter the corrected item. If listing more than 3 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-2.

2. Use the following Relationship codes:

SP = Spouse CH = Child√√√√√ GC = Guardianship or Foster Child √√
CU = Civil Union Partner √ CUCH = Civil Union Child √ SC = Step Child√√√√√
DP = Domestic Partner √√√ DPCH = Domestic Partner Child √√√ DC = Disabled Child √√√√

If you are adding an Adopted Child, Civil Union Partner and child, Domestic Partner and child or a Disabled Child, please contact the EUTF at 808-586-7390 or toll free, 1-800-295-0089 or visit our website at eutf.hawaii.gov for more information. Other EUTF forms to include with EC-2 (if applicable):

√ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes

√√ Legal documents for guardianship or foster child

√√√ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership, and Affidavit of "Dependency" for Tax Purposes

√√√√ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

√√√√√ Student Certification if enrolling dependent age 19-23

3. Gender – Write/type either M or F.
4. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
5. Dependent/Student certification. Your initials confirm that you are certifying that your spouse/partner and dependent children are eligible to be enrolled under your health plans. You also confirm that you will provide a copy of your child(ren)'s birth certificate and/or Social Security card if requested by the EUTF. If you have dependent children ages 19 through 23 who are full-time students, your initials confirm they are full-time students at an accredited college or school. You further confirm that you will provide a copy of your child(ren)'s student verification letters required by the EUTF.
6. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. You may add your Civil Union Partner or Domestic Partner at any time outside of Open Enrollment, provided all required documents have been received by EUTF within 30 days of the event date. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.

SECTION 5 – MEDICARE

IMPORTANT NOTICE: When you or your dependent(s) become eligible for Medicare Part B, you or your dependent(s) must enroll in Medicare Part B and forward proof of enrollment (Medicare card showing Medicare Part B effective date and Direct Deposit Authorization Form) to the EUTF. Failure to comply may result in loss of medical and prescription drug coverage.

SECTION 6 – UNITEDHEALTHCARE MEDICARE ADVANTAGE PLAN

IMPORTANT NOTICE: You must be enrolled in Medicare Parts A and B in order to enroll in the UNTEDHEALTHCARE Medicare Advantage plan.

1. For retiree-beneficiary, enter your full name as it appears on your Medicare card. If you are enrolling your spouse/partner, they must also enter their full name as it appears on their Medicare card.
2. Enter your Medicare claim number as it appears on your Medicare card. If you are enrolling your spouse/partner, they must also enter their Medicare claim number as it appears on their Medicare card.
3. End-Stage Renal Disease information is required for enrollment into the UnitedHealthcare Medicare Advantage plan. Please mark the appropriate box.
4. You can receive a full pre-enrollment kit by calling UnitedHealthcare or by attending one of the open enrollment meetings

SECTION 7 – RETIREE AND SPOUSE/PARTNER SIGNATURE

Your signature certifies that the information provided in this application is true and complete and you agree to abide by the terms and conditions of the benefit plans selected. Retiree affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student and is also unmarried. Please enter date of Retiree's signature. If you are enrolling yourself **and your spouse/partner** in the UnitedHealthcare plan, your spouse/partner MUST provide a signature and date in section 7.

You must submit the EC-2 to the EUTF office within 60 days of the date of retirement. You may send it by mail or hand deliver. The addresses are printed at the bottom of page 2 of the enrollment form.

EC-2 Rev. Oct 2016	Hawaii Employer-Union Health Benefits Trust Fund **EC-2: Enrollment Form for Retirees**	PLEASE SUBMIT THIS FORM EC-2 TO THE EUTF

SECTION 1: RETIREE DATA

Please complete all applicable fields below. Social Security numbers are required to process new retirees and dependent enrollments. **

Name (Last, First, Middle Initial)

_____

Home Phone (_____) _____

Work Phone (_____) _____

Mobile Phone (_____) _____

Email _____

Mailing Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ Newly Retired
Date of Retirement (MM/DD/YYYY)

_____/_____/_____

☐ Open Enrollment (effective 01/01/2017)

Retiree's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
(☐ Check this box if status change)

_____/_____/_____

☐ Qualifying Event (describe)

_____

Event Date: _____/_____/_____

Civil Union Partner (Civil Union Status)
☐ IRS Qualified ☐ Not Qualified
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)

_____/_____/_____

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP Date: (MM/DD/YYYY)
(☐ Check this box if status change)

_____/_____/_____

Special Note: If your Spouse/Civil Union or Domestic Partner is a State or County Employee or Retiree, please provide the following:
NAME: SSN: DOB:

SECTION 2: COVERAGE AND CONTRIBUTION SELECTION

Skip this section if RETIREE does NOT pay towards health plan benefits.

If events are filed within 30 days of the qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section
Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

Available Options for this Section

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

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If no selection is made, EUTF will assume no changes are being made.

Choose only one box in each plan selection

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family	
Medical	PPO-90/10 **HMSA** Medical No Prescription Drug Coverage	☐	☐	☐	☐	
PPO	**UnitedHealthcare** Medicare Advantage Grp. 13840-Medicare A&B required No Prescription Drug Coverage	☐	☐	☐	☐	(All enrollees must be enrolled in Medicare Parts A&B)
Prescription Drug	**CVS Caremark** Prescription Drug (Not a valid selection with Kaiser)	☐	☐	☐	☐	
HMO	HMO-**Kaiser** Medical (Includes Kaiser Prescription Drug)	☐	☐	☐	☐	
Dental	Hawaii Dental Service	☐	☐	☐	☐	
Vision	Vision Service Plan	☐	☐	☐	☐	
Life	USAble Life	☐	☐	Not available to dependents		

Retiree's Name _____

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add/delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, CU=Civil Union Partner, DP=Domestic Partner, CH=your Child or your Spouse's Child, CUCH=Civil Union Partner's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-2 for new birth. Please be sure to submit an EC-2 to update our records for your newborn once the information is received/issued by SSA.

Continue Coverage	Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MMDDYYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at http://eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.
Dependent Certification and Student Certification– See Section regarding Dependent and Student Certification on "Instructions for Completing Form EC-2" for more information.

I certify that my spouse/partner and/or dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ **(initials)**

I certify that my dependent child is a full-time student and have attached all documentation as required in Section 4 regarding dependent and student certification in the "Instructions for Completing Form EC-2". _____ **(initials)**

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires all Medicare eligible retirees and their dependents to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF retiree benefit plans. If you or your dependent(s) are Medicare eligible and are not enrolled in Medicare Part B, you must enroll immediately and provide EUTF with a copy of your Medicare card. If you are already enrolled, be sure EUTF has a copy of your Medicare card.

SECTION 6: UNITEDHEALTHCARE MEDICARE ADVANTAGE PLAN (UHC)

If you or any of your dependents are enrolling in the UnitedHealthcare Medicare Advantage Plan, YOU MUST COMPLETE THE INFORMATION BELOW (the information is on your red, white and blue Medicare card):

Retiree – Name of Beneficiary: _____ **Medicare Claim #** _____

Do you have End Stage Renal Disease (ESRD) ☐ Yes ☐ No

Spouse/Partner – Name of Beneficiary: _____ **Medicare Claim #** _____

Do you have End Stage Renal Disease (ESRD) ☐ Yes ☐ No

If the above information is not completed, your enrollment into the UnitedHealthcare Medicare Advantage Plan may be rejected resulting in no medical coverage.

SECTION 7: RETIREE & SPOUSE/PARTNER 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 for 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 selected

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. This form supersedes all forms and submissions I 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 penalty for perjury.

Retiree Signature: _____ Date Signed: _____

Retiree Spouse/Partner Signature: _____ Date Signed: _____ (Signature & date required if enrolling in UHC)

Please submit your signed EC-2 form by mail to:

EUTF
P.O. Box 2121
Honolulu, HI 96805-2121

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite1700, Honolulu, HI 96813

Customer Service Call Center

Oahu (808) 586-7390
Toll Free 1(800) 295-0089

INSTRUCTIONS FOR COMPLETING FORM EC-2H

Print or type clearly. If this form is unreadable, incomplete, or does not contain all information required, it will be sent back to you without action.

SECTION 1 - RETIREE DATA

1. Enter your last name, first name, middle initial.
2. Enter your contact information.
3. Enter your address information. If your residence address differs from your mailing address, you need to enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box **only** during the annual or limited Open Enrollment period.
5. Enter your gender and birth date.
6. Mark the Qualifying Event box if you are making changes during the year when it is not Open Enrollment; and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
7. If you are Married, or in a Civil Union, or in a Domestic Partnership please be sure to check the appropriate boxes and include the date you were Married, or entered in a Civil Union, or entered in a Domestic Partnership. You must attach a copy of required documents.
8. Special Note: If your Spouse, Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her name, date of birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND CONTRIBUTION START SELECTION

Complete this section only if you pay towards health plan benefits

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option selected.
3. The event date for Marriage and Civil Union is the marriage date or civil union certification date, respectively. The event date to add a Domestic Partner (DP) is the date the Declaration of DP is notarized.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose ONE medical and ONE dental plan. Your choice of the prescription drug and vision plan will depend on the medical plan that you select.
2. If you have other health plan coverage and do not want to participate in the HSTA VB plans, mark the "Cancel/Waive" box for each plan that you choose not to select.
3. Life Insurance is provided by the state for the retiree only.

Write your name in the top right corner of page 2.

SECTION 4 – DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number. Social Security Number is <u>not</u> a required field when submitting an initial EC-2H for new birth. Please be sure to submit an EC-2H to update our records for your newborn once the information is received/issued by the Social Security Administration. If making changes to your dependent's data, enter the corrected item. If listing more than 3 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-2H.
2. Use the following Relationship codes:

SP = Spouse	CH = Child√√√√√	GC = Guardianship or Foster Child √√
CU = Civil Union Partner √	CUCH = Civil Union Child √	SC = Step Child√√√√√
DP = Domestic Partner √√√	DPCH = Domestic Partner Child √√√	DC = Disabled Child √√√√

If you are adding an Adopted Child, Civil Union Partner and child, Domestic Partner and child or a Disabled Child, please contact the EUTF at 808-586-7390 or toll free, 1-800-295-0089 or visit our website at eutf.hawaii.gov for more information. Other EUTF forms to include with EC-2 (if applicable):

√ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes
√√ Legal documents for guardianship or foster child
√√√ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership, and Affidavit of "Dependency" for Tax Purposes
√√√√ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child
√√√√√ Student Certification if enrolling dependent age 19-23

3. Gender – Write/type either M or F.
4. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
5. Dependent/Student certification. Your initials confirm that you are certifying that your spouse/partner and dependent children are eligible to be enrolled under your health plans. You also confirm that you will provide a copy of your child(ren)'s birth certificate and/or Social Security card if requested by the EUTF. If you have dependent children ages 19 through 23 who are full-time students, your initials confirm they are full-time students at an accredited college or school. You further confirm that you will provide a copy of your child(ren)'s student verification letters required by the EUTF.
6. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. You may add your Civil Union Partner or Domestic Partner at any time outside of Open Enrollment, provided all required documents have been received by EUTF within 30 days of the event date. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.

SECTION 5 – MEDICARE

IMPORTANT NOTICE: When you or your dependent(s) become eligible for Medicare Part B, you or your dependent(s) must enroll in Medicare Part B and forward proof of enrollment (Medicare card showing Medicare Part B effective date and Direct Deposit Authorization Form) to the EUTF. Failure to comply may result in loss of medical and prescription drug coverage.

