



Department of Budget and Finance

RELEASE DATE: July 29, 2013

REQUEST FOR PROPOSALS No. RFP-13-001

SEALED OFFERS FOR Actuarial Services for Other Post Employment Benefits STATE OF HAWAII DEPARTMENT OF BUDGET AND FINANCE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

WILL BE RECEIVED UP TO 12:00 P.M. (HST) ON

AUGUST 29, 2013

IN THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND, CITY FINANCIAL TOWER, 201 MERCHANT STREET, SUITE 1520 HONOLULU, HAWAII 96813. DIRECT QUESTIONS RELATING TO THIS SOLICITATION TO SANDRA YAHIRO, TELEPHONE (808) 586-7390, FACSIMILE (808) 586-2161 OR E-MAIL AT EUTFADMIN@HAWAII.GOV.

Sandra Yahiro
Procurement Officer

RFP-13-001

Name of Company

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SECTION ONE
INTRODUCTION, TERMS AND ACRONYMS, KEY DATES

1.1 INTRODUCTION

The Hawaii Employer-Union Health Benefits Trust Fund seeks proposals from highly qualified firms to provide actuarial services to be used for planning, budgeting, accounting, and financial reporting purposes relative to Government Accounting Standards Board (GASB) Statement Nos. 43 and 45. The actuarial service will include studies of the health care plans and other postemployment benefits (collectively called OPEB) provided by the State of Hawaii (State) and its political subdivisions (the counties) to public employees, retirees, and their dependents through the Hawaii Employer-Union Health Benefits Trust fund (EUTF).

The purpose of this RFP is to obtain data in accordance with actuarial standards of practice regarding EUTF's OPEB plans that will satisfy the requirements of GASB Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*.

1.2 CANCELLATION

The Request for Proposals (RFP) may be cancelled and any or all proposals rejected in whole or in part, without liability to the State, when it is determined to be in the best interest of the State.

1.3 TERMS AND ACRONYMS USED THROUGHOUT THE SOLICITATION

BAFO	=	Best and Final Offer
CPO	=	Chief Procurement Officer
EUTF	=	Hawaii Employer-Union Health Benefits Trust Fund
GC	=	General Conditions, issued by the Department of the Attorney General
GET	=	General Excise Tax
HAR	=	Hawaii Administrative Rules
HRS	=	Hawaii Revised Statutes
Offeror	=	Any individual, partnership, firm, corporation, joint venture, or representative or agent submitting an offer in response to this solicitation
Procurement Officer	=	The contracting officer for the State of Hawaii, EUTF
RFP	=	Request for Proposal
State	=	State of Hawaii, including its departments, agencies, and political subdivisions

1.4 RFP SCHEDULE AND SIGNIFICANT DATES

Proposals must be received by 12:00 PM, HST on August 29, 2013. Late proposals will be rejected and not considered. The table below represents the State's best estimate of the schedule that will be followed. All times indicated are based on Hawaii Standard Time (HST). These dates are estimates only and are subject to change at EUTF's sole discretion. EUTF reserves the right to change any date(s) as deemed necessary and in the best interest in the State of Hawaii. If a component of this schedule, such as "Proposal Due date/time" is delayed, the rest of the schedule will likely be shifted by the same number of days. Any change to the RFP Schedule and Significant Dates shall be reflected in and issued in an addendum. The approximate schedule is as follows:

Release of Request for Proposals	July 29, 2013
Due date to Submit Registration Form	August 5, 2013
Due date to Submit Written Questions	August 8, 2013
State's Response to Written Questions	August 14, 2013
Proposals Due date/time	August 29, 2013 12:00 PM, HST
Proposal Evaluations	August/September 2013
Discussion with Priority Listed Offerors (if necessary)	September 11, 2013
Best and Final Offer (if necessary)	September 16, 2013
Notice of Award	September 25, 2013
Contract Start Date	October 1, 2013
Final Report Issued	May 31, 2014

1.5 ISSUING OFFICE AND CONTACT PERSON

This RFP is issued by EUTF. The issuing office is:

Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant St., Suite 1520
Honolulu, HI 96813

The individual listed below is the sole point of contact from the date of release of this RFP until the selection of the winning contractor. Questions will be accepted only if submitted in writing and received on or before the day and time specified in Section 1.4, *RFP Schedule and Significant Dates*.

Ms. Sandra Yahiro
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant St., Suite 1520
Honolulu, HI 96813
Telephone: (808) 586-7390
Fax: (808) 586-2320
Email: eutfadmin@hawaii.gov

1.6 QUESTIONS AND ANSWERS PRIOR TO OPENING OF PROPOSALS

All questions shall be submitted in writing to the contact person by the due date specified in Section 1.4, *RFP Schedule and Significant Dates*, as amended. No telephone calls will be accepted. If an Offeror wants a formal answer to questions concerning this RFP, the Offeror must submit such questions to the contact person by the due date.

The State will respond to questions through Addenda/Amendments by the date specified in Section 1.4, *RFP Schedule and Significant Dates*, as amended. To facilitate a meaningful response, written questions should reference the page, paragraph, and line or sentence to which the question relates. Such inquiries must contain identification of the Offeror, its telephone and fax numbers, and the RFP number. The EUTF is not responsible for delays or non-receipt of such responses or any communications by the Offerors.

1.7 REGISTRATION

Offerors interested in responding to this solicitation are encouraged to register with the RFP contact noted in Section 1.5, *Issuing Office and Contact Person*. Offerors who have registered with EUTF will receive courtesy notices of any addendum that has been issued for this RFP. To register, email or fax a completed Registration Form (Attachment 3) to the RFP contact person by August 5, 2013. Failure to register may result in the Offeror not receiving notification of changes or addenda to the RFP. It should be noted that Offerors are ultimately responsible for being aware of any addenda issued by EUTF and should frequently refer back to the SPO website to check for any addenda that has been issued.

1.8 SUBMISSION OF PROPOSALS

Each Offeror shall submit only one (1) proposal. The format and contents of the proposal are specified in Section Three. One (1) original and nine (9) copies of the proposal, and three (3) electronic copies in PDF format on CD must be submitted and received by EUTF by the closing date for receipt of proposals as shown in Section 1.4, *RFP Schedule and Significant Dates*. Any proposal received after this date and time will be rejected. The original proposal must be single sided, unbound and clearly marked "Original." Each copy must be marked "Copy ___ of 9." Copies may be bound and double sided. Proposals shall be mailed or hand delivered to:

Ms. Sandra Yahiro
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant St., Suite 1520
Honolulu, HI 96813

If proposal is to be hand delivered, the envelope shall be marked "hand delivered, proposal due August 29, 2013, 12:00 PM, HST."

The outside cover of the package containing the proposal shall be marked:
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
Proposal Submitted in Response to:
RFP No. 13-001

1.9 DISQUALIFICATION OF PROPOSALS

The EUTF reserves the right to consider as acceptable only those proposals submitted in accordance with the requirements set forth or referenced in this RFP and which demonstrate an understanding of the issues involved and the scope of services requested. Any proposal offering terms and conditions contrary to those included in this RFP may be rejected without further consideration.

Grounds for disqualification include:

- Proof of collusion among Offerors, in which case all proposals involved in the collusive action will be rejected and any participant to such collusion will be barred from future bidding until reinstated as a qualified Offeror.
- Offeror's lack of responsibility and cooperation as shown by past work or services rendered.
- Offeror's being in arrears on existing contracts with the State or having defaulted on previous contracts.
- Delivery of the proposal after the time specified in Section 1.4, *RFP Schedule and Significant Dates*.
- Offeror's failure to pay, or satisfactorily settle, all bills overdue for labor and materials on former contracts with the State at the time of issuance of the RFP.
- Proposal is unsigned.
- Proposal does not comply with applicable laws, or contains provisions contrary to applicable law.
- Proposal is conditional, incomplete, or irregular in such a way as to make the proposal ambiguous as to its meanings.
- Proposal has provisions reserving the right to accept or reject the award, or to enter into a contract pursuant to an award, or provisions contrary to those required in the RFP.
- Hand written proposals will be rejected.

1.10 PROPOSAL AMENDMENTS

The EUTF reserves the right to amend this RFP at any time prior to the closing date for best and final offers.

1.11 FUNDING

Execution of any contract between the State and the successful Offeror is contingent upon the availability of funds. In addition, any contract resulting from this RFP shall be

enforceable only to the extent of the availability of funds. No damages or interest shall accrue against the State or EUTF as a result of the non-availability of funds.