SECTION 6 – RETIREE SIGNATURE

Your signature certifies that the information provided in this application is true and complete. Retiree agrees to abide by the terms and conditions of the benefit plans selected. Retiree affirms that any listed dependent child, age 19 through 23, is attending a college, university or technical school as a full-time student and is also unmarried. Please enter date of Retiree's signature.

You must submit the EC-2H to the EUTF office. You may send it by mail or hand deliver. The addresses are printed at the bottom of page 2 of the enrollment form.

EC-2H Rev. Oct 2016	Hawaii Employer-Union Health Benefits Trust Fund **EC-2H: Enrollment Form for HSTA VB Retirees**	PLEASE SUBMIT THIS FORM EC-2H TO THE EUTF

SECTION 1: RETIREE DATA

Please complete all applicable fields below. Social Security numbers are required to process new retirees and dependent enrollments. **

Name (Last, First, Middle Initial)

_____

Home Phone (____) _____

Work Phone (____) _____

Mobile Phone (____) _____

Email _____

Mailing Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ Open Enrollment (effective 01/01/2017)

Retiree's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female

Birth Date: (MM/DD/YYYY)

____/____/_____

Marital Status ☐ Married ☐ Single

Marriage Date: (MM/DD/YYYY)

(☐ Check this box if status change)

____/____/_____

☐ Qualifying Event (describe)

_____

Event Date: _____/_____/_____

Civil Union Partner (Civil Union Status)

☐ IRS Qualified ☐ Not Qualified

Civil Union Date: (MM/DD/YYYY)

(☐ Check this box if status change)

_____/_____/_____

Domestic Partner (DP Status)

☐ IRS Qualified ☐ Not Qualified

DP Date: (MM/DD/YYYY)

(☐ Check this box if status change)

_____/_____/_____

Special Note: If your Spouse/Civil Union or Domestic Partner is a State or County Employee or Retiree, please provide the following:

NAME: SSN: DOB:

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

Skip this section if RETIREE does NOT pay towards health plan benefits.

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates. If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section

Adoption, Birth, Marriage, Civil Union, Domestic Partner, Placement for Adoption, Guardianship, New Eligible Student

Available Options for this Section

☐ Coverage starts day of the event & premium contributions 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 contributions start 1st day of the **first** pay period√ following event

☐ Coverage and premium contributions start 1st day of the **second** pay period√ following event

√ (1st or 16th of the month)

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If no selection is made, EUTF will assume no changes are being made.

Choose only one box in each plan selection

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
Medical PPO	HSTA VB - PPO-90/10 **HMSA** Medical, Prescription Drug Coverage, Vision, Chiro	☐	☐	☐	☐
HMO	HSTA VB - HMO-**Kaiser** Medical, (Includes Kaiser Prescription Drug), Vision, Chiro	☐	☐	☐	☐
Other Plans		**Cancel/Waive**	**Self**	**2-Party**	**Family**
Dental	HSTA VB - Hawaii Dental Service	☐	☐	☐	☐
Life	HSTA VB - USAble Life	☐	☐	Not available to dependents	

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Retiree's Name _____

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents enrolled or who you want to add or delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, CU=Civil Union Partner, DP=Domestic Partner, CH=your Child or your Spouse's Child, CUCH=Civil Union Partner's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-2H for new birth. Please be sure to submit an EC-2H to update our records for your newborn once the information received/issued by SSA.

Continue Coverage	Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MMDDYYYY)	Social Security Number**	Relationship *	Gender M / F	Medical	Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐

Detailed eligibility information is available at http://eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.
Dependent Certification and Student Certification– See Section regarding Dependent and Student Certification on "Instructions for Completing Form EC-2H" for more information.

I certify that my spouse and/or dependent children meet eligibility requirements for enrollment in the HSTA VB plans. _____ **(initials)**

I certify that my dependent child is a full-time student and have attached all documentation as required in Section 4 regarding dependent and student certification in the "Instructions for Completing Form EC-2". _____ **(initials)**

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires retirees and their dependents to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF retiree benefit plans. If you or your dependent(s) are Medicare eligible and are not enrolled in Medicare Part B, you must enroll immediately and provide EUTF with a copy of your Medicare card. If you are already enrolled, be sure EUTF has a copy of your Medicare card.

SECTION 6: RETIREE 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 for 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 selected

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. This form supersedes all forms and submissions I 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 penalty for perjury.

Retiree Signature: _____ Date Signed: _____

Please submit your signed EC-2H form by mail to:

EUTF
P.O. Box 2121
Honolulu, HI 96805-2121

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite 1700, Honolulu, HI 96813

Customer Service Call Center

Oahu (808) 586-7390
Toll Free 1(800) 295-0089

DAVID Y. IGE
GOVERNOR

STATE OF HAWAII
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HAWAII 96805-2121
Oahu (808) 586-7390
Toll Free 1(800) 295-0089
www.eutf.hawaii.gov

March 1, 2017

TO: COBRA Participants

FROM: Derek Mizuno, Administrator

SUBJECT: 2017 Active Health Plan Premium Rates and Open Enrollment for COBRA Participants

The Trustees of the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) approved health plan premium rates for 2017. These premium rates and any plan design changes will be effective July 1, 2017.

An open enrollment period will be conducted from **April 3, 2017 through April 28, 2017** to provide you with an opportunity to make changes to your COBRA health plan enrollments if you wish to do so. Changes submitted during this open enrollment period will be effective July 1, 2017. Your completed form must be postmarked to the EUTF on **or before April 28, 2017.**

Please note that if you do **NOT** want to make changes you do **NOT** need to complete the EUTF COBRA OE Enrollment Form or HSTA COBRA OE Enrollment Form.

The attached rates for COBRA participants are applicable until June 30, 2018.

- Attachment #1 is a chart of the EUTF COBRA Active Rates effective July 1, 2017.
- Attachment #2 is a chart of the HSTA VB COBRA Active Rates effective July 1, 2017.

Note: Separate invoices will be billed by each carrier selected.

Enclosed you will find the 2017 Active Employee Reference Guide (Guide) for July 1, 2017 through June 30, 2018.

Frequently Asked Questions

Can I change plans now?

Yes. Please complete and submit the COBRA OE Enrollment Form that can be found in the COBRA Open Enrollment packet.

If I want to make a change during the open enrollment, where do I send my completed COBRA OE Enrollment Form?

Mail your completed COBRA OE form to EUTF. Our mailing address is:

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
ATTN: COBRA OE Unit
P. O. Box 2121
Honolulu, HI 96805-2121

Your completed form must be postmarked to EUTF on or before April 28, 2017**.**

If I do not complete a Continuation of Coverage COBRA OE Enrollment Form during the COBRA open enrollment period, will my health benefits terminate?

No. You do not need to complete a COBRA OE Enrollment Form to continue your current coverage. However, if you do not make payment directly to the carriers by the first of each month, your coverage will be terminated.

I want to make a change and if I forget to check any box next to the various choices, what happens?

It will be assumed you do not want coverage and that you have waived coverage.

Can I select only medical and not prescription drug coverage?

No. Active Employees **must** elect both medical and prescription drugs plans, which are bundled, as mandated by the Affordable Care Act (Obama Care).

If I do not want to make changes, do I still need to complete a COBRA OE Enrollment Form?

No.

Will EUTF be conducting any open enrollment sessions that we can attend?

Yes. The schedule of Open Enrollment Informational Sessions is in the enclosed Guide.

If I have questions, who can I contact?

We suggest you visit the EUTF website at eutf.hawaii.gov first to see if the information you need is available there. Click on the following links that may be pertinent:

- COBRA Continuation Coverage, or
- Links to Carrier Websites

If you still have questions, we prefer you email them to eutf.cobra@hawaii.gov. In the subject line type: "URGENT – COBRA OE INQUIRY". EUTF can answer your questions pertaining to eligibility and timing of submission of forms. However, if you have questions related to the benefits in any plan, we recommend you contact the applicable insurance carrier. Their contact information is as follows:

Hawaii Medical Service Association (HMSA): Oahu: (808) 948-6499, Toll-free: 1 (800) 766-4672 P. O. Box 860, Attention: Membership Services Dept. Honolulu, HI 96808-0860	**CVS Caremark (Billing handled by ARM, Ltd.):** Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway Arlington Heights, IL 60004
Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free: 1 (800) 966-5955 711 Kapiolani Boulevard Honolulu, HI 96813	**SilverScript:** Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway Arlington Heights, IL 60004
Hawaii Dental Service (HDS): (808) 529-9310, Toll-free: 1 (866) 702-3883 700 Bishop Street Suite 700 Honolulu, HI 96813	**Vision Service Plan (VSP):** Toll-free: 1 (800) 400-4569 select #2 P.O. Box 997100 Sacramento, CA 95899
Royal State National Insurance Company (RSN): (808) 539-1600, Toll-free: 1 (800) 890-9022 819 S Beretania Street Honolulu, HI 96813	**ChiroPlan Hawaii, Inc.:** (808) 621-4744, Toll-Free: 1-800-414-8845 711 Kilani Avenue #3 Wahiawa, HI 96786

INSTRUCTIONS FOR COMPLETING FORM EUTF COBRA OE ENROLLMENT FORM

Please print or type clearly. If the EUTF COBRA OE Enrollment Form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit your signed EUTF COBRA OE Enrollment Form to the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) by mail:

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
ATTN: COBRA OE Unit
P.O. Box 2121
Honolulu, HI 96805-2121

SECTION 1 - EMPLOYEE DATA

1. Enter your last name, first name, middle initial.
2. Enter your contact information.
3. Enter your address information. If your **mailing** address differs from your **residential** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box **only** during the annual or special open enrollment period.
5. Provide your Social Security number and your dependent(s) Social Security number.
6. Enter your gender and birth date.

SECTION 2 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the “Cancel/Waive” box for each plan that you choose not to select. If you do not mark a box, EUTF will assume you are selecting Cancel/Waive.
3. To be eligible for the Royal State Supplemental plan coverage, you must have other medical coverage from another source, not including this employer.

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 3 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your dependent(s) data. If making changes to your dependent’s data, enter the corrected item. If listing more than four dependents, write/type “Continued” on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EUTF COBRA OE Enrollment Form.
2. Use the following Relationship codes:

SP = Spouse	CH = Child	SC = Step Child
DP = Domestic Partner	DPCH = Domestic Partner’s Child	GC = Guardianship or Foster Child
CU = Civil Union Partner	CUCH = Civil Union Partner’s Child	DC = Disabled Child

3. Gender – Write/type either M or F.
4. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self” box in Section 2.

SECTION 4 – COBRA PAYMENT INFORMATION

Checks must made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage. The monthly COBRA rates are subject to change.

SECTION 5 – COBRA PARTICIPANTS AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected.

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EUTF
COBRA OE
Enrollment Form
Rev. April 2017

Hawaii Employer-Union Health Benefits Trust Fund

EUTF: COBRA OE Enrollment Form

PLEASE SUBMIT THIS EUTF COBRA OE ENROLLMENT FORM BY MAIL TO THE EUTF. PO BOX 2121, HONOLULU, HI 96805

SECTION 1: COBRA PARTICIPANT DATA

Please complete all applicable fields below. Social Security numbers are required to process this form.

Name (Last Name, First Name, Middle Initial)

_____

Home Phone (_____) _____
Mobile Phone (_____) _____
Work Phone (_____) _____

Email _____

Residence Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ Open Enrollment (effective 07/01/2017)

Social Security Number (SSN)

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

SECTION 2: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If you do not check a box, EUTF will assume you are selecting Cancel/Waive.

Medical/Prescription Drug Plan Type	**Carrier Selection**	**You may only choose one medical/prescription drug plan** Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical, Includes Drug Coverage	☐	☐	☐	☐
	PPO-80/20 **HMSA** Medical, Includes Drug Coverage	☐	☐	☐	☐
	PPO-75/25 **HMSA** Medical, Includes Drug Coverage	☐	☐	☐	☐
HMO	HMO-**HMSA** Includes Drug Coverage	☐	☐	☐	☐
	HMO-**Kaiser** Standard Includes Drug Coverage	☐	☐	☐	☐
	HMO-**Kaiser** Comprehensive Includes Drug Coverage	☐	☐	☐	☐
Supplemental	Supplemental-Royal State National Insurance Company (Includes Supplemental Drug Coverage) *** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another non EUTF health plan.	☐	☐	☐	☐

Other Plans			Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	if enro ling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Vision	Vision Service Plan	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Chiro	ChiroPlan Hawaii		☐	☐	☐	☐

Note: Separate invoices will be billed by each carrier selected.

Employee's Name _____

SECTION 3: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Continue Coverage	Add	Delete	Dependent: Last Name, First Name, Middle **Initial**	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision	Chiro
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐

SECTION 4: COBRA PAYMENT INFORMATION

Checks must made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage. The monthly COBRA rates are subject to change.

Hawaii Medical Service Association (HMSA): Oahu (808) 948-6499, Toll-free 1 (800) 766-4672 P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860	CVS Caremark [billing handled by ARM Ltd.]: Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway, Arlington Heights, IL 60004
Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free 1 (800) 966-5955 711 Kapiolani Boulevard, Honolulu, HI 96813	Vision Service Plan (VSP): Toll-free 1 (800) 400-4569 select #2 P.O. Box 997100, Sacramento, CA 95899
Hawaii Dental Service (HDS): (808) 529-9310, Toll-free 1 (866) 702-3883 700 Bishop Street Suite 700, Honolulu, HI 96813	ChiroPlan Hawaii: (808) 621-4744, Neighbor Islands 1 (800) 414-8845 711 Kilani Avenue, Suite 3, Wahiawa, HI 96786
Royal State National Insurance Company (RSN): (808) 539-1600, Toll-free: 1 (800) 890-9022 819 S Beretania Street, Honolulu, HI 96813	

SECTION 5: COBRA PARTICIPANT AUTHORIZATION AND 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 for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of COBRA. I have read the benefit materials, understand the limitations and qualifications of the COBRA benefits program and agree to abide by the terms and conditions of the benefit plans selected.

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. This form supersedes all forms and submissions I previously made for COBRA 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 penalty for perjury.

By signing this EC-1 form, I acknowledge that I am authorizing EUTF to forward the information I have provided on this form to the carriers that I have selected in Section 2. I understand that my information will only be used as necessary by the carriers for my COBRA continuation coverage enrollment.

COBRA Participant Signature: _____ Date Signed: _____

If you do not submit this completed EUTF COBRA OE Enrollment Form by April 28, 2017, you will lose your right to make changes to your COBRA continuation enrollment.

Please submit your signed EUTF COBRA OE Enrollment Form by mail to:
EUTF, ATTN: COBRA OE Unit, P.O. Box 2121, Honolulu, HI 96805-2121

INSTRUCTIONS FOR COMPLETING FORM HSTA VB COBRA OE ENROLLMENT FORM

Please print or type clearly. If the HSTA VB COBRA OE Enrollment Form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit your HSTA VB COBRA OE Enrollment Form to the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) by mail:

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
ATTN: COBRA OE Unit
P.O. Box 2121
Honolulu, HI 96805-2121

SECTION 1 - EMPLOYEE DATA

1. Enter your last name, first name, middle initial.
2. Enter your contact information.
3. Enter your address information. If your **mailing** address differs from your **residential** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box **only** during the annual or special open enrollment period.
5. Provide your Social Security number and your dependent(s) Social Security number.
6. Enter your gender and birth date.

SECTION 2 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the “Cancel/Waive” box for each plan that you choose not to select. If you do not mark a box, EUTF will assume you are selecting Cancel/Waive.

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 3 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your dependent(s) data. If making changes to your dependent’s data, enter the corrected item. If listing more than four dependents, write/type “Continued” on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your HSTA VB COBRA OE Enrollment Form.
2. Use the following Relationship codes:

SP = Spouse	CH = Child	SC = Step Child
DP = Domestic Partner	DPCH = Domestic Partner’s Child	GC = Guardianship or Foster Child
CU = Civil Union Partner	CUCH = Civil Union Partner’s Child	DC = Disabled Child

3. Gender – Write/type either M or F.
4. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self” box in Section 3.

SECTION 4 – COBRA PAYMENT INFORMATION

Checks must made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage. The monthly COBRA rates are subject to change.

SECTION 5 – COBRA PARTICIPANTS AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected.

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto’s decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto’s decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

You may elect EUTF COBRA plans as an alternative to HSTA VB plans. If you decide to do so, you will not be permitted to re-enroll in HSTA VB plans.

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HSTA VB
COBRA OE
Enrollment Form
Rev. April 2017

Hawaii Employer-Union Health Benefits Trust Fund

HSTA VB: COBRA OE Enrollment Form

PLEASE SUBMIT THIS HSTA VB COBRA OE ENROLLMENT FORM BY MAIL TO THE EUTF. PO BOX 2121, HONOLULU, HI 96805

SECTION 1: COBRA PARTICIPANT DATA

Please complete all applicable fields below. Social Security numbers are required to process this form.

Name (Last Name, First Name, Middle Initial)

_____

Home Phone (_____) _____
Mobile Phone (_____) _____
Work Phone (_____) _____

Email _____

Residence Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ Open Enrollment (effective 07/01/2017)

Social Security Number (SSN)

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

SECTION 2: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If you do not check a box, EUTF will assume you are selecting Cancel/Waive.

Medical/Prescription Drug Plan Type	**Carrier Selection**	**You may only choose one medical/prescription drug plan** Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical, CVS Prescription Drug, Vision	☐	☐	☐	☐
	PPO-80/20 **HMSA** Medical, CVS Prescription Drug, Vision	☐	☐	☐	☐
HMO	HMO-**Kaiser** Comprehensive Medical, Prescription Drug, Vision	☐	☐	☐	☐

Other Plans			**Cancel/Waive**	**Self**	**2-Party**	**Family**
Dental	Hawaii Dental Service	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Supplemental Dental	Supplemental Hawaii Dental Service	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Vision	Vision Service Plan	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Chiro	ChiroPlan Hawaii		☐	☐	☐	☐

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Note: Separate invoices will be billed by each carrier selected.

Employee's Name _____

SECTION 3: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Continue Coverage	Add	Delete	Dependent: Last Name, First Name, Middle **Initial**	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision	Chiro
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐	☐

SECTION 4: COBRA PAYMENT INFORMATION

Checks must made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage. The monthly COBRA rates are subject to change.

Hawaii Medical Service Association (HMSA): Oahu (808) 948-6499, Toll-free 1 (800) 766-4672 P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860	CVS Caremark [billing handled by ARM Ltd.]: Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway, Arlington Heights, IL 60004
Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free 1 (800) 966-5955 711 Kapiolani Boulevard, Honolulu, HI 96813	Vision Service Plan (VSP): Toll-free 1 (800) 400-4569 select #2 P.O. Box 997100, Sacramento, CA 95899
Hawaii Dental Service (HDS): (808) 529-9310, Toll-free 1 (866) 702-3883 700 Bishop Street Suite 700, Honolulu, HI 96813	ChiroPlan Hawaii: (808) 621-4744, Neighbor Islands 1 (800) 414-8845 711 Kilani Avenue, Suite 3, Wahiawa, HI 96786
Royal State National Insurance Company (RSN): (808) 539-1600, Toll-free: 1 (800) 890-9022 819 S Beretania Street, Honolulu, HI 96813	

SECTION 5: COBRA PARTICIPANT AUTHORIZATION AND 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 for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of COBRA. I have read the benefit materials, understand the limitations and qualifications of the COBRA benefits program and agree to abide by the terms and conditions of the benefit plans selected.

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. This form supersedes all forms and submissions I previously made for COBRA 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 penalty for perjury.

By signing this EC-1 form, I acknowledge that I am authorizing EUTF to forward the information I have provided on this form to the carriers that I have selected in Section 2. I understand that my information will only be used as necessary by the carriers for my COBRA continuation coverage enrollment.

COBRA Participant Signature: _____ Date Signed: _____

If you do not submit this completed EUTF COBRA OE Enrollment Form by April 28, 2017, you will lose your right to make changes to your COBRA continuation enrollment.

Please submit your signed HSTA VB COBRA OE Enrollment Form by mail to:
EUTF, ATTN: COBRA OE Unit, P.O. Box 2121, Honolulu, HI 96805-2121

INSTRUCTIONS FOR COMPLETING FORM EC-1

Please print clearly or type. If the Form EC-1 is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the Form EC-1 to your Personnel Office or Department Personnel Officer (DPO) for verification, signature, and routing to EUTF within 30 days (180 days for newborns) of the event date. For DOE Employees: You must submit your EC-1 form to the DOE-EBU Office at PO Box 2360, Honolulu, HI 96804.

SECTION 1 - EMPLOYEE DATA

1. Enter your Last Name, First Name, and Middle Initial.
2. Enter your contact information.
3. Enter your address information. If your **residence** address differs from your **mailing** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the New Hire/Newly Eligible box if:
   A) You are a new employee; and enter the effective date you were hired, or
   B) Your employment status is changing from part time (25% FTE) to full time (50% -100% FTE) employment; and enter the effective date you will become full time.
5. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
6. Mark the Termination box if you are terminating your employment, and enter your last day of employment.
7. If you are enrolling with the EUTF for the first time, you are required to provide your Social Security Number and your dependent(s) Social Security Number.
8. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a gender and a birth date.
9. Mark the Qualifying Event During the Plan Year box if you have made any changes during the year, and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Change in Public Employer, Transfer In/Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
10. If you are Married, in a Civil Union, or Domestic Partnership, please be sure to check the appropriate boxes and include the date you were Married, entered into a Civil Union, or entered into a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health or your marriage certificate. If you do not receive the certificate within 60 days of the date of the event, contact the EUTF. A notarized Declaration of Domestic Partnership form is required (form is available on the EUTF website).
11. Special Note: If you have a Spouse, Civil Union Partner or Domestic Partner please provide his/her Name, Date of Birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 - COVERAGE AND CONTRIBUTION START SELECTION

1. If the “Qualifying Event” that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contributions start 1st day of the pay period in which the effective date of coverage occurs) will be the default option selected.

SECTION 3 - PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the “Cancel/Waive” box for each plan that you choose not to select. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.
3. To be eligible for the Royal State Supplemental plan coverage, you must have other medical coverage from another source, not including this employer.
4. The RSN ChiroPlan is included with all medical plans, including the Royal State Supplemental plan.
5. Life insurance is provided for the employee only.
6. FOR STATE EMPLOYEES ONLY*: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://dhrd.hawaii.gov. Please inquire with your DPO or DHRD on completing a PCP-2 form.
   -Mark one of the following boxes: ☐ Enroll or ☐ Do NOT Enroll.
   *The State allows its employees to pay for health premiums on a pre-tax basis. For more information please visit www.dhrd.hawaii.gov

   FOR COUNTY EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is administered by the Budget and Fiscal Services Department. Please contact your Department Personnel Office for more information on available options.