Depending on the prices proposed, the current level of funding may be insufficient to support the entire scope of the project. If the current level is insufficient to support the entire project, the State reserves the right to negotiate with the Offeror(s) to reduce the price(s) and/or the project's scope of work, and to select specific sections described in the Scope of Services for inclusion in the resulting contract. Any such contract will be written to include only those portions selected by EUTF and may be written to be contingent upon further funding for the project. However, the evaluation of the proposals shall be based on the proposals' satisfying the entire scope regardless of whether less than the entire scope is included in the contract.

EUTF also reserves the right to subsequently select additional sections of the scope to be completed by the contractor as additional funds become available. The price of any additional sections shall be at the prices agreed upon between EUTF and the contractor prior to the execution of the contract. The existing contract will then be amended to include the selected additional sections at those mutually agreed upon final prices.

SECTION TWO

BACKGROUND AND SCOPE OF WORK

2.1 PROJECT OVERVIEW AND HISTORY

The Governmental Accounting Standards Board (GASB) has issued Statement Nos. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and 45 *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*. These accounting and financial reporting standards require the State to obtain actuarial valuations for employee-beneficiaries that are participating in the Other Post Employment Benefits (OPEB) plans offered by the State and the counties through the Hawaii Employer-Union Health Benefits Trust Fund (EUTF or EUTF Plan). The EUTF uses an investment consultant to advise trustees on how to invest these funds.

Moreover, the State and counties will be required to report in their annual financial reports certain additional data pertaining to OPEB plans. As of June 30, 2013, the counties have contributed approximately \$300 million to their OPEB costs. Additionally, Act 268 SLH 2013 requires public employers to pre-fund OPEB contributions, and created a task force to examine the unfunded liabilities of EUTF.

The purpose of this procurement is to secure professional services to obtain data in accordance with actuarial standards of practice regarding the EUTF's OPEB plans that will satisfy the requirements of the GASB Statements Nos. 43 and 45. The GASB statements require actuarial valuations for active and retired State and county employees. The GASB statements also require certain data updated on an annual basis in accordance with stated parameters.

This procurement is intended to obtain, among other things: calculation of the total and net OPEB obligation, a calculation of the annual required contribution, annual OPEB cost, and a determination of the funding impact for the EUTF Plan and the State and county public employees. The previous OPEB report is attached to this document as Exhibit F.

2.2 SCOPE OF WORK

All services provided to EUTF shall be in accordance with this RFP, including its attachments and any addenda.

The contractor must perform an actuarial valuation in accordance with actuarial standards of practice for the State, and the counties' OPEB plans provided through EUTF that will satisfy the requirements of GASB Statement Nos. 43 *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and 45 *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*.

The valuation date will be as of July 1, 2013 and biennially thereafter.

- A. Actuarial valuation. The contractor shall prepare an actuarial valuation of the EUTF classified as an agent multiple employer plan following GASB Statement Nos. 43 and 45 standards to include:

1. An actuarial valuation of the EUTF OPEB as of July 1, 2013 for each public employer participating in the EUTF, i.e., the State of Hawaii, City and County of Honolulu, the County of Hawaii, the County of Maui, the County of Kauai, the Board of Water Supply of Honolulu, the Hawaii Department of Water Supply, and the Kauai Department of Water Supply. With respect to each actuarial evaluation, contractor shall prepare and deliver to the State any and all statements, reports, and documents that an actuary would reasonably be expected to prepare and deliver in connection with an actuarial valuation conducted in accordance with GASB Statements 43 and 45. This includes the Annual Required Contribution (ARC) for the employers' fiscal years ending June 30, 2014. Medicare Part B premiums for the State and counties shall also be included in the actuarial valuation.
2. The actuarial present value of total projected benefits.
3. The annual required contribution (ARC) of the State and county public employers for the current fiscal year plus two subsequent years.
4. Annual OPEB cost for the current fiscal year plus two subsequent years.
5. Actuarial valuation reports. A written report to the State on each actuarial valuation conducted is required for a total of 8 reports plus a consolidated report. Reports must be in the form and covering the subjects as specified by the State. The initial report shall be completed by May 31, 2014. Subsequent actuarial valuation reports due during the term of the contract shall be completed by the date or dates specified in advance by the State. All actuarial valuation reports shall contain the following information:
 - a. An executive summary for formal presentation to the EUTF board of trustees, the State's executive branch and the Legislature as well as the county executive and legislative bodies.
 - b. All data necessary for the EUTF Plan and the State and county public employers to comply with the reporting and disclosure provision of GASB Statement Nos. 43 and 45 including without limitation:
 - i. Actuarial accrued liability
 - ii. Actuarial value of accrued assets
 - iii. Unfunded actuarial liability (UAAL) – funded percent of UAAL
 - iv. Normal cost
 - v. Annual OPEB cost (AOC), as a dollar amount and percentage of covered payroll
 - vi. Net OPEB obligation (NOO)
 - c. A description of:
 - i. EUTF OPEB plan provisions, including group(s) covered and benefits valued
 - ii. Actuarial methods including:
 1. Actuarial funding method
 2. UAAL amortization policy
 3. All actuarial assumptions
 - iii. Data used in the valuation, including age/service distribution table(s)
 - iv. Perform an annual gain/loss analysis to determine reasons for changes in the UAAL, if and when prior actuarial valuations is available as support

- v. Assess the data for inconsistencies and make recommendations for enhancing data quality
 6. For each employer, a valuation forecast of 30 years of UAAL, ARC, pay-as-you-go, funded percentage prospected asset balance gain as required by the stated funding policy of the State noted in Act 268, SLH 2013.
 7. With respect to each actuarial valuation, the contractor shall attend and make presentations at three meetings on the island of Oahu. One of the meetings shall be to make presentations to the EUTF board of trustees, one meeting shall be to make a presentation to the Legislature, and another meeting shall be to make presentations to the public employers, i.e., the State of Hawaii, City and County of Honolulu, the County of Hawaii, the County of Maui, the County of Kauai, the Board of Water Supply of Honolulu, the Hawaii Department of Water Supply, and the Kauai Department of Water Supply. Additional meetings may also be required on an as-needed basis. The cost for each additional meeting shall be noted on Attachment 2, Offer Form OF-2.
- B. Impact of OPEB Standards. The contractor shall provide recommendations on managing the OPEB obligation to include the following:
1. Impact of Act 268, SLH 2013 on the Financial Statement(s) of the EUTF Plan and the Comprehensive Annual Financial Report (CAFR), as well as the financial statements of the public employers (City and County of Honolulu, the County of Hawaii, the County of Maui, the County of Kauai, the Board of Water Supply of Honolulu, the Hawaii Department of Water Supply, and the Kauai Department of Water Supply).
 2. Alternative strategies for managing the OPEB obligation.
- C. Assumptions. The contractor shall validate assumptions prior to making calculations based on the following:
1. EUTF Plan, classified as an agent multiple employer plan.
 2. Investment rate of return: A percentage rate to be mutually agreed upon by the State and Contractor.
 3. Actuarial cost method: Contractor shall make calculations using all acceptable methods and recommend the method that is most beneficial to the State. A comparative analysis reflecting the advantages and disadvantages of each method should also be provided.
 4. Value of the plan assets: As specified by each employer
 5. Amortization period: 30 years
 6. Amortization method: Level Dollar or Level Percent. The method to be mutually agreed upon by the State and Contractor.
- D. Additional Services. The Contractor shall provide technical assistance and analysis either orally or in written form, in connection with miscellaneous questions that may arise from time to time relative to the funding of the EUTF Plan including, but not limited to: amounts reported under GASB 43 and 45 due to changes or proposed changes in EUTF OPEB plan design; changes or proposed changes in covered populations; review of pending or proposed legislation; review of changes or proposed changes to accounting standards; meetings and presentations to stakeholders such as the Legislature, State Executive Branch, unions, EUTF and counties; and other operational issues. In addition, the State may at any time, with written notice to the Contractor, request the Contractor to perform other actuarial services on behalf of the State including

but not limited to actuarial services for technical assistance in connection with proposed changes to plan design and assumptions. If the Contractor intends to bill the State for any advice or service requested by the State, the Contractor shall so notify the State prior to providing such advice or service. The Contractor shall provide a separate listing of hourly rates for each employment type (i.e. Senior Actuarial Analyst, Support Services, etc.) that may be required to provide optional technical assistance and analysis. No additional services shall be performed unless requested by the State and agreed to by the Contractor.

2.3 HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND RESPONSIBILITIES

The EUTF is an agency of the State, and is administratively attached to the Department of Budget and Finance for administrative purposes. The statutes establishing and governing the operations of the EUTF are found in Chapter 87A, Hawaii Revised Statutes (HRS). The EUTF is administered by a board of ten trustees who are appointed by the Governor. Five trustees represent the employee-beneficiaries, one of whom represents retirees. These five trustees are selected by the Governor from a list of candidates provided by the exclusive employee representative organizations. The remaining five trustees, also appointed by the Governor, represent the public employers. The Board's responsibilities include determining the nature and scope of benefit plans, negotiating and entering into contracts with insurance carriers, establishing eligibility and management policies, and overseeing EUTF activities.