INSTRUCTIONS FOR COMPLETING FORM EC-1 (continued)

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number (SSN). Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the SSN blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1.
2. Use the following Relationship codes:

SP Spouse √	CH = Child √√√√√	SC = Step Child √√√√√
DP Domestic Partner √√√	DPCH Domestic Partner's Child √√√	GC Guardianship or Foster Child √√
CU Civil Union Partner √	CUCH = Civil Union Partner's Child √	DC Disabled Child √√√√

3. For Relationship codes with a √ or √√ or √√√ or √√√√, please see below for other required forms.
4. Other EUTF and/or DRHD forms to include with EC-1 (if applicable):
   - √ Marriage or Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes for Civil Unions
   - √√ Legal documents for guardianship or foster child
   - √√√ EUTF Declaration of Domestic Partnership and Affidavit of "Dependency" for Tax Purposes
   - √√√√ Disability Certification for Dependent Children (Form D-1) for enrolling a disabled child
   - √√√√√ Student certification if enrolling dependent age 19-23 in dental and/or vision plans
5. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF through your employer within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. Additions of a Civil Union Partner or a Domestic Partner are permitted outside of Open Enrollment. For a New Civil Union submitted within 30 days from the date of the civil union, the effective date of coverage is based on the event date. For a New Domestic Partner submitted within 30 days from the date of notarized signature, the effective date of coverage is based on the date of the notary. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
6. Gender – Write/type either M or F.
7. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
8. Dependent and Student certification. You must provide a copy of your child(ren)'s birth certificate and/or social security card if requested by the EUTF. You also must provide a copy of your child(ren)'s student verification letter on school letterhead, signed by the registrar, as required by the EUTF.

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you or your dependents are covered under another health plan, or if you selected the Royal State Supplemental plan, you are required to complete this section.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).
3. If you have ever been or are currently covered as a dependent under a state or county employee or retiree plan, please provide the state or county employee or retiree's Name, Date of Birth and Social Security Number, (SSN optional) on the corresponding line.

Note: To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must have health coverage through another source, not including this employer.

SECTION 6 - EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from your salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

You must submit the EC-1 through your personnel office. Your personnel office confirms that you are a current employee and are eligible for health benefits through the EUTF. Your personnel office will forward your EC-1 to EUTF.

For DOE Employees: You must submit your EC-1 form to the DOE-EBU Office at PO Box 2360, Honolulu, HI 96804.

EMPLOYER VALIDATION **[for EMPLOYER USE ONLY]**

1. Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education, 010022 for University of Hawaii, 010053 for Budget and Finance, etc.
2. Department and Division/School - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. Enter the date the EC-1 was received from the employee. The date recorded should be the date that the **employer** received the Form EC-1, not the date the DPO / employer designee received it.
5. Please provide contact phone and fax numbers.
6. DPO / employer designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1 was signed by the DPO / employer designee.

EC-1
Rev. 04/2017

Hawaii Employer-Union Health Benefits Trust Fund

EC-1: Enrollment Form for Active Employees

DUE DATE: This form must be submitted to your Personnel Officer or Departmental Personnel Office within 30 days (180 days for newborns) of the event date.

Please submit this form to your personnel office.
DOE employees submit to:
DOE-EBU
P O Box 2360
Honolulu HI 96804

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social security numbers are required to process new hires.

Name (Last Name, First Name, Middle Initial)

_____

Home Phone (____) _____
Mobile Phone (____) _____
Work Phone (____) _____
Email _____

Mailing Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip code _____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip code _____

☐ New Hire/Newly Eligible
Date of Hire/Newly Eligible: (MM/DD/YYYY)

_____/_____/ _____

☐ Open Enrollment (effective 07/01/2017)

☐ Termination of Employment
Date of Termination: (MM/DD/YYYY)

_____/_____/ _____

Employee's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/ _____

☐ Mid-Year Qualifying Event (describe)

Mid-Year Qualifying Event Date:

_____/_____/_____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)

_____/_____/_____

☐ **Civil Union**
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)

_____/_____/_____

Domestic Partner (DP Status)
☐ RS Qualified ☐ Not Qualified
Notary Date: (MM/DD/YYYY)

_____/_____/_____

Special Note: If you are married, in a civil union or domestic partnership, please provide your spouse/partner's Name, Date of Birth, SSN:

Name: _____ DOB: _____/_____/_____ SSN: _____

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

If your event is listed below, please select one of the three options, otherwise skip this section.

Some events allow for a selection of the Coverage and PremiunContribution Start Dates.

Qualifying Events for this Section
Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section
☐ Coverage starts day of the event & premium contributions 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 contributions start 1st day of the **first** pay period following event
☐ Coverage and premium contributions start 1st day of the **second** pay period following event

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If no selection is made, EUTF will assume no changes are being made.

Medical/Prescription Drug Plan Type	Carrier Selection	You may only choose one medical/prescription drug plan: Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	PPO-80/20 **HMSA** Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	PPO-75/25 **HMSA** Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
HMO	HMO-**HMSA** CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	HMO-**Kaiser** Standard Prescription Drug, RSN Chiro	☐	☐	☐	☐
	HMO-**Kaiser** Comprehensive Prescription Drug, RSN Chiro	☐	☐	☐	☐
Supplemental	Supplemental- Royal State National Insurance Company (Includes Supplemental Drug Coverage), Chiro *** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under a non- EUTF health plan. See Section 5 on "Instructions for Completing Form EC-1"	☐	☐	☐	☐

Other Plans			Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Vision	Vision Service Plan	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Life	USAble Life		☐	☐		

For STATE Employees ONLY*	Do NOT Enroll	Enroll
Premium Conversion Plan	☐	☐

*The State allows its employees to pay for health premiums on a pre-tax basis. For more information please visit www.dhrd.hawaii.gov
For County Employees: Please contact your DPO for more information on Premium Conversion or Flex Plan options.

Employee's Name:

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH=Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information received/issued by the SSA.

Continue Coverage	Add	Delete	Dependent Last Name, First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐

Detailed eligibility information is available at http://eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.
Dependent Certification and Student Certification – See Section 4 item 8 on "Instructions for Completing Form EC-1" for more information.

SECTION 5: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide the type of plan, name of the plan, subscriber's name, and dependents on the plan.

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Are you on this Plan?	Are all dependents listed in Section 4 on this Plan? If no, list below which dependents are on this plan.
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Have you ever been or are you currently covered as a dependent under a state or county employee or retiree plan? ☐ Yes ☐ No
If "Yes", please provide the information as requested below of the state or county employee or retiree:
Name: (Last Name, First Name, Middle Initial) _____ DOB: ____/____/_____ SSN: (Optional) _____

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form also meet the eligibility requirements for enrollment in the EUTF plans. I understand that the benefit elections made on this application are in effect for 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 selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

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. This form supersedes all forms and submissions I 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 penalty for perjury.

Employee: Signature: _____ Date Signed: _____

Department ID#	Department	Division/School	Bargaining Unit
Date EC-1 Received in Employing Office / /		DPO Phone Number	DPO Fax Number
DPO (or employer designee's) Printed Name: DPO (or employer designee's) 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.			Date of DPO (or employer designee's) Signature / /
Remarks:			

INSTRUCTIONS FOR COMPLETING FORM EC-1H

Use of this form is for members currently enrolled in the HSTA VB plans. If you are not currently enrolled in the HSTA VB plans, please use the EC-1 form.

Please print clearly or type. If the Form EC-1H is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the completed Form EC-1H to your Personnel Office (DOE-EBU) at PO Box 2360, Honolulu HI 96804) or your Charter School Personnel Office for verification, signature, and routing to EUTF within 30 days (180 days for newborns) of the event date.

SECTION 1 - EMPLOYEE DATA

1. Enter your Last Name, First Name, and Middle Initial.
2. Enter your contact information.
3. Enter your address information. If your **residence** address differs from your **mailing** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
5. Mark the Termination box if you are terminating your employment, and enter your last day of employment.
6. Enter your gender and birth date. EUTF is unable to process your paperwork without a gender and a birth date.
7. Mark the Qualifying Event During the Plan Year box if you have made any changes during the year, and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Change in Public Employer, Transfer In/Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
8. If you are Married, in a Civil Union, or Domestic Partnership, please be sure to check the appropriate boxes and include the date you were Married, entered into a Civil Union, or entered into a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health or your marriage certificate. If you do not receive the certificate within 60 days of the date of the event, contact the EUTF. A notarized Declaration of Domestic Partnership form is required (form is available on the EUTF website).
9. Special Note: If you have a Spouse, Civil Union Partner or Domestic Partner please provide his/her Name, Date of Birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 - COVERAGE AND CONTRIBUTION START SELECTION

1. If the “Qualifying Event” that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contributions start 1st day of the pay period in which the effective date of coverage occurs) will be the default option selected.

SECTION 3 - PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the “Cancel/Waive” box for each plan that you choose not to select. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.
3. The RSN ChiroPlan and Vision Service Plan (VSP) for vision are included with all medical plans.
4. Life insurance is provided for the employee only.
5. FOR STATE EMPLOYEES ONLY*: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://dhrd.hawaii.gov. Please inquire with your Personnel Office (DOE-EBU), Charter School or DHRD on completing a PCP-2 form.

   -Mark one of the following boxes: ☐ Enroll or ☐ Do NOT Enroll.

   *The State allows its employees to pay for health premiums on a pre-tax basis. For more information please visit www.dhrd.hawaii.gov

INSTRUCTIONS FOR COMPLETING FORM EC-1H (continued)

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number (SSN). Social Security Number is not a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the SSN blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1H.
2. Use the following Relationship codes:

SP Spouse √	CH = Child √√√√√	SC = Step Child √√√√√
DP Domestic Partner √√√	**DPCH Domestic Partner's Child √√√**	**GC Guardianship or Foster Child √√**
CU Civil Union Partner √	CUCH = Civil Union Partner's Child √	**DC Disabled Child √√√√**

3. **For Relationship codes with a √ or √√ or √√√ or √√√√, please see below for other required forms.**
4. Other EUTF and/or DRHD forms to include with EC-1H (if applicable):
   - √ Marriage or Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes for Civil Unions
   - √√ **Legal documents for guardianship or foster child**
   - √√√ **EUTF** Declaration of Domestic Partnership and Affidavit of "Dependency" for Tax Purposes
   - √√√√ **Disability Certification for Dependent Children (Form D**-1) for enrolling a disabled child
   - √√√√√ **Student certification if enrolling dependent age 19**-23 in dental and/or vision plans
5. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF through your employer within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. Additions of a Civil Union Partner or a Domestic Partner are permitted outside of Open Enrollment. For a New Civil Union submitted within 30 days from the date of the civil union, the effective date of coverage is based on the event date. For a New Domestic Partner submitted within 30 days from the date of notarized signature, the effective date of coverage is based on the date of the notary. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
6. Gender – Write/type either M or F.
7. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
8. Dependent and Student certification. You must provide a copy of your child(ren)'s birth certificate and/or social security card if requested by the EUTF. You also must provide a copy of your child(ren)'s student verification letter on school letterhead, signed by the registrar, as required by the EUTF.

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you or your dependents are covered under another health plan, you are required to complete this section.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).
3. If you have ever been or are currently covered as a dependent under a state or county employee or retiree plan, please provide the state or county employee or retiree's Name, Date of Birth and Social Security Number, (SSN optional) on the corresponding line.

SECTION 6 – EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from your salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

For Charter School Employees: You must submit the EC-1H through your personnel office. Your personnel office confirms that you are a current employee and are eligible for health benefits through the EUTF. Your personnel office will forward your EC-1H to EUTF.

For DOE Employees: You must submit your EC-1H to the DOE-EBU Office at P O Box 2360, Honolulu, HI 96804.

EMPLOYER VALIDATION **[for EMPLOYER USE ONLY]**

1. Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education.
2. Department and School/Office - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. Enter the date the EC-1H was received from the employee. The date recorded should be the date that the **employer** received the Form EC-1H, not the date the Personnel Office (DOE-EBU) or Charter School / employer designee received it.
5. Please provide contact phone and fax numbers.
6. Personnel Office (DOE-EBU) or Charter School / employer designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1H was signed by the Personnel Office (DOE-EBU) or Charter School / employer designee.

EC-1H
Rev. 04/2017

Hawaii Employer-Union Health Benefits Trust Fund

EC-1H: Enrollment Form for HSTA VB Active BU 05/45 Employees

DUE DATE: This form must be submitted to DOE-EBU within 30 days (180 days for newborns) of the event date.

DOE employees please submit this form to:
DOE-EBU
P O Box 2360
Honolulu HI 96804

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social security numbers are required to process new hires.

Name (Last Name, First Name, Middle Initial)

_____

Home Phone (____) _____
Mobile Phone (____) _____
Work Phone (____) _____

Email _____

Mailing Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip code _____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip code _____

☐ Open Enrollment (effective 07/01/2017)

☐ Termination of Employment
Date of Termination: (MM/DD/YYYY)

_____/_____/_____

Employee's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

☐ Mid-Year Qualifying Event (describe)

Mid-Year Qualifying Event Date:

_____/_____/_____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)

_____/_____/_____

☐ **Civil Union**
Civil Union Date: (MM/DD/YYYY)

_____/_____/_____

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
Notary Date: (MM/DD/YYYY)

_____/_____/_____

Special Note: If you are married, in a civil union or domestic partnership, please provide your spouse/partner's Name, Date of Birth , SSN :

Name: _____ DOB: _____/_____/_____ SSN: _____

SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

If your event is listed below, please select one of the three options, otherwise skip this section.

Some events allow for a selection of the Coverage and Premium Contribution Start Dates.

Qualifying Events for this Section
Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section
☐ Coverage starts day of the event & premium contributions 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 contributions start 1st day of the **first** pay period following event
☐ Coverage and premium contributions start 1st day of the **second** pay period following event

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If no selection is made, EUTF will assume no changes are being made.

Medical/Prescription Drug Plan Type	Carrier Selection	You may only choose one medical/prescription drug plan: Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical, CVS Prescription Drug, Vision, RSN Chiro	☐	☐	☐	☐
PPO	PPO-80/20 **HMSA** Medical, CVS Prescription Drug, Vision, RSN Chiro	☐	☐	☐	☐
HMO	HMO-**Kaiser** Comprehensive Medical, Prescription Drug, Vision, RSN Chiro	☐	☐	☐	☐

Other Plans			Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Supplemental Dental	Supplemental Hawaii Dental Service	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Vision	Vision Service Plan	if enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Life	USAble Life		☐	☐		

For STATE Employees ONLY*	Do NOT Enroll	Enroll
Premium Conversion Plan	☐	☐

*The State allows its employees to pay for health premiums on a pre-tax basis. For more information please visit www.dhrd.hawaii.gov

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Employee's Name:

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH=Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H to update our records for your newborn once the information received/issued by the SSA.

Continue Coverage	Add	Delete	Dependent Last Name, First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐

Detailed eligibility information is available at http://eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.
Dependent Certification and Student Certification – See Section 4 item 8 on "Instructions for Completing Form EC-1H" for more information.

SECTION 5: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide the type of plan, name of the plan, subscriber's name, and dependents on the plan.

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Are you on this Plan?	Are all dependents listed in Section 4 on this Plan? If no, list below which dependents are on this plan.
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Have you ever been or are you currently covered as a dependent under a state or county employee or retiree plan? ☐ Yes ☐ No
If "Yes", please provide the information as requested below of the state or county employee or retiree:
Name: (Last Name, First Name, Middle Initial) _____ DOB: ____/____/_____ SSN: (Optional) _____

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form also meet the eligibility requirements for enrollment in the EUTF plans. I understand that the benefit elections made on this application are in effect for 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 selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

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. This form supersedes all forms and submissions I 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 penalty for perjury.

Employee: Signature: _____ Date Signed: _____

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

DAVID Y. IGE
GOVERNOR

STATE OF HAWAII
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HAWAII 96805-2121
Oahu (808) 586-7390
Toll Free 1(800) 295-0089
www.eutf.hawaii.gov

October 10, 2016

TO: COBRA Participants

FROM: Derek Mizuno, Administrator

SUBJECT: 2017 Retiree Health Plan Premium Rates and Open Enrollment for COBRA Participants

The Trustees of the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) approved health plan premium rates for 2017. These premium rates and any plan design changes will be effective January 1, 2017.

An open enrollment period will be conducted from **October 10, 2016 through October 31, 2016** to provide you with an opportunity to make changes to your COBRA health plan enrollments if you wish to do so. Changes submitted during this open enrollment period will be effective January 1, 2017. Your completed form must be postmarked to the EUTF **on or before October 31, 2016.**

Please note that if you do **NOT** want to make changes you do **NOT** need to complete the EUTF COBRA OE Enrollment Form or HSTA COBRA OE Enrollment Form.

The attached rates for COBRA participants are applicable until December 31, 2017.

- Attachment #1 is a chart of the EUTF COBRA Retiree Rates effective January 1, 2017.
- Attachment #2 is a chart of the HSTA VB COBRA Retiree Rates effective January 1, 2017.

Note: Separate invoices will be billed by each carrier selected.

Enclosed you will find the 2017 Retiree Reference Guide for January 1, 2017 – December 31, 2017 as well as a COBRA OE Enrollment Form.

Frequently Asked Questions

Can I change plans now?
Yes. Please complete and submit the appropriate COBRA OE Enrollment Form dated October 2016.

If I want to make a change during the open enrollment, where do I send my completed COBRA OE Enrollment Form?
Mail your completed COBRA OE form to EUTF. Our mailing address is:

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
ATTN: COBRA OE Unit
P. O. Box 2121
Honolulu, HI 96805-2121

Your completed form must be postmarked to EUTF on or before **October 31, 2016.**

If I do not complete a Continuation of Coverage COBRA OE Enrollment Form during the COBRA open enrollment period, will my health benefits terminate?
No. You do not need to complete a COBRA OE Enrollment Form to continue your current coverage. However, if you do not make payment directly to the carriers (see attached rates) by the first of each month, your coverage will be terminated.

I want to make a change and if I forget to check any box next to the various choices, what happens?
It will be assumed you do not want coverage and that you waived coverage.

Can I select only medical and not prescription drug coverage?
Yes. Unlike the Active Employee medical and prescription drugs plans, which are bundled, the Retiree plans are not, with the exception of the Kaiser medical and drug plans.

If I do not want to make changes, do I still need to complete a COBRA OE Enrollment Form?
No.

Will EUTF be conducting any open enrollment sessions that we can attend?
Yes (see the attached Schedule of Open Enrollment Informational Sessions).

If I have questions, who can I contact?
We suggest you visit the EUTF website at eutf.hawaii.gov first to see if the information you need is available there. Click on the following links that may be pertinent:

- COBRA Continuation Coverage, or
- Links to Carrier Websites

If you still have questions, we prefer you email them to eutf.cobra@hawaii.gov. In the subject line type: "URGENT – COBRA OE INQUIRY". EUTF can answer your questions pertaining to eligibility and timing of submission of forms. However, if you have questions related to the benefits in any plan, we recommend you contact the applicable insurance carrier.

Their contact information is as follows:

Hawaii Medical Service Association (HMSA): Oahu: (808) 948-6499, Toll-free: 1 (800) 766-4672 P. O. Box 860, Attention: Membership Services Dept. Honolulu, HI 96808-0860	**CVS Caremark (Billing handled by ARM, Ltd.):** Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway Arlington Heights, IL 60004
Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free: 1 (800) 966-5955 711 Kapiolani Boulevard Honolulu, HI 96813	**SilverScript:** Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway Arlington Heights, IL 60004
Hawaii Dental Service (HDS): (808) 529-9310, Toll-free: 1 (866) 702-3883 700 Bishop Street Suite 700 Honolulu, HI 96813	**Vision Service Plan (VSP):** Toll-free: 1 (800) 400-4569 select #2 P.O. Box 997100 Sacramento, CA 95899

Schedule of Open Enrollment Informational Sessions for Retirees

Date	Island	Location	Time
Oct 10	Maui	UH Maui College	9:00am, 11:00am
Oct 10	Online	Webinar	8:00am, 1:00pm
Oct 11	Oahu	Hawaii State Capitol	9:00am, 11:00am
Oct 12	Hawaii - Hilo	Aunty Sally Kaleohano's Luau Hale	1:00pm, 3:00pm
Oct 13	Molokai	Kualapuu Park & Community Center	9:00am
Oct 13	Lanai	Lanai Community Center	9:00am
Oct 14	Oahu	Windward Community College	9:00am, 11:00am
Oct 17	Kauai	Kauai Community College	9:00am, 11:00am
Oct 18	Oahu	Hawaii State Capitol	9:00am, 11:00am
Oct 19	Hawaii - Kona	West Hawaii Civic Center	9:00am, 11:00am
Oct 19	Online	Webinar	8:00am, 1:00pm
Oct 20	Oahu	UH Manoa	9:00am, 11:00am
Oct 21	Oahu	Leeward Community College	9:00am, 11:00am

MOLOKAI
Kualapuu Park & Community Center
1 Uwao Street
Kualapuu, HI 96757

LANAI
Lanai Community Center
8th Street
Lanai City, HI 96763

KAUAI
Kauai Community College
OCET Room 106 C and D
3-1901 Kaumualii Highway
Lihue, Hawaii 96766

MAUI
UH Maui College
Pilina Multi-Purpose Room
310 W. Kaahumanu Ave.
Kahului, HI 96732

HAWAII - KONA
West Hawaii Civic Center
Community Meeting Hale, Bldg G
74-5044 Ane Keohokalole Highway
Kailua-Kona, HI 96740

HAWAII - HILO
Aunty Sally Kaleohano's Luau Hale
799 Piilani Street
Hilo, HI 96720

OAHU

Hawaii State Capitol
Auditorium
415 S. Beretania Street
Honolulu, HI 96813

University of Hawaii at Manoa
Kuykendall Auditorium
2445 Campus Road
Honolulu, HI 96822

Windward Community College
Hale Palanakila, Room 104
45-720 Keaahala Road
Kaneohe, HI 96744

Leeward Community College
Education Building
Lecture Hall 201A and B
96-045 Ala Ike Street
Pearl City, HI 96782

How to Access the Webinar

1) Go to eutf.hawaii.gov
2) In the top menu bar select "Training/Resources" and click on "Members"
3) Select the "Webinars" tab
4) Select the desired webinar link

EUTF Monthly Retiree COBRA Rates [to be updated later]

EUTF Monthly Retiree COBRA Rates

Benefit Plan	Type of Enrollment	Regular COBRA 1/1/2017 - 12/31/2017
MEDICAL PLANS - MEDICARE		
HMSA PPO Medicare	Self	
	Two Party	
	Family	
UnitedHealthcare (UHC) Medicare Advantage PPO	Self	
	Two-Party (both Medicare)	
Medicare Prescription Drug – SilverScript	Self Two-Party Family	
Kaiser HMO Medicare Kaiser Prescription Drug	Self Two-Party Family	
MEDICAL PLANS - NON-MEDICARE		
HMSA PPO Non-Medicare	Self Two-Party Family	
Non-Medicare Prescription Drug – CVS Caremark	Self	
	Two-Party	
	Family	
Kaiser HMO Non-Medicare Kaiser Prescription Drug	Self	
	Two-Party	
	Family	
DENTAL PLAN		
HDS Dental	Self Two-Party Family	
VISION PLAN		
VSP Vision	Self Two-Party	
	Family	