Under Chapter 87A, HRS the EUTF is authorized to design, provide, and administer health and other benefit plans for State and county employees, retirees, and their dependents. The benefit plans include medical, prescription drug, chiropractic, dental, vision, and life insurance.

The EUTF also provides reimbursements to retirees and their spouses who participate in Medicare Part B.

Public employer contributions to pay for these plans, insofar as retirees are concerned, are set or limited by provisions of Chapter 87A, HRS. A description of the EUTF's OPEB plans are noted in Exhibit C in this RFP.

2.4 TERM OF CONTRACT

The contract is intended to start on or about October 1, 2013 and end on June 30, 2016. The contract shall include three options to extend the contract for two additional years each.

Unless terminated, the Contractor and the State may extend the term of the contract for three additional 24 month periods or portions thereof without the necessity of re-soliciting, upon mutual agreement in writing at least sixty (60) days prior to the expiration of the contract. The contract price or commission paid to the Contractor for the extended period shall remain the same or as described in the offer.

When interests of the State or the Contractor so require, the State or the Contractor may terminate the contract for convenience by providing six (6) weeks prior written notice to the other party.

2.5 CONTRACT ADMINISTRATOR

For the purposes of this contract, Sandra Yahiro, Acting Administrator, (808) 586-7390, or authorized representative, is designated the Contract Administrator.

SECTION THREE

PROPOSAL FORMAT AND CONTENT

3.1 OFFEROR'S AUTHORITY TO SUBMIT AN OFFER

The State will not participate in determinations regarding an Offeror's authority to sell a product or service. If there is a question or doubt regarding an Offeror's right or ability to obtain and sell a product or service, the Offeror shall resolve that question prior to submitting an offer.

3.2 REQUIRED REVIEW

3.2.1 Before submitting a proposal, each Offeror must thoroughly and carefully examine this RFP, any attachment, addendum, and other relevant document, to ensure Offeror understands the requirements of the RFP. Offeror must also become familiar with State, local, and Federal laws, statutes, ordinances, rules, and regulations that may in any manner affect cost, progress, or performance of the work required.

3.2.2 Should Offeror find defects and questionable or objectionable items in the RFP, Offeror shall notify the EUTF in writing prior to the deadline for written questions as stated in the RFP Section 1.4, *Schedule and Significant Dates*, as amended. This will allow the issuance of any necessary corrections and/or amendments to the RFP by addendum, and mitigate reliance of a defective solicitation and exposure of proposal(s) upon which award could not be made.

3.3 PROPOSAL PREPARATION COSTS

Any and all costs incurred by the Offeror in preparing or submitting a proposal shall be the Offeror's sole responsibility whether or not any award results from this RFP. The State shall not reimburse such costs.

3.4 TAX LIABILITY

3.4.1 Work to be performed under this solicitation is a business activity taxable under Chapter 237, HRS and if applicable, taxable under Chapter 238, HRS. Contractor is advised that they are liable for the Hawaii GET at the current 4.5% for sales made on Oahu, and at the 4% rate for the islands of Hawaii, Maui, Molokai, and Kauai, or if changed by state law. If, however, an Offeror is a person exempt by the HRS from paying the GET and therefore not liable for the taxes on this solicitation, Offeror shall state its tax exempt status and cite the HRS chapter or section allowing the exemption.

3.4.2 Federal I.D. Number and Hawaii General Excise Tax License I.D. Offeror shall submit its current Federal I.D. Number and Hawaii General Excise Tax License I.D. number in the space provided on Attachment 1, Offer Form OF-1, thereby attesting that the Offeror is doing business in the State and that Offeror will pay such taxes on all sales made to the State.

3.5 PROPERTY OF STATE

All proposals become the property of the State of Hawaii.

3.6 CONFIDENTIAL INFORMATION

3.6.1 If an Offeror believes that any portion of a proposal, offer, specification, protest, or correspondence contains information that should be withheld from disclosure as confidential, the Offeror shall inform the Procurement Officer named on the cover of this RFP in writing and provide justification to support the Offeror's confidentiality claim. Price is not considered confidential and will not be withheld.

3.6.2 An Offeror shall request in writing nondisclosure of information such as designated trade secrets or other proprietary data Offeror considers to be confidential. Such requests for nondisclosure shall accompany the proposal, be clearly marked in the RFP, and shall be readily separable from the proposal in order to facilitate eventual public inspection of the non-confidential portion of the proposal. All information Offeror believes is confidential, and not to be disclosed to the public shall also be listed on Attachment 4.

3.7 EXCEPTIONS

Should Offeror take any exception to the terms, conditions, specifications, or other requirements listed in the RFP, Offeror shall list such exceptions in this section of the Offeror's proposal in Attachment 5. Offeror shall reference the RFP section where exception is taken, a description of the exception taken, and the proposed alternative, if any. The State reserves the right to accept or reject any request for exceptions.

3.8 PROPOSAL OBJECTIVES

3.8.1 One of the objectives of this RFP is to make proposal preparation easy and efficient, while giving Offerors ample opportunity to highlight their proposals. The evaluation process must also be manageable and effective.

3.8.2 Proposals shall be prepared in a straightforward and concise manner, in a format that is reasonably consistent and appropriate for the purpose. Emphasis will be on completeness and clarity of content.

3.8.3 When an Offeror submits a proposal, it shall be considered a complete plan for accomplishing the tasks described in this RFP and any supplemental tasks the Offeror has identified as necessary to successfully complete the obligations outlined in this RFP.

3.8.4 The proposal shall describe in detail the Offeror's ability and availability of services to meet the goals and objectives of this RFP as stated in Section 2.2, *Scope of Work*.

3.8.5 Offeror shall submit a proposal that includes an overall strategy, timeline and plan for the work proposed as well as expected results and possible shortfalls.

3.9 PROPOSAL FORMS

3.9.1 To be considered responsive, the Offeror's proposal shall respond to and include all items specified in this RFP and any subsequent addendum. Any proposal offering any other set of terms and conditions that conflict with the terms and conditions provided in the RFP or in any subsequent addendum may be rejected without further consideration.

3.9.2 Offer Form, OF-1. Offer Form, OF-1 is required to be completed using Offeror's exact legal name as registered with the State of Hawaii Department of Commerce and Consumer Affairs, if applicable, in the appropriate space on Offer Form, OF-1 (Attachment 1). Failure to do so may delay proper execution of the Contract.

The Offeror's authorized signature on the Offer Form, OF-1 shall be an original signature in ink, which shall be required before an award, if any, can be made. The submission of the proposal shall indicate Offeror's intent to be bound.

3.9.3 Offer Form, OF-2. Pricing shall be submitted on Offer Form OF-2 (Attachment 2). The price shall be the all-inclusive cost, including the GET, to the State. No other costs will be honored. Any unit prices shall be inclusive.

3.10 PROPOSAL CONTENTS

Proposals must:

3.10.1 Include a transmittal letter to confirm that the Offeror shall comply with the requirements, provisions, terms, and conditions specified in this RFP.

3.10.2 Include a signed Offer Form OF-1 with the complete name and address of Offeror's firm and the name, mailing address, email, telephone number, and fax number of the person the State should contact regarding the Offeror's proposal.

3.10.3 If subcontractor(s) will be used, append a statement to the transmittal letter from each subcontractor, signed by an individual authorized to legally bind the subcontractor and stating:

- a. The general scope of work to be performed by the subcontractor;
- b. The subcontractor's willingness to perform the indicated tasks.

3.10.4 Provide all of the information requested in this RFP in the order specified.

3.10.5 Be organized into sections, following the exact format using all titles, subtitles, and numbering, with tabs separating each section described below. Each section must be addressed individually and pages must be numbered.

- a. Transmittal Letter
The transmittal letter must be included as part of the proposal and shall be signed by an individual authorized to legally bind the Offeror. See Attachment 1, Offer Form OF-1.