HSTA VB Monthly Retiree COBRA Rates [to be updated later]

HSTA VB Monthly Retiree COBRA Rates

Benefit Plan	Type of Enrollment	Regular COBRA
		1/1/2017 - 12/31/2017
MEDICAL PLANS - MEDICARE		
HMSA PPO Medicare	Self	
	Two Party	
	Family	
Medicare Prescription Drug – SilverScript	Self	
	Two-Party	
	Family	
Kaiser HMO Medicare Kaiser Prescription Drug	Self	
	Two-Party	
	Family	
MEDICAL PLANS - NON-MEDICARE		
HMSA PPO Non-Medicare	Self	
	Two-Party	
	Family	
Non-Medicare Prescription Drug – CVS Caremark	Self	
	Two-Party	
	Family	
Kaiser HMO Non-Medicare Kaiser Prescription Drug	Self	
	Two-Party	
	Family	
DENTAL PLAN		
HDS Dental	Self	
	Two-Party	
	Family	
VISION PLAN		
VSP Vision	Self	
	Two-Party	
	Family	
CHIROPRACTIC PLAN		
Royal State Chiro	Self	
	Two-Party	
	Family	

INSTRUCTIONS FOR COMPLETING FORM EUTF COBRA OE ENROLLMENT FORM

Please print or type clearly. If the EUTF COBRA OE Enrollment Form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit your signed EUTF COBRA OE Enrollment Form to the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) by mail:

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
ATTN: COBRA OE Unit
P.O. Box 2121
Honolulu, HI 96805-2121

SECTION 1 - EMPLOYEE DATA

1. Enter your last name, first name, middle initial.
2. Enter your contact information.
3. Enter your address information. If your **mailing** address differs from your **residential** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box.
5. Provide your Social Security number and your dependent(s) Social Security number.
6. Enter your gender and birth date.

SECTION 2 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan (bundled), one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF COBRA plans, mark the “Cancel/Waive” box for each plan that you choose not to select. If you do not mark a box, EUTF will assume you are selecting Cancel/Waive.
3. If you are enrolling a new dependent(s) ages 19-23 who are unmarried and fulltime students, please attach a copy of the student certification letter with this enrollment form.
4. IMPORTANT INFORMATION: The new Medicare PPO medical plan under UnitedHealthcare is NOT a medical plan option for COBRA retirees.

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 3 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your dependent(s) data. If making changes to your dependent’s data, enter the corrected item. If listing more than four dependents, write/type “Continued” on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EUTF COBRA OE Enrollment Form.
2. Use the following Relationship codes:

SP = Spouse	CH = Child or your spouse’s Child	SC = Step Child
DP = Domestic Partner	DPCH = Domestic Partner’s Child	GC = Guardianship or Foster Child
CU = Civil Union Partner	CUCH = Civil Union Partner’s Child	DC = Disabled Child

3. Gender – Write/type either M or F.
4. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self” box in Section 2.

SECTION 4 – COBRA PAYMENT INFORMATION

Checks must made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage. The monthly COBRA rates are subject to change.

SECTION 5 – COBRA PARTICIPANTS AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected.

EUTF
COBRA RET OE
Enrollment Form
Rev. Oct 2016

Hawaii Employer-Union Health Benefits Trust Fund

EUTF: COBRA RETIREE OE Enrollment Form

PLEASE SUBMIT THIS EUTF COBRA OE ENROLLMENT FORM BY MAIL TO THE EUTF: PO BOX 2121, HONOLULU, HI 96805

SECTION 1: COBRA PARTICIPANT DATA

Please complete all applicable fields below. Social Security numbers are required to process this form.

Name (Last Name, First Name, Middle Initial)

_____

Home Phone (_____) _____
Mobile Phone (_____) _____
Work Phone (_____) _____

Email _____

Residence Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ Open Enrollment (effective 01/01/2017)

Social Security Number (SSN)

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

SECTION 2: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If you do not check a box, EUTF will assume you are selecting Cancel/Waive.

Medical/Prescription Drug Plan — **You may only choose one medical/prescription drug plan**

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 **HMSA** Medical No Prescription Drug Coverage	☐	☐	☐	☐
HMO	HMO-**Kaiser** Medical Includes Prescription Drug Coverage, Chiro	☐	☐	☐	☐
Prescription Drug	**CVS Caremark** Prescription Drug (Not a valid selection with Kaiser)	☐	☐	☐	☐

Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	☐	☐	☐	☐
Vision	Vision Service Plan	☐	☐	☐	☐

Note: Separate invoices will be billed by each carrier selected.

SECTION 3: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Continue Coverage	Add	Delete	Dependent: Last Name, First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐

SECTION 4: COBRA PAYMENT INFORMATION

Checks must made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage. The monthly COBRA rates are subject to change.

Hawaii Medical Service Association (HMSA): Oahu (808) 948-6499, Toll-free 1 (800) 766-4672 P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860	CVS Caremark [billing handled by ARM Ltd.]: Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway, Arlington Heights, IL 60004
Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free 1 (800) 966-5955 711 Kapiolani Boulevard, Honolulu, HI 96813	SilverScript [billing handled by ARM Ltd.]: Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway, Arlington Heights, IL 60004
Hawaii Dental Service (HDS): (808) 529-9310, Toll-free 1 (866) 702-3883 700 Bishop Street Suite 700, Honolulu, HI 96813	Vision Service Plan (VSP): Toll-free 1 (800) 400-4569 select #2 P.O. Box 997100, Sacramento, CA 95899

SECTION 5: COBRA PARTICIPANTAUTHORIZATION AND 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 for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of COBRA. I have read the benefit materials, understand the limitations and qualifications of the COBRA benefits program and agree to abide by the terms and conditions of the benefit plans selected. .

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. This form supersedes all forms and submissions I previously made for COBRA 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 penalty for perjury.

By signing this EC-2 form, I acknowledge that I am authorizing EUTF to forward the information I have provided on this form to the carriers that I have selected in Section 2. I understand that my information will only be used as necessary by the carriers for my COBRA continuation coverage enrollment.

COBRA Participant Signature: _____ Date Signed: _____

If you do not submit this completed EUTF COBRA OE Enrollment Form by October 31, 2016, you will lose your right to make changes to your COBRA continuation enrollment.

Please submit your signed EUTF COBRA OE Enrollment Form by mail to:
EUTF, ATTN: COBRA OE Unit, P.O. Box 2121, Honolulu, HI 96805-2121

INSTRUCTIONS FOR COMPLETING FORM HSTA VB COBRA OE ENROLLMENT FORM

Please print or type clearly. If the HSTA VB COBRA OE Enrollment Form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit your HSTA VB COBRA OE Enrollment Form to the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) by mail:

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
ATTN: COBRA OE Unit
P.O. Box 2121
Honolulu, HI 96805-2121

SECTION 1 - EMPLOYEE DATA

1. Enter your last name, first name, middle initial.
2. Enter your contact information.
3. Enter your address information. If your **mailing** address differs from your **residential** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box.
5. Provide your Social Security number and your dependent(s) Social Security number.
6. Enter your gender and birth date.

SECTION 2 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan (bundled), one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF COBRA plans, mark the “Cancel/Waive” box for each plan that you choose not to select. If you do not mark a box, EUTF will assume you are selecting Cancel/Waive.
3. If you are enrolling a new dependent(s) ages 19-23 who are unmarried and fulltime students, please attach a copy of the student certification letter with this enrollment form.
4. The RSN ChiroPlan is included with both medical plans.
5. IMPORTANT INFORMATION: The new EUTF Medicare PPO medical plan under UnitedHealthcare is NOT a medical plan option for COBRA retirees.

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 3 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your dependent(s) data. If making changes to your dependent’s data, enter the corrected item. If listing more than four dependents, write/type “Continued” on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your HSTA VB COBRA OE Enrollment Form.
2. Use the following Relationship codes:

SP = Spouse	CH = Child or your spouse’s Child	SC = Step Child
DP = Domestic Partner	DPCH = Domestic Partner’s Child	GC = Guardianship or Foster Child
CU = Civil Union Partner	CUCH = Civil Union Partner’s Child	DC = Disabled Child

3. Gender – Write/type either M or F.
4. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self” box in Section 2.

SECTION 4 – COBRA PAYMENT INFORMATION

Checks must be made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage. The monthly COBRA rates are subject to change.

SECTION 5 – COBRA PARTICIPANTS AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected.

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto’s decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto’s decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

You may elect EUTF COBRA plans as an alternative to HSTA VB plans. If you decide to do so, you will not be permitted to re-enroll in HSTA VB plans in the future.

HSTA VB
COBRA OE
Enrollment Form
Rev. Oct 2016

Hawaii Employer-Union Health Benefits Trust Fund

HSTA VB: COBRA OE Enrollment Form

PLEASE SUBMIT THIS HSTA VB COBRA OE ENROLLMENT FORM BY MAIL TO THE EUTF: PO BOX 2121, HONOLULU, HI 96805

SECTION 1: COBRA PARTICIPANT DATA

Please complete all applicable fields below. Social Security numbers are required to process this form.

Name (Last Name, First Name, Middle Initial)

_____

Home Phone (_____) _____
Mobile Phone (_____) _____
Work Phone (_____) _____

Email _____

Residence Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ Open Enrollment (effective 01/01/2017)

Social Security Number (SSN)

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

SECTION 2: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If you do not check a box, EUTF will assume you are selecting Cancel/Waive.

Medical/Prescription Drug Plan — **You may only choose one medical/prescription drug plan**

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
PPO	HSTA VB - PPO-90/10 **HMSA** Medical, No Prescription Drug Coverage	☐	☐	☐	☐
HMO	HSTA VB - HMO-**Kaiser** Medical, Prescription Drug Coverage, Vision, Chiro	☐	☐	☐	☐
Prescription Drug	**CVS Caremark** Prescription Drug (Not a valid selection with Kaiser)	☐	☐	☐	☐

Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	HSTA VB - Hawaii Dental Service	☐	☐	☐	☐
Vision	HSTA VB - Vision Service Plan	☐	☐	☐	☐

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with Judge Sakamoto's decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Note: Separate invoices will be billed by each carrier selected.

SECTION 3: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled.

Continue Coverage	Add	Delete	Dependent: Last Name, First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐

SECTION 4: COBRA PAYMENT INFORMATION

Checks must be made payable to each respective insurance carrier. Payment is due the first day of each month. Failure to make payment by the due date will result in the termination of this coverage. The monthly COBRA rates are subject to change.

Hawaii Medical Service Association (HMSA): Oahu (808) 948-6499, Toll-free 1 (800) 766-4672 P.O. Box 860, Attn: Membership Services Dept., Honolulu, HI 96808-0860	CVS Caremark [billing handled by ARM Ltd.]: Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway, Arlington Heights, IL 60004
Kaiser Permanente (Kaiser): (808) 432-5955, Toll-free 1 (800) 966-5955 711 Kapiolani Boulevard, Honolulu, HI 96813	SilverScript [billing handled by ARM Ltd.]: Toll-free: 1 (800) 392-1770 ARM Ltd., 814 W. Northwest Highway, Arlington Heights, IL 60004
Hawaii Dental Service (HDS): (808) 529-9310, Toll-free 1 (866) 702-3883 700 Bishop Street Suite 700, Honolulu, HI 96813	Vision Service Plan (VSP): Toll-free 1 (800) 400-4569 select #2 P.O. Box 997100, Sacramento, CA 95899

SECTION 5: COBRA PARTICIPANT AUTHORIZATION AND 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 for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of COBRA. I have read the benefit materials, understand the limitations and qualifications of the COBRA benefits program and agree to abide by the terms and conditions of the benefit plans selected.