- b. **Executive summary**
The executive summary shall clearly and concisely summarize and highlight the contents of the proposal in such a way to provide EUTF with a broad understanding of the proposal.
- c. **Approach to the Project**
Provide an overview of the project with the objective of demonstrating the Offeror's understanding of the RFP requirements. The section should contain a description of how the project will be carried out and why this approach was selected. Include anticipated problem areas, if any.
- Provide point by point written confirmation for each of the tasks and deliverables listed in Section Two, Background and Scope of Work, as to how the Offeror's proposal meets the requirement.
- d. **Work Plan and Schedule**
Provide a detailed task-by-task work plan for the entire project. Ample time should be allotted for approval of each deliverable.
- Provide a chart developing the project schedule and milestones.
 - Provide provisions for handling potential or actual problems.
 - Include assumptions or constraints identified by the Offeror.
 - Include details and method to be used in managing, controlling, and reporting project activities.
- e. **Experience and Capabilities.**
- 1) A complete, relevant, and current client listing.
 - 2) The number of years Offeror has been in business and the number of years Offeror has performed services specified by this RFP.
 - 3) A list of key personnel and associated resumes for those who will be dedicated to this project. Key personnel shall be identified and a description of their duties for this contract shall be provided. Key personnel shall not be replaced without the prior approval of EUTF. References for individuals to be assigned to this account may be verified. Reference checking is not limited to those references supplied by the Offeror.
 - 4) A list of at least three (3) references from the Offeror's client listing that may be contacted by the State as to the Offeror's past and current job performance. Offeror shall provide names, titles, organizations, telephone numbers, email and postal addresses. Additionally, any client of the Offeror that is used as a reference shall submit a completed *Reference Information Questionnaire*, which is included as Attachment 8.

- 5) A summary listing of judgments or pending lawsuits or actions against; adverse contract actions, including termination(s), suspension, imposition of penalties, or other actions relating to failure to perform or deficiencies in fulfilling contractual obligations against your firm. If none, so state.
 - 6) A list of sample projects and/or examples of written plans.
 - 7) A list of former clients, including contact information, of those that did not renew contracts with Offeror within the past five years. List must include reason for non-renewal.
- f. Pricing.
Offeror shall propose a total price for the entire project. The price will include all costs associated with the project including all applicable taxes. See Attachment 2, Offer Form OF-2.

3.11 RECEIPT AND REGISTER OF PROPOALS

Proposals will be received and receipt verified by two or more EUTF officials on or after the date and time specified in Section One, or as amended.

The register of proposals and proposals of the Offeror(s) shall be open to public inspection upon posting of award pursuant to Section 103D-701, HRS.

3.12 BEST AND FINAL OFFER (BAFO)

If the State determines a best and final offer (BAFO) is necessary, it shall request one from the Offeror. Any BAFO must be received by the Issuing Office no later than the date and time specified in Section 1.4, *RFP Schedule and Significant Dates*. If a BAFO is not requested by EUTF, or if requested and not submitted by an Offeror, the previous submittal will be construed as its best and final offer. After BFAO are received, final evaluations will be conducted for an award. All proposals become the property of EUTF.

3.13 MODIFICATION PRIOR TO SUBMITTAL DEADLINE OR WITHDRAWAL OF OFFERS

3.13.1 The Offeror may modify or withdraw a proposal before the proposal due date and time.

3.13.2 Any change, addition, deletion of attachment(s) or data entry of an Offer may be made prior to the deadline for submittal of offers.

3.14 MISTAKES IN PROPOSALS

3.14.1 Mistakes shall not be corrected after award of contract.

3.14.2 When the Procurement Officer knows or has reason to conclude before award that a mistake has been made, the Procurement Officer should request the Offeror to confirm the proposal. If the Offeror alleges mistake, the proposal may be corrected or withdrawn pursuant to this section.

- 3.14.3 Once discussions are commenced or after best and final offers are requested, any priority-listed Offeror may freely correct any mistake by modifying or withdrawing the proposal until the time and date set for receipt of best and final offers.
- 3.14.4 If discussions are not held, or if the best and final offers upon which award will be made have been received, mistakes shall be corrected to the intended correct offer whenever the mistake and the intended correct offer are clearly evident on the face of the proposal, in which event the proposal may not be withdrawn.
- 3.14.5 If discussions are not held, or if the best and final offers upon which award will be made have been received, an Offeror alleging a material mistake of fact which makes a proposal non-responsive may be permitted to withdraw the proposal if: the mistake is clearly evident on the face of the proposal but the intended correct offer is not; or the Offeror submits evidence which clearly and convincingly demonstrates that a mistake was made.

Technical irregularities are matters of form rather than substance evident from the proposal document, or insignificant mistakes that can be waived or corrected without prejudice to other Offerors; that is, when there is no effect on price, quality, or quantity. If discussions are not held or if best and final offers upon which award will be made have been received, the Procurement Officer may waive such irregularities or allow an Offeror to correct them if either is in the best interest of the State. Examples include the failure of an Offeror to: return the number of signed proposals required by the request for proposals; sign the proposal, but only if the unsigned proposal is accompanied by other material indicating the Offeror's intent to be bound; or to acknowledge receipt of amendment to the request for proposal, but only if it is clear from the proposal that the Offeror received the amendment and intended to be bound by its terms; or the amendment involved had no effect on price, quality or quantity.

SECTION FOUR

EVALUATION CRITERIA

Evaluation criteria and the associated points are listed below. The award will be made to the responsible Offeror whose proposal is determined to be the most advantageous to the State based on the evaluation criteria listed in this section. Please see noted attachments for further instructions.

The total number of points used to score this contract is 100.

- 1) Qualifications and experience (25)
See Attachment 6
- 2) Technical approach (25)
See Attachment 7
- 3) Cost proposal (50)
See Attachment 2

SECTION FIVE

CONTRACTOR SELECTION AND CONTRACT AWARD

5.1 EVALUATION OF PROPOSALS

The Procurement Officer, or an evaluation committee of at least three (3) qualified State employees selected by the Procurement Officer, shall evaluate proposals. The evaluation will be based solely on the evaluation criteria set out in Section Four of this RFP.

Prior to holding any discussion, a priority list shall be generated consisting of offerors determined to be acceptable or potentially acceptable. However, proposals may be accepted without such discussions.

If numerous acceptable and potentially acceptable proposals are submitted, the evaluation committee may limit the priority list to the three highest ranked, responsible Offerors. The priority listed offerors may be afforded the opportunity to submit Best and Final Offers (BAFO). If Best and Final Offers are not requested, or are not submitted, the previous submittals will be construed as the Best and Final Offers. After the Best and Final Offers are received, final evaluations will be conducted.

5.2 DISCUSSION WITH PRIORITY LISTED OFFERORS

The State may invite priority listed Offerors to discuss their proposals to ensure thorough, mutual understanding. The State in its sole discretion shall schedule the time and location for these discussions, generally within the timeframe indicated in *RFP Schedule and Significant Dates*. The State may also conduct discussions with priority listed Offerors to clarify issues regarding the proposals before requesting Best and Final Offers, if necessary.

5.3 AWARD OF CONTRACT

Method of Award. Award will be made to the responsible Offeror whose proposal is determined to be the most advantageous to the State based on the evaluation criteria set forth in the RFP. If award is made, the successful Offeror will be required to enter into a formal written contract with the State and shall be required to sign a business associate agreement (BAA). The RFP, the Offeror's accepted proposal, and the executed contract comprise the contract. A copy of the contract form and applicable general conditions can be found in Exhibit A. A copy of the business associate agreement can be found in Exhibit B. The RFP and the successful proposal will be incorporated in the resulting contract by reference; to the extent that they conflict, the terms of the RFP shall govern, unless otherwise agreed upon by EUTF in the contract.

5.4 RESPONSIBILITY OF OFFERORS

Offeror is advised that in order to be awarded a contract under this solicitation, Offeror will be required, to be compliant with all laws governing entities doing business in the State including the following chapters and pursuant to Section 103D-310(c), HRS:

1. Chapter 237, HRS General Excise Tax Law;
2. Chapter 383, HRS Hawaii Employment Security Law;
3. Chapter 386, HRS Worker's Compensation Law;
4. Chapter 392, HRS Temporary Disability Insurance;
5. Chapter 393, HRS Prepaid Health Care Act; and
6. Section 103D-310(c), HRS Certificate of Good Standing (COGS) for entities doing business in the State.

The State will verify compliance on Hawaii Compliance Express (HCE).

Hawaii Compliance Express. 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.

Vendors/contractors/service providers should register with (HCE) 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 required for the execution of contract and final payment.

Timely Registration on HCE. Vendors/contractors/service providers are advised to register on HCE soon as possible. If a vendor/contractor/service provider is not compliant on HCE at the time of award, an Offeror will not receive the award.

A BAA must be signed by the Offeror. See Exhibit B.

5.5 PROPOSAL AS PART OF THE CONTRACT

This RFP and all or part of the successful proposal will be incorporated into the contract by reference.

5.6 PUBLIC EXAMINATION OF PROPOSALS

Except for confidential portions, the proposals shall be made available for public inspection upon posting of award pursuant to Section 103D-701, HRS.

If a person is denied access to a State procurement record, the person may appeal the denial to the office of information practices in accordance with Section 92F-42(12), HRS.

5.7 DEBRIEFING

Pursuant to Section 3-122-60, HAR, a non-selected Offeror may request a debriefing to understand the basis for award.

A written request for debriefing shall be made within three (3) working days after the posting of the award of the contract. The Procurement Officer or designee shall hold the debriefing within seven (7) working days to the extent practicable from the receipt date of written request.

Any protest by the requestor following a debriefing, shall be filed within five (5) working days, as specified in Section 103D-303(h), HRS.

5.8 PROTEST PROCEDURES

Pursuant to Section 103D-70, HRS and Section 3-126-3 HAR, an actual or prospective Offeror who is aggrieved in connection with the solicitation or award of a contract may submit a protest. Any protest shall be submitted in writing to the Procurement Officer at:

Sandra Yahiro
201 Merchant St., Suite 1520
Honolulu, HI 96813

A protest shall be submitted in writing within five (5) working days after the aggrieved person knows or should have known of the facts giving rise thereto; provided that a protest based upon the content of the solicitation shall be submitted in writing prior to the date set for receipt of offers. Further provided that a protest of an award or proposed award shall be submitted within five (5) working days after the posting of award or if requested, within five (5) working days after the PO's debriefing was completed.

The notice of award, if any, resulting from this solicitation shall be posted on the Procurement Awards, Notices and Solicitations (PANS), which is available on the SPO website: <http://www.hawaii.gov/spo2/source/>.

5.9 APPROVALS

Any agreement arising out of this offer may be subject to the approval of the Department of the Attorney General, and to all further approvals, including the approval of the Governor, as required by statute, regulation, rule, order, or other directive.

5.10 CONTRACT EXECUTION

Successful Offeror receiving award shall enter into a formal written contract in the form as in Exhibit A. Upon selection and award of the contract(s), EUTF will send the formal contract(s) to the successful Offeror for signature. The contract shall be signed by the successful Offeror and returned with any required documents, within 7 calendar days after receipt by the Offeror or within such time as EUTF may allow. Failure to keep this deadline may result in a cancellation of the award and contract. EUTF reserves the right to cancel any contract, and request new proposals or negotiate with remaining Offerors, if EUTF is not satisfied with the awarded contractor's performance.

No work is to be undertaken by the Contractor prior to the effective date of contract. The State of Hawaii is not liable for any work, contract costs, expenses, loss of profits, or any damages whatsoever incurred by the Contractor prior to the official starting date.

If an option to extend is mutually agreed upon, the Contractor shall be required to execute a supplement to the contract for the additional extension period.

5.11 INSURANCE

5.11.1 Prior to the contract start date, the Contractor shall procure at its sole expense and maintain insurance coverage acceptable to the State in full force and effect

throughout the term of the Contract. The Offeror shall provide proof of insurance for the following minimum insurance coverage(s) and limit(s) in order to be awarded a contract. The type of insurance coverage is listed as follows:

1. Commercial General Liability Insurance

Commercial general liability insurance coverage against claims for bodily injury and property damage arising out of all operations, activities or contractual liability by the Contractor, its employees and subcontractors during the term of the Contract. This insurance shall include the following coverage and limits specified or required by any applicable law: bodily injury and property damage coverage with a minimum of \$1,000,000 per occurrence; personal and advertising injury of \$1,000,000 per occurrence; broadcasters' liability insurance of \$1,000,000 per occurrence; and with an aggregated limit of \$2,000,000. The commercial general liability policy shall be written on an occurrence basis and the policy shall provide legal defense costs and expenses in addition to the limits of liability stated above. The Contractor shall be responsible for payment of any deductible applicable to this policy.

2. Automobile Liability Insurance

Automobile liability insurance covering owned, non-owned, leased, and hired vehicles with a minimum of \$1,000,000 for bodily injury for each person, \$1,000,000 for bodily injury for each accident, and \$1,000,000 for property damage for each accident.

3. Professional Liability (Errors and Omissions) Insurance

Professionals Liability Insurance covering all activities under the contract with a minimum of \$1,000,000 per claim and with an aggregated limit of \$2,000,000.

4. Appropriate levels of per occurrence insurance coverage for workers' compensation and any other insurance coverage required by Federal or State law.

5.11.2 The Contractor shall deposit with the EUTF, on or before the effective date of the Contract, certificate(s) of insurance necessary to satisfy the EUTF that the provisions of the Contract have been complied with, and to keep such insurance in effect and provide the certificate(s) of insurance to the EUTF during the entire term of the Contract. Upon request by the EUTF, the Contractor shall furnish a copy of the policy or policies.

5.11.3 The Contractor will immediately provide written notice to the SPO and contracting department or agency should any of the insurance policies evidenced on its Certificate of Insurance form be cancelled, limited in scope, or not renewed up expiration.

5.11.4 The certificates of insurance shall contain the following clauses:

1. "The State of Hawaii and the EUTF and its Board of Trustees, are added as additional insureds with respect to operations performed for the State of Hawaii."
2. "It is agreed that any insurance maintained by the State of Hawaii will apply in excess of, and not contribute with, insurance provided by this policy."

5.11.5. Failure of the Contractor to provide and keep in force such insurance shall constitute a material default under the Contract, entitling the State to exercise any or all of the remedies provided in the Contract (including without limitation terminating the Contract). The procuring of any required policy or policies of insurance shall not be construed to limit the Contractor's liability hereunder, or to fulfill the indemnification provisions of the Contract. Notwithstanding said policy or policies of insurance, the Contractor shall be responsible for the full and total amount of any damage, injury, or loss caused by the Contractor's negligence or neglect in the provision of services under the Contract.

5.12 PERFORMANCE BONDS

No performance or payment bond is required for this RFP.

5.13 PAYMENT

Contractor shall be paid upon delivery of draft actuarial valuation report (60%) and final actuarial valuation report (40%). Contractor shall submit invoices and payment will be made according to general terms and conditions.

5.14 CONTRACT INVALIDATION

If any provision of this contract is found to be invalid, such invalidation will not be construed to invalidate the entire contract.

SECTION SIX
SPECIAL PROVISIONS

6.1 OFFER GUARANTY

A proposal security deposit is NOT required for this RFP.

SECTION SEVEN

ATTACHMENTS AND EXHIBITS

- Attachment 1: OFFER FORM, OF-1
 - Attachment 2: OFFER FORM, OF-2
 - Attachment 3: REGISTRATION FORM
 - Attachment 4: CONFIDENTIAL INFORMATION
 - Attachment 5: EXCEPTIONS
 - Attachment 6: QUALIFICATIONS AND EXPERIENCE
 - Attachment 7: TECHNICAL APPROACH
 - Attachment 8: REFERENCE INFORMATION QUESTIONNAIRE
-
- Exhibit A: CONTRACT FORM and AG GENERAL CONDITIONS
 - Exhibit B: BUSINESS ASSOCIATE AGREEMENT
 - Exhibit C: PLAN DESCRIPTION
 - Exhibit D: CHAPTER 87A, HRS
 - Exhibit E: EUTF ADMINISTRATIVE RULES
 - Exhibit F: EUTF OPEB ACUTARIAL VALUATION STUDY
PREPARED BY AON HEWITT, JUNE 30, 2012
 - Exhibit G: ACT 268, SLH 2013

**OFFER FORM
OF-1**

Actuarial Services for Other Post Employment Benefits
STATE OF HAWAII
DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)
RFP-13-001

Procurement Officer
Department of Budget and Finance/EUTF
State of Hawaii
Honolulu, Hawaii 96813

Dear Procurement Officer:

The undersigned has carefully read and understands the terms and conditions specified in the Specifications and Special Provisions attached hereto, and in the General Conditions, by reference made a part hereof and available upon request; and hereby submits the following offer to perform the work specified herein, all in accordance with the true intent and meaning thereof. The undersigned further understands and agrees that by submitting this offer, 1) he/she is declaring his/her offer is not in violation of Chapter 84, Hawaii Revised Statutes, concerning prohibited State contracts, and 2) he/she is certifying that the price(s) submitted was (were) independently arrived at without collusion.

Offeror is:

- Sole Proprietor Partnership *Corporation Joint Venture
- Other _____
- *State of incorporation: _____

Hawaii General Excise Tax License I.D. No. _____

Federal I.D. No. _____

Payment address (other than street address below): _____
City, State, Zip Code: _____

Business address (street address): _____
City, State, Zip Code: _____

Respectfully submitted:

Date: _____

(x) _____
Authorized (Original) Signature

Telephone No.: _____

Name and Title (Please Type or Print)

Fax No.: _____

E-mail Address: _____

** _____
Exact Legal Name of Company (Offeror)

**If Offeror is a "dba" or a "division" of a corporation, furnish the exact legal name of the corporation under which the awarded contract will be executed:

**OFFER FORM
OF-2**

Total contract cost for accomplishing the development and delivery of the services.