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. This form supersedes all forms and submissions I previously made for COBRA 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 penalty for perjury.

By signing this EC-2H form, I acknowledge that I am authorizing EUTF to forward the information I have provided on this form to the carriers that I have selected in Section 2. I understand that my information will only be used as necessary by the carriers for my COBRA continuation coverage enrollment.

COBRA Participant Signature: _____ Date Signed: _____

If you do not submit this completed HSTA VB COBRA OE Enrollment Form by October 31, 2016, you will lose your right to make changes to your COBRA continuation enrollment.

Please submit your signed HSTA VB COBRA OE Enrollment Form by mail to:
EUTF, ATTN: COBRA OE Unit, P.O. Box 2121, Honolulu, HI 96805-2121

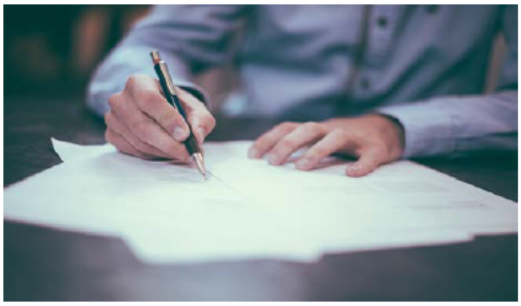
Mark Your Calendar!

EUTF Active Employee Open Enrollment Period April 3 - 28, 2017

Plan and premium changes effective July 1, 2017

Open Enrollment is your only opportunity to make changes to your health plan enrollment without experiencing a qualifying life event. Now is the time to think about your health benefits.

- ✓ Know which plans you are enrolled in now
- ✓ Learn about plan and premium cost changes
- ✓ Make a decision about which plans best suit your needs
- ✓ Attend an Open Enrollment Informational Session



During Open Enrollment you can make the following changes:

- ➢ Add, remove or change health plans
- ➢ Add or remove dependents
- ➢ Now is also a good time to tell us if you've had a change of address

How do I make changes to my enrollment?

- ➢ Complete an EC-1 or EC-1H (HSTA VB members only) enrollment form and submit it to your personnel office or open enrollment designee no later than April 28, 2017.

If you do not want to make any changes to your enrollment, do nothing. Current plan selections will continue into the new plan year.

For more information, visit our website at eutf.hawaii.gov. You may also attend an open enrollment informational session or review new plan premiums attached to this flier. If you have any questions contact the EUTF at 586-7390 (Oahu) or toll free at 1-800-295-0089.

2017 Schedule of Open Enrollment Informational Sessions for Active Employees

Date	Island	Location	Time
March 30	Hawaii-Hilo	Aunty Sally Kaleohano's Luau Hale	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 3	Kauai	Kauai War Memorial Hall	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 4	Maui	UH Maui College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 5	Oahu	Mission Memorial Auditorium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 6	Online	Webinar	8:00-9:30am, 10:30am-12:00pm, 3:00-4:30pm
Apr 7	Oahu	UH West Oahu	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 10	Maui	UH Maui College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 10	Online	Webinar	8:00-9:30am, 10:30am-12:00pm, 3:00-4:30pm
Apr 11	Hawaii-Kona	West Hawaii Civic Center	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 12	Oahu	Windward Community College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 13	Oahu	Aloha Stadium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 17	Kauai	Kauai War Memorial Hall	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 18	Oahu	Mission Memorial Auditorium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 19	Lanai	Lanai Community Center	8:30-10:00am, 10:30am-12:00pm
Apr 19	Online	Webinar	8:00-9:30am, 10:30am-12:00pm, 3:00-4:30pm
Apr 20	Oahu	UH Manoa	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 21	Oahu	Leeward Community College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 24	Molokai	Kualapuu Park & Community Center	8:30-10:00am, 10:30am-12:00pm
Apr 25	Hawaii-Hilo	Aunty Sally Kaleohano's Luau Hale	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 26	Online	Webinar	8:30-10:00am, 1:30am-3:00pm
Apr 27	Oahu	Aloha Stadium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm

MAUI

UH Maui College
Pilina Multi-Purpose Room
310 W. Kaahumanu Avenue
Kahului, HI 96732

KAUAI

Kauai War Memorial Auditorium
4191 Hardy Street
Lihue, HI 96766

OAHU

Aloha Stadium
Hospitality Room
99-500 Salt Lake Boulevard
Honolulu, HI 96818

Mission Memorial Auditorium
550 South King Street
Honolulu, HI 96813

MOLOKAI

Kualapuu Park & Community Center
1 Uwao Street
Kualapuu, HI 96757

LANAI

Lanai Community Center
8th Street
Lanai City, HI 96763

UH West Oahu
Campus Center C208
91-1001 Farrington Highway
Kapolei, HI 96707

Leeward Community College
Education Building
Lecture Hall 201 A and B
96-045 Ala Ike Street
Pearl City, HI 96782

HAWAII

Aunty Sally Kaleohano's Luau Hale
799 Piilani Street
Hilo, HI 96720

West Hawaii Civic Center
Community Meeting Hale, Bldg. G
74-5044 Ane Keohokalole Highway
Kailua-Kona, HI 96740

Windward Community College
Hale Akoakoa Room 101-105
45-720 Keaahala Road
Kaneohe, HI 96744

UH Manoa
Kuykendall Auditorium
2445 Campus Road
Honolulu, HI 96822

How to Access the Webinar

1) Go to eutf.hawaii.gov
2) In the top menu bar select "Learning Center" and click on "Webinars"
3) Select the desired webinar

Schedule of Open Enrollment Informational Sessions for Retirees

Date	Island	Location	Time
Oct 10	Maui	UH Maui College	9:00am, 11:00am
Oct 10	Online	Webinar	8:00am, 1:00pm
Oct 11	Oahu	Hawaii State Capitol	9:00am, 11:00am
Oct 12	Hawaii - Hilo	Aunty Sally Kaleohano's Luau Hale	1:00pm, 3:00pm
Oct 13	Molokai	Kualapuu Park & Community Center	9:00am
Oct 13	Lanai	Lanai Community Center	9:00am
Oct 14	Oahu	Windward Community College	9:00am, 11:00am
Oct 17	Kauai	Kauai Community College	9:00am, 11:00am
Oct 18	Oahu	Hawaii State Capitol	9:00am, 11:00am
Oct 19	Hawaii - Kona	West Hawaii Civic Center	9:00am, 11:00am
Oct 19	Online	Webinar	8:00am, 1:00pm
Oct 20	Oahu	UH Manoa	9:00am, 11:00am
Oct 21	Oahu	Leeward Community College	9:00am, 11:00am

MOLOKAI
Kualapuu Park & Community Center
1 Uwao Street
Kualapuu, HI 96757

LANAI
Lanai Community Center
8th Street
Lanai City, HI 96763

KAUAI
Kauai Community College
OCET Room 106 C and D
3-1901 Kaumualii Highway
Lihue, Hawaii 96766

MAUI
UH Maui College
Pilina Multi-Purpose Room
310 W. Kaahumanu Ave.
Kahului, HI 96732

HAWAII - KONA
West Hawaii Civic Center
Community Meeting Hale, Bldg G
74-5044 Ane Keohokalole Highway
Kailua-Kona, HI 96740

HAWAII - HILO
Aunty Sally Kaleohano's Luau Hale
799 Piilani Street
Hilo, HI 96720

OAHU

Hawaii State Capitol
Auditorium
415 S. Beretania Street
Honolulu, HI 96813

University of Hawaii at Manoa
Kuykendall Auditorium
2445 Campus Road
Honolulu, HI 96822

Windward Community College
Hale Palanakila, Room 104
45-720 Keaahala Road
Kaneohe, HI 96744

Leeward Community College
Education Building
Lecture Hall 201 A and B
96-045 Ala Ike Street
Pearl City, HI 96782

How to Access the Webinar

1) Go to eutf.hawaii.gov
2) In the top menu bar select "Training/Resources" and click on "Members"
3) Select the "Webinars" tab
4) Select the desired webinar link

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

EFFECTIVE JULY 1, 2017

BU'S 00, 01, 02, 03, 04, 06, 08, 09, 10, 11, 13, 14: FOR ALL EMPLOYERS EXCEPT COUNTY OF MAUI

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	Self	$186.29	$372.58	$307.06	45.2%	$679.64
Prescription Drug - CVS Caremark	Two-Party	$458.72	$917.44	$731.96	44.4%	$1,649.40
RSN Chiropractic	Family	$577.79	$1,155.58	$946.90	45.0%	$2,102.48
PPO - 80/20 Plan - HMSA Medical	Self	$131.05	$262.10	$307.06	53.9%	$569.16
Prescription Drug - CVS Caremark	Two-Party	$324.65	$649.30	$731.96	53.0%	$1,381.26
RSN Chiropractic	Family	$406.82	$813.64	$946.90	53.8%	$1,760.54
PPO - 75/25 Plan - HMSA Medical	Self	$27.12	$54.24	$292.34	84.3%	$346.58
Prescription Drug - CVS Caremark	Two-Party	$72.30	$144.60	$696.20	82.8%	$840.80
RSN Chiropractic	Family	$85.11	$170.22	$901.34	84.1%	$1,071.56
HMSA HMO	Self	$235.65	$471.30	$307.06	39.4%	$778.36
Prescription Drug - CVS Caremark	Two-Party	$578.62	$1,157.24	$731.96	38.7%	$1,889.20
RSN Chiropractic	Family	$730.71	$1,461.42	$946.90	39.3%	$2,408.32
HMO - Kaiser Comprehensive Medical	Self	$137.58	$275.16	$307.06	52.7%	$582.22
Kaiser Prescription Drug	Two-Party	$341.34	$682.68	$731.96	51.7%	$1,414.64
RSN Chiropractic	Family	$428.62	$857.24	$946.90	52.5%	$1,804.14
HMO - Kaiser Standard Medical	Self	$35.46	$70.92	$307.06	81.2%	$377.98
Kaiser Prescription Drug	Two-Party	$93.15	$186.30	$731.96	79.7%	$918.26
RSN Chiropractic	Family	$112.00	$224.00	$946.90	80.9%	$1,170.90
Supplemental - Royal State National	Self	$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party	$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family	$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN						
HDS Dental	Self	$6.79	$13.58	$18.82	58.1%	$32.40
	Two-Party	$13.59	$27.18	$37.62	58.1%	$64.80
	Family	$22.37	$44.74	$61.88	58.0%	$106.62
VISION PLAN						
VSP Vision	Self	$1.30	$2.60	$3.90	60.0%	$6.50
	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the actual premium for the PPO 75/25 Plan until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
FOR ACTIVE EMPLOYEES FORMERLY UNDER THE HSTA VEBA
BU 05