July 1, 2013 Report	\$ _____
July 1, 2015 Report	\$ _____
Total cost	\$ _____

Optional extensions:

July 1, 2017 Report	\$ _____
July 1, 2019 Report	\$ _____
July 1, 2021 Report	\$ _____
Total cost	\$ _____

Hourly fee for providing "Additional Services" described in Section 2.2 D on page 9.

Contract ending June 30, 2016 \$ _____ per hour x 100 hours = _____

Optional extensions:

Contract ending June 30, 2018	\$ _____ per hour x 100 hours = _____
Contract ending June 30, 2020	\$ _____ per hour x 100 hours = _____
Contract ending June 30, 2022	\$ _____ per hour x 100 hours = _____

Cost of additional meetings described in Section 2.2 A5 on page 9. Include all expenses such as travel, hotel, etc.

Additional meeting (including expenses) \$ _____ per day x 3 days = _____

Note: Pricing shall include labor, materials, supplies, all applicable taxes, and any other costs incurred to provide the specified services.

Offeror _____
Name of Company

REGISTRATION FORM
RFP NO. 13-001
ACTUARIAL SERVICES FOR OTHER POST EMPLOYMENT BENEFITS

Email or fax this Registration Form by **August 5, 2013** to:

Ms. Sandra Yahiro
Hawaii Employer-Union Health Benefits Trust Fund
Telephone: (808) 586-7390
Fax: (808) 586-2320
Email: eutfadmin@hawaii.gov

Offeror Information	
Name of Company	
Mailing Address	
Name and Title of Contact Person	
Email Address	
Telephone Number	
Facsimile Number	

CONFIDENTIAL INFORMATION

List all information believed to be confidential and not to be disclosed to the public.
Identify the page numbers and sections in the proposal where the information is located.

EXCEPTIONS

Should Offeror take any exception to the terms, conditions, specifications, or other requirements listed in the RFP, Offeror shall list such exceptions in the space below. Offeror shall reference the RFP section where exception is taken, a description of the exception taken, and the proposed alternative, if any. The State reserves the right to accept or reject any request for exceptions.

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION A
--

OFFEROR NAME:	
----------------------	--

SECTION A — MANDATORY QUALIFICATIONS

The Offeror must address ALL Mandatory Qualifications section items and provide, in sequence, the information and documentation as required (referenced with the associated item references).

The Procurement Officer will review all general mandatory qualifications, including but not limited to the following:

- Proposal received on or before the Proposal Deadline.
- Offeror did NOT submit alternate proposals.
- Offeror did NOT submit multiple proposals in a different form.
- Technical Proposal does NOT contain any restrictions of the rights of the State or other qualification of the proposal.

The Procurement Officer will also review the proposal to determine if the Mandatory Requirement Items (below) are met and mark each with pass or fail. For each requirement that is not met, the Proposal Evaluation Team must review the proposal and attach a written determination.

NOTICE: In addition to these qualifications, the State will also evaluate compliance with ALL RFP qualifications.

Proposal Page # (to be completed by Offeror)	Mandatory Qualification Items	State Use ONLY
		Pass/Fail
	A.1 Provide the Offer Form OF-1 completed and signed, by an individual empowered to bind the Offeror to the provisions of this RFP and any resulting contract. <i>Each Offeror <u>must</u> sign the Offer Form OF-1 (Attachment 1).</i>	
	A.2 Provide a current written bank reference, in the form of a standard business letter, indicating that the Offeror's business relationship with the financial institution is in positive standing.	
	A.3 Provide three (3) <i>Reference Information Questionnaires</i> completed by three (3) separate References. See Attachment 8.	
	A.4 Provide a statement of whether the Offeror or any individual who shall perform work under the contract has a possible conflict of interest (e.g., employment by the State of Hawaii) and, if so, the nature of that conflict. <i>Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.</i>	
	A.5 Provide a statement of whether the Offeror is suspended, debarred, or proposed for debarment by the federal government or any state or local government.	

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION B**OFFEROR NAME:****SECTION B — QUALIFICATIONS & EXPERIENCE**

The Offeror must address ALL Qualifications and Experience section items and provide, in sequence, the information and documentation as required (referenced with the associated item references).

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the proposal's "qualifications and experience" responses.

Proposal Page # (to be completed by Offeror)	Qualifications & Experience Items
	B.1 Describe the Offeror's form of business (<i>i.e.</i> , individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the name, mailing address, and telephone number of the person the State should contact regarding the proposal.
	B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of the Offeror company within the last ten years, and if so, an explanation providing relevant details.
	B.3 Provide a statement of whether there is any pending litigation against the Offeror; and if such litigation exists, an attached opinion of counsel as to whether the pending litigation will impair the Offeror's performance in a contract under this RFP.
	B.4 Provide a statement of whether, in the last ten years, the Offeror has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors, and if so, an explanation providing relevant details.
	B.5 Provide a statement of whether there are any pending Securities Exchange Commission investigations involving the Offeror, and if such are pending or in progress, an explanation providing relevant details and an attached opinion of counsel as to whether the pending investigation(s) will impair the Offeror's performance in a contract under this RFP.
	B.6 Provide a brief, descriptive statement indicating the Offeror's credentials to deliver the services sought under this RFP.
	B.7 Briefly describe how long the Offeror has been performing the services required by this RFP and include the number of years in business.
	B.8 Describe the Offeror organization's number of employees, client base, and location of offices.
	B.9 Provide a narrative description of the proposed project team, its members, and organizational structure.

ATTACHMENT 6

	<p>B.10 Provide a personnel roster and resumes of key people who shall be assigned by the Offeror to perform duties or services under the contract (The roster shall include the estimated number of hours to be worked on the contract for each person. The resumes shall detail each individual's title, education, current position with the Offeror, and employment history) as well as an organizational chart highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrating the lines of authority and designate the individual responsible for the completion of each service component and deliverable of the RFP.</p> <p>Provide a summary presenting the number of years of experience the key people who shall be assigned have had in providing actuarial services concerning the funding of retirement benefits, the design and funding of health insurance benefits and/or the application of accounting standards to retirement or insurance plans each with at least 5,000 employee participants.</p>
	<p>B.11 Provide a statement of whether the Offeror intends to use subcontractors, and if so, the names and mailing addresses of the committed subcontractors and a description of the scope and portions of the work the subcontractors will perform.</p>
	<p>B.12 Provide three customer references for similar projects as well as a list, if any, of all current contracts with the State of Hawaii and all those completed within the previous five year period.</p> <p>The three customer references must meet the following criteria:</p> <ul style="list-style-type: none"> • Must have a minimum of 5,000 employees • Must maintain an array of employee and retiree benefits (e.g., health insurance benefit options, term life insurance, other optional coverage) • Services provided to the customer must have included completed actuarial studies <p>The references shall be provided to the State in the form of questionnaires that have been fully completed by the individual providing the reference. The State has included the reference check questionnaire to be used, as RFP Attachment 8. THE OFFEROR MUST USE THIS FORM, OR AN EXACT DUPLICATE THEREOF.</p> <p>The Offeror will be solely responsible for obtaining the fully completed reference check questionnaires, and for including them within the Offeror's sealed Proposal. In order to obtain and submit the completed reference check questionnaire, the Offeror shall follow the process detailed below exactly:</p> <ol style="list-style-type: none"> 1. Offeror makes an exact duplicate (paper or Word electronic document) of the State's form, as it appears in RFP Attachment 8; 2. Offeror sends the copy of the form to the reference it has chosen, along with a new, standard #10 envelope that is capable of being sealed; 3. Offeror directs the individual providing the reference check feedback to complete the form in its entirety, sign and date it, seal it with in the provided envelope. The individual may prepare a manual document or complete the exact duplicate Word document and print the completed copy for submission. After sealing the envelope, the individual providing the reference, <u>must sign his or her name in ink across the sealed portion of the envelope</u> and return it directly to the Offeror. The Offeror will give the reference check provider a deadline, such that the Offeror will be able to

collect all references in time to include them within its sealed Technical Proposal.

4. When the Offeror receives the sealed envelopes from the reference check providers, the Offeror will not open them. Instead, the Offeror will enclose all of the unopened reference check envelopes in an easily identifiable larger envelope, and will include this envelope as a part of the written Technical Proposal. Therefore, when the State opens the Technical Proposal box, the State will find a clearly labeled envelope enclosed, which contains all of the sealed reference check envelopes.
5. The State will base its reference check evaluation on the contents of these envelopes. THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.

Each completed questionnaire must include:

- Offeror's name;
- Organization name;
- Name, title, and telephone number of the organization contact knowledgeable about the project work;
- Date reference form was completed; and
- Responses to numbered items in RFP Attachment 8

The list of contracts with the State of Hawaii must include:

- The contract number;
- The contract term; and
- The procuring state agency for each reference.