EFFECTIVE JULY 1, 2017

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution *	Percent Employer	Total
MEDICAL PLANS						
HSTA VB HMSA 90/10 PPO	Self	$168.37	$336.74	$273.44	44.8%	$610.18
Prescription Drug, RSN Chiropractic,	Two-Party	$407.80	$815.60	$661.24	44.8%	$1,476.84
VSP Vision	Family	$519.97	$1,039.94	$842.98	44.8%	$1,882.92
HSTA VB HMSA 80/20 PPO	Self	$117.90	$235.80	$273.44	53.7%	$509.24
Prescription Drug, RSN Chiropractic,	Two-Party	$285.34	$570.68	$661.24	53.7%	$1,231.92
VSP Vision	Family	$363.74	$727.48	$842.98	53.7%	$1,570.46
HSTA VB Kaiser Comprehensive	Self	$120.96	$241.92	$273.44	53.1%	$515.36
Prescription Drug, RSN Chiropractic,	Two-Party	$293.61	$587.22	$661.24	53.0%	$1,248.46
VSP Vision	Family	$374.74	$749.48	$842.98	52.9%	$1,592.46
DENTAL PLAN						
HSTA VB HDS Dental	Self	$7.50	$15.00	$20.04	57.2%	$35.04
	Two-Party	$14.98	$29.96	$40.10	57.2%	$70.06
	Family	$24.66	$49.32	$65.98	57.2%	$115.30
HSTA VB HDS Supplemental Dental	Self	$4.15	$8.30	$10.98	57.0%	$19.28
	Two-Party	$8.30	$16.60	$21.96	57.0%	$38.56
	Family	$12.45	$24.90	$32.94	57.0%	$57.84
VISION PLAN						
HSTA VB VSP Vision	Self	$1.30	$2.60	$3.90	60.0%	$6.50
	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
HSTA VB USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
BU 07

EFFECTIVE JULY 1, 2017

BU 07: FOR STATE OF HAWAII

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	Self	$175.98	$351.96	$327.68	48.2%	$679.64
Prescription Drug - CVS Caremark	Two-Party	$429.77	$859.54	$789.86	47.9%	$1,649.40
RSN Chiropractic	Family	$544.93	$1,089.86	$1,012.62	48.2%	$2,102.48
PPO - 80/20 Plan - HMSA Medical	Self	$120.74	$241.48	$327.68	57.6%	$569.16
Prescription Drug - CVS Caremark	Two-Party	$295.70	$591.40	$789.86	57.2%	$1,381.26
RSN Chiropractic	Family	$373.96	$747.92	$1,012.62	57.5%	$1,760.54
PPO - 75/25 Plan - HMSA Medical	Self	$16.81	$33.62	$312.96	90.3%	$346.58
Prescription Drug - CVS Caremark	Two-Party	$43.35	$86.70	$754.10	89.7%	$840.80
RSN Chiropractic	Family	$52.25	$104.50	$967.06	90.2%	$1,071.56
HMSA HMO	Self	$225.34	$450.68	$327.68	42.1%	$778.36
Prescription Drug - CVS Caremark	Two-Party	$549.67	$1,099.34	$789.86	41.8%	$1,889.20
RSN Chiropractic	Family	$697.85	$1,395.70	$1,012.62	42.0%	$2,408.32
HMO - Kaiser Comprehensive Medical	Self	$127.27	$254.54	$327.68	56.3%	$582.22
Kaiser Prescription Drug	Two-Party	$312.39	$624.78	$789.86	55.8%	$1,414.64
RSN Chiropractic	Family	$395.76	$791.52	$1,012.62	56.1%	$1,804.14
HMO - Kaiser Standard Medical	Self	$25.15	$50.30	$327.68	86.7%	$377.98
Kaiser Prescription Drug	Two-Party	$64.20	$128.40	$789.86	86.0%	$918.26
RSN Chiropractic	Family	$79.14	$158.28	$1,012.62	86.5%	$1,170.90
Supplemental - Royal State National	Self	$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party	$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family	$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN						
HDS Dental	Self	$6.79	$13.58	$18.82	58.1%	$32.40
	Two-Party	$13.59	$27.18	$37.62	58.1%	$64.80
	Family	$22.37	$44.74	$61.88	58.0%	$106.62
VISION PLAN						
VSP Vision	Self	$1.30	$2.60	$3.90	60.0%	$6.50
	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the prescription drug plan actual premium until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
BU 12

EFFECTIVE JULY 1, 2017:

BU12: FOR CITY AND COUNTY OF HONOLULU, COUNTY OF KAUAI, COUNTY OF HAWAII

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	Self	$148.56	$297.12	$252.84	46.0%	$549.96
Prescription Drug - CVS Caremark	Two-Party	$379.11	$758.22	$616.42	44.8%	$1,374.64
RSN Chiropractic	Family	$484.91	$969.82	$811.20	45.5%	$1,781.02
PPO - 80/20 Plan - HMSA Medical	Self	$102.82	$205.64	$252.84	55.1%	$458.48
Prescription Drug - CVS Caremark	Two-Party	$264.73	$529.46	$616.42	53.8%	$1,145.88
RSN Chiropractic	Family	$336.61	$673.22	$811.20	54.6%	$1,484.42
PPO - 75/25 Plan - HMSA Medical	Self	$20.22	$40.44	$244.32	85.8%	$284.76
Prescription Drug - CVS Caremark	Two-Party	$58.16	$116.32	$595.10	83.6%	$711.42
RSN Chiropractic	Family	$68.91	$137.82	$783.58	85.0%	$921.40
HMSA HMO	Self	$195.30	$390.60	$252.84	39.3%	$643.44
Prescription Drug - CVS Caremark	Two-Party	$496.22	$992.44	$616.42	38.3%	$1,608.86
RSN Chiropractic	Family	$636.80	$1,273.60	$811.20	38.9%	$2,084.80
HMO - Kaiser Comprehensive Medical	Self	$122.85	$245.70	$252.84	50.7%	$498.54
Kaiser Prescription Drug	Two-Party	$314.97	$629.94	$616.42	49.5%	$1,246.36
RSN Chiropractic	Family	$401.75	$803.50	$811.20	50.2%	$1,614.70
HMO - Kaiser Standard Medical	Self	$30.62	$61.24	$252.84	80.5%	$314.08
Kaiser Prescription Drug	Two-Party	$84.27	$168.54	$616.42	78.5%	$784.96
RSN Chiropractic	Family	$102.75	$205.50	$811.20	79.8%	$1,016.70
Supplemental - Royal State National	Self	$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party	$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family	$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN						
	Self	$6.79	$13.58	$18.82	58.1%	$32.40
HDS Dental	Two-Party	$13.59	$27.18	$37.62	58.1%	$64.80
	Family	$22.37	$44.74	$61.88	62.8%	$106.62
VISION PLAN						
	Self	$1.30	$2.60	$3.90	60.0%	$6.50
VSP Vision	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the prescription drug plan actual premium until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
MAUI COUNTY
BU 12

EFFECTIVE JULY 1, 2017:

BU12: FOR COUNTY OF MAUI

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	Self	$148.56	$297.12	$252.84	46.0%	$549.96
Prescription Drug - CVS Caremark	Two-Party	$371.39	$742.78	$631.86	46.0%	$1,374.64
RSN Chiropractic	Family	$481.24	$962.48	$818.54	46.0%	$1,781.02
PPO - 80/20 Plan - HMSA Medical	Self	$102.82	$205.64	$252.84	55.1%	$458.48
Prescription Drug - CVS Caremark	Two-Party	$257.01	$514.02	$631.86	55.1%	$1,145.88
RSN Chiropractic	Family	$332.94	$665.88	$818.54	55.1%	$1,484.42
PPO - 75/25 Plan - HMSA Medical	Self	$20.22	$40.44	$244.32	85.8%	$284.76
Prescription Drug - CVS Caremark	Two-Party	$50.44	$100.88	$610.54	85.8%	$711.42
RSN Chiropractic	Family	$65.24	$130.48	$790.92	85.8%	$921.40
HMSA HMO	Self	$195.30	$390.60	$252.84	39.3%	$643.44
Prescription Drug - CVS Caremark	Two-Party	$488.50	$977.00	$631.86	39.3%	$1,608.86
RSN Chiropractic	Family	$633.13	$1,266.26	$818.54	39.3%	$2,084.80
HMO - Kaiser Comprehensive Medical	Self	$122.85	$245.70	$252.84	50.7%	$498.54
Kaiser Prescription Drug	Two-Party	$307.25	$614.50	$631.86	50.7%	$1,246.36
RSN Chiropractic	Family	$398.08	$796.16	$818.54	50.7%	$1,614.70
HMO - Kaiser Standard Medical	Self	$30.62	$61.24	$252.84	80.5%	$314.08
Kaiser Prescription Drug	Two-Party	$76.55	$153.10	$631.86	80.5%	$784.96
RSN Chiropractic	Family	$99.08	$198.16	$818.54	80.5%	$1,016.70
Supplemental - Royal State National	Self	$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party	$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family	$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN						
	Self	$6.79	$13.58	$18.82	58.1%	$32.40
HDS Dental	Two-Party	$13.59	$27.18	$37.62	58.1%	$64.80
	Family	$14.29	$28.58	$78.04	73.2%	$106.62
VISION PLAN						
	Self	$1.30	$2.60	$3.90	60.0%	$6.50
VSP Vision	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the prescription drug plan actual premium until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
MAUI COUNTY
ALL BU's EXCEPT BU 12

EFFECTIVE JULY 1, 2017

ALL BU's EXCEPT BU 12: FOR COUNTY OF MAUI

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	Self	$183.34	$366.68	$312.96	46.0%	$679.64
Prescription Drug - CVS Caremark	Two-Party	$444.97	$889.94	$759.46	46.0%	$1,649.40
RSN Chiropractic	Family	$567.24	$1,134.48	$968.00	46.0%	$2,102.48
PPO - 80/20 Plan - HMSA Medical	Self	$128.10	$256.20	$312.96	55.0%	$569.16
Prescription Drug - CVS Caremark	Two-Party	$310.90	$621.80	$759.46	55.0%	$1,381.26
RSN Chiropractic	Family	$396.27	$792.54	$968.00	55.0%	$1,760.54
PPO - 75/25 Plan - HMSA Medical	Self	$24.17	$48.34	$298.24	84.3%	$346.58
Prescription Drug - CVS Caremark	Two-Party	$58.55	$117.10	$723.70	82.8%	$840.80
RSN Chiropractic	Family	$74.56	$149.12	$922.44	84.1%	$1,071.56
HMSA HMO	Self	$232.70	$465.40	$312.96	40.2%	$778.36
Prescription Drug - CVS Caremark	Two-Party	$564.87	$1,129.74	$759.46	40.2%	$1,889.20
RSN Chiropractic	Family	$720.16	$1,440.32	$968.00	40.2%	$2,408.32
HMO - Kaiser Comprehensive Medical	Self	$134.63	$269.26	$312.96	53.8%	$582.22
Kaiser Prescription Drug	Two-Party	$327.59	$655.18	$759.46	53.7%	$1,414.64
RSN Chiropractic	Family	$418.07	$836.14	$968.00	53.7%	$1,804.14
HMO - Kaiser Standard Medical	Self	$32.51	$65.02	$312.96	82.8%	$377.98
Kaiser Prescription Drug	Two-Party	$79.40	$158.80	$759.46	82.7%	$918.26
RSN Chiropractic	Family	$101.45	$202.90	$968.00	82.7%	$1,170.90
Supplemental - Royal State National	Self	$8.52	$17.04	$25.52	60.0%	$42.56
Supplemental Prescription Drug	Two-Party	$21.16	$42.32	$63.40	60.0%	$105.72
RSN Chiropractic	Family	$23.52	$47.04	$70.48	60.0%	$117.52
DENTAL PLAN						
	Self	$6.79	$13.58	$18.82	58.1%	$32.40
HDS Dental	Two-Party	$13.59	$27.18	$37.62	58.1%	$64.80
	Family	$14.29	$28.58	$78.04	73.2%	$106.62
VISION PLAN						
	Self	$1.30	$2.60	$3.90	60.0%	$6.50
VSP Vision	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

*** Continuation of July 1, 2016 to June 30, 2017 monthly employer contributions until a collective bargaining agreement is reached. For the PPO 75/25 Plan, the monthly employer contribution is limited to the prescription drug plan actual premium until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website www.eutf.hawaii.gov for updated information regarding their premiums and contributions.**