Each evaluator will generally consider the results of reference inquiries by the State regarding all references provided (both state and non-state). Current or prior contracts with the State are not a prerequisite and are not required for the maximum evaluation score possible, and the existence of such contracts with the State will not automatically result in the addition or deduction of evaluation points.

(Maximum Section B Score = 25)

SCORE (for all Section B items above, B.1 through B.13):

ATTACHMENT 7

TECHNICAL PROPOSAL & EVALUATION GUIDE — SECTION C				
OFFEROR NAME:				
SECTION C — TECHNICAL APPROACH				
<p>The Offeror must address ALL Technical Approach section items and provide, in sequence, the information and documentation as required (referenced with the associated item references). A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the proposal's response to each item. Each evaluator will use the following whole number, raw point scale for scoring each item:</p> <p style="text-align: center;"><i>0 = little value 1 = poor 2 = fair 3 = satisfactory 4 = good 5 = excellent</i></p> <p>The RFP Coordinator will multiply each item score by the assigned weight with the product being the item's raw weighted score for purposes of calculating the section score as detailed at the end of this table.</p>				
Proposal Page # (to be completed by Offeror)	Technical Approach Items	State Use ONLY		
		Score	Item Weight	Raw Weighted Score
	C.1 Provide a narrative that illustrates the Offeror's understanding of the State's requirements and project schedule.		5	
	C.2 Provide a narrative that illustrates how the Offeror will complete the Scope of Services accomplish required objectives, and meet the State's project schedule.		15	
	C.3 <u>Actuarial Valuation and its Funding Impact</u> Describe how the Offeror will perform the actuarial valuation including: the calculation of the actuarial present value of total projected benefits, the annual required contribution (ARC), the annual OPEB cost, valuation forecasts, and funding impacts for the healthcare plan. For each step in the process, please describe in detail any expected tasks to be performed by the State and any documentation expected to be provided by the State, in addition to the tasks and data currently described in this RFP. Please include a description of the proposed work product resulting from completion of this study and submit a sample funding study. This sample may be a copy of the Offeror's previous work product done for another client or it may be the Offeror's conceptual sample study.		40	

ATTACHMENT 7

	<p>C.4 Provide a work plan for the completion of this set of projects including the identification of key issues, decision points, summary of major activities, a schedule indicating week by week completion of key activities, deliverables to be provided and staff and technical resources to be applied. Where reference can be made to specific staff members or positions identified elsewhere in the proposal, such reference should be contained in the response. If not mentioned previously, the experience of staff should be described.</p>		<p>40</p>	
<p>Total Raw Weighted Score: <i>(sum of Raw Weighted Scores above)</i></p>				
<p style="text-align: center;">Total Raw Weighted Score</p> <hr style="width: 40%; margin-left: 0;"/> <p>Maximum possible raw weighted score <i>(i.e., 5 x the sum of item weights above)</i></p>				

X 25

(maximum section score)

= SCORE:

STATE OF HAWAII
RFP NO. 13-001
ACTUARIAL SERVICES FOR OTHER POST EMPLOYMENT BENEFITS

REFERENCE INFORMATION QUESTIONNAIRE

Offeror's Name:

Dates Actuarial Services were rendered by Offeror:

From	To
<input type="text"/>	<input type="text"/>

Reference (Client Organization) Name:

Estimated number of eligible employees served by your pension or retiree benefit programs:

Individual Responding to This
Request for Reference Information:

Printed Name

Signature (MUST BE THE SAME AS THE SIGNATURE ACROSS THE
ENVELOPE SEAL)

Individual's Title:

Individual's Telephone Number:

Date Reference Form Was Completed:

NOTE: Reference should complete responses to the seven items that appear on the following pages. If completed using a Word document, use as much space as required. If completed manually, record response in space provided.

1. Describe the services provided by the Vendor to your organization beginning with valuations of other post-employment benefits (OPEB).

Please respond to the remaining questions (#2-7) by rating the OPEB valuation work separately from other actuarial services provided by the Vendor.

2. Please rate your overall satisfaction with the Offeror on a scale of 1 to 5, with 1 being "least satisfied" and 5 being "most satisfied."

3. If you answered 3 or less to the previous question, what could the Offeror have done to improve their rating?

4. Please indicate your level of satisfaction with the Offeror's project management structures, processes, and personnel? Use a scale of 1 to 5; with 1 being "least satisfied," and 5 being "most satisfied."

5. Rate your level of satisfaction with the Offeror's line-level staff (e.g. business and analyst staff). Use a scale of 1 to 5; with 1 being "least satisfied" and 5 being "most satisfied."

6. As far as you know, has the Offeror remained (or did the Offeror remain) in compliance with the contract throughout their provision of services to your organization? If not, please explain.

7. Would you use the services of the Offeror again? Indicate on a scale of 1 to 5: with 1 being "absolutely not" and 5 being "absolutely yes."



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
State of Hawaii ("STATE"), by its
(hereafter also referred to as the HEAD OF THE PURCHASING AGENCY or designee ("HOPA")),
whose address is
and
("CONTRACTOR"), a
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 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

(Name of Contractor)

(Signature)

(Print Name)

(Print Title)

(Date)

CORPORATE SEAL
(If available)

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.

(Notary Stamp or Seal)

(Signature)

(Print Name)

Notary Public, State of _____

My commission expires: _____

Doc. Date: _____ # Pages: _____

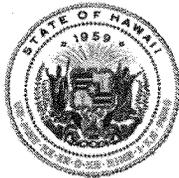
Notary Name: _____ Circuit _____

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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GENERAL CONDITIONS

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 section 103D-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. CPO 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 or ten per cent (10%) of the initial contract price, whichever increase is higher, must receive the prior approval of the CPO.
- 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 Acting Administrator, whose address is 201 Merchant Street, Suite 1520, 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 Protection 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 8 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.

HAWAI‘I EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (“STATE”)

By _____
Its Acting Administrator

Date: _____, 2013

[*name of business associate*]
 (“BUSINESS ASSOCIATE”)

By _____
Its _____

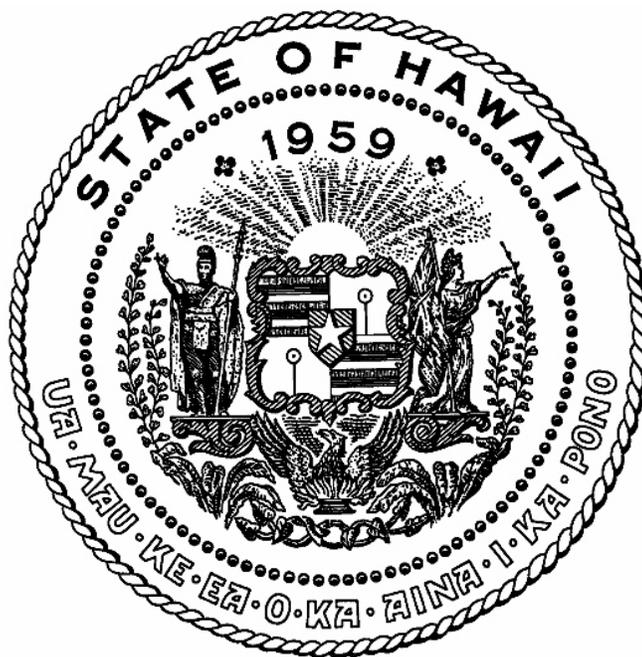
Date: _____, 2013

APPROVED AS TO FORM:

Deputy Attorney General

Hawaii Employer-Union Health Benefits Trust Fund

REFERENCE GUIDE (EUTF and HSTA VB)



FOR ACTIVE EMPLOYEE BENEFIT PLANS *Effective July 1, 2013 through June 30, 2014*

Disclaimer: This Reference Guide offers general information on your health and other benefits plans. Your health benefits are exclusively governed by Hawaii Statutes and the EUTF Administrative Rules, as they are amended from time to time. Nothing in this Guide is intended to amend, change, or contradict the Hawaii Statutes and the EUTF Administrative Rules. This Guide is not a legal document or contract and the information in the Guide is not intended as legal advice or to create any legal or contractual liabilities.

Welcome to Open Enrollment for EUTF Active Employee Benefit Plans

The Open Enrollment period for EUTF Active Employee Health and Life insurance plans will be from April 15, 2013 through May 10, 2013.

Why is Open Enrollment special?

Now is the time when you can 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 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

Open enrollment is your only opportunity to make these 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 July 1, 2013. So, now is the time to think about health benefits.

Here are the important dates:

- **Open Enrollment Election Period:** April 15, 2013 through May 10, 2013
- New coverage becomes effective: July 1, 2013
- Rates change effective: July 1, 2013
- Plan Period: July 1, 2013 through June 30, 2014

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?
- **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 3 for complete enrollment instructions.

IF YOU DON'T WANT TO MAKE ANY CHANGES, DO NOTHING. If you don't fill out a form, your current plan selections and covered dependents will continue into the new plan year. If you are currently enrolled in the HMSA HDHP plan or the Kaiser Basic plan, please refer to page 3.

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 assistance.

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Plan Administrator Changes

EUTF Medical Plans

Effective July 1, 2013 for Actives: The EUTF High Deductible Health Plan (HDHP) – HMSA will be replaced by the EUTF 75/25 PPO Plan – HMSA with CVS Caremark as the administrator for prescription drugs. The EUTF Kaiser Basic HMO Plan will also be replaced by the EUTF Kaiser Standard HMO Plan. If you do nothing during Open Enrollment, you will automatically be enrolled in the plans listed below. You have the option to enroll in a new plan by submitting the Form EC-1.

	What if:	Then:
Current Benefit Plan		Your Plan Effective July 1, 2013
EUTF HDHP – HMSA Medical and HMSA Prescription Drug	I do nothing.	EUTF 75/25 PPO – HMSA Medical and CVS Caremark Prescription Drug
EUTF Kaiser Basic HMO Medical and Prescription Drug	I do nothing.	EUTF Kaiser Standard HMO Medical and Prescription Drug

There are no changes to the HSTA VB plans. HSTA VB refers to plans created for HSTA members who were previously enrolled in the HSTA VEBA plans.

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

During Open Enrollment, all active employees are invited to explore healthcare 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 plan:	CVS Caremark & Kaiser
Supplemental Medical & Drug Plans:	HMSA & Royal State National
Dental plan:	HDS
Vision plan:	VSP
Life insurance:	Royal State National
Chiropractic plan:	Royal State National

If you are not sure which plan you're enrolled in now, refer to the carrier websites or call the carrier customer service numbers which are on your ID cards. There are also links to carrier websites on the EUTF website eutf.hawaii.gov.

- 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 includes links to insurance carriers' web pages along with the latest information regarding the open enrollment. Questions regarding specific provisions such as are certain services covered should be directed to the carriers. Please refer to page 59 for contact information. The Summary of Benefits and Coverage for the various plans can be found at EUTF's website at eutf.hawaii.gov.
- Step 4: How much will it cost you?** Review the rates on pages 6-8 which show the total cost. At the time of printing, no new agreements have been reached between the employers and unions in regards to dividing the costs of EUTF benefits. The most current cost sharing information between the employer and employee can be obtained from your union representative or your personnel office.
- Step 5: Who do you need to cover?** You can add or drop dependents to your plan, including a spouse, domestic partner (DP), civil union partner (CUP) or eligible children. Adding a domestic or civil union partner requires additional documentation. Please contact the EUTF to obtain the appropriate forms or go to the EUTF website, eutf.hawaii.gov, to download those forms. Refer to the Employee – Dependent Eligibility section of this Guide for details on who can be enrolled as an eligible dependent.
- Step 6: Complete the Enrollment Form: Make your selections on the Form EC-1 for Active Employees, or EC-1H for those eligible for HSTA VB plans. Please refer to pages 50-57 for a copy or these forms can be downloaded from the EUTF website, eutf.hawaii.gov.**

A: To make changes to your personal information, such as your address, complete Section 1 on the Form EC-1 or 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 or 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 at the initial enrollment (except newborns).

C: Employees who are 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.

NOTE: Fill out all sections of the form, not just the information that is changing.

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, unless you experience a qualifying event.

Last Step: Submit the completed and signed form to your identified open enrollment designee no later than May 10, 2013.

The designee may be your office secretary, financial officer, human resources personnel—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 MAY 10, 2013 WILL BE REJECTED.

The EUTF will send you an enrollment **confirmation notice** after processing is completed. The confirmation notice allows you to ensure that the changes you submitted were entered correctly. If you note an error, notify the EUTF immediately. **However, after May 10, 2013 we can only make changes if there is an error in our processing. We cannot change the selections you made on the original form submitted.**

IMPORTANT: If any of your dependents are no longer eligible due to a divorce, reaching maximum child age or losing full-time student status, 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.

Note: The Open Enrollment period for COBRA participants is also taking place during this time. Please refer to the EUTF website for information.

Monthly Premiums - EUTF Plans

**ALL BU'S EXCEPT BU12
HSTA VEBA ACTIVE EMPLOYEES WHO OPT TO TRANSFER TO EUTF PLANS (BU 05,45)
BU 05, 45 EMPLOYEES HIRED ON OR AFTER JANUARY 1, 2011
EFFECTIVE JULY 1, 2013 THROUGH JUNE 30, 2014**

Benefit Plan	Type of Enrollment	Premium	Admin Fee	Total Contribution Required
MEDICAL PLANS				
PPO – 90/10 Plan – HMSA Medical RSN Chiropractic	Self	\$376.37	\$2.15	\$378.52
	Two-Party	\$913.01	\$4.51	\$917.52
	Family	\$1,163.73	\$6.55	\$1,170.28
PPO – 80/20 Plan – HMSA Medical RSN Chiropractic	Self	\$345.19	\$2.13	\$347.32
	Two-Party	\$837.33	\$4.51	\$841.84
	Family	\$1,067.25	\$6.55	\$1,073.80
PPO – 75/25 Plan – HMSA Medical RSN Chiropractic	Self	\$308.75	\$2.13	\$310.88
	Two-Party	\$748.87	\$4.49	\$753.36
	Family	\$954.43	\$6.57	\$961.00
EUTF Prescription Drug – CVS Caremark	Self	\$70.37	\$0.63	\$71.00
	Two-Party	\$170.97	\$1.27	\$172.24
	Family	\$217.85	\$1.87	\$219.72
HMO – HMSA Medical Prescription Drug – CVS Caremark RSN Chiropractic	Self	\$488.94	\$2.74	\$491.68
	Two-Party	\$1,186.46	\$5.78	\$1,192.24
	Family	\$1,512.30	\$8.42	\$1,520.72
HMO – Kaiser Comprehensive Medical Kaiser Prescription Drug RSN Chiropractic	Self	\$465.97	\$2.75	\$468.72
	Two-Party	\$1,131.67	\$5.77	\$1,137.44
	Family	\$1,443.07	\$8.45	\$1,451.52
HMO – Kaiser Standard Medical Kaiser Prescription Drug RSN Chiropractic	Self	\$325.29	\$2.75	\$328.04
	Two-Party	\$789.79	\$5.77	\$795.56
	Family	\$1,006.95	\$8.45	\$1,015.40
Supplemental – HMSA Medical HMSA Supplemental Prescription Drug RSN Chiropractic	Self	\$225.49	\$2.75	\$228.24
	Two-Party	\$546.99	\$5.77	\$552.76
	Family	\$696.83	\$8.45	\$705.28
Supplemental – Royal State National Supplemental Prescription Drug RSN Chiropractic	Self	\$41.48	\$2.76	\$44.24
	Two-Party	\$103.04	\$5.76	\$108.80
	Family	\$114.54	\$8.42	\$122.96
DENTAL PLAN				
HDS Dental	Self	\$30.28	\$0.32	\$30.60
	Two-Party	\$60.56	\$0.64	\$61.20
	Family	\$99.64	\$0.96	\$100.60
VISION PLAN				
VSP Vision	Self	\$5.96	\$0.08	\$6.04
	Two-Party	\$11.04	\$0.12	\$11.16
	Family	\$14.42	\$0.18	\$14.60
LIFE INSURANCE*				
Royal State National Life Insurance	Employee	\$4.12	\$0.04	\$4.16

*Employer paid

Monthly Premiums - EUTF Plans

BU12
EFFECTIVE JULY 1, 2013 THROUGH JUNE 30, 2014

Benefit Plan	Type of Enrollment	Premium	Admin Fee	Total Contribution Required
MEDICAL PLANS				
PPO – 90/10 Plan – HMSA Medical RSN Chiropractic	Self	\$313.03	\$2.13	\$315.16
	Two-Party	\$781.95	\$4.49	\$786.44
	Family	\$1,013.05	\$6.55	\$1,019.60
PPO – 80/20 Plan – HMSA Medical RSN Chiropractic	Self	\$287.39	\$2.13	\$289.52
	Two-Party	\$717.81	\$4.51	\$722.32
	Family	\$929.89	\$6.55	\$936.44
PPO – 75/25 Plan – HMSA Medical RSN Chiropractic	Self	\$257.07	\$2.13	\$259.20
	Two-Party	\$642.01	\$4.51	\$646.52
	Family	\$831.63	\$6.57	\$838.20
EUTF Prescription Drug – CVS Caremark	Self	\$51.34	\$0.62	\$51.96
	Two-Party	\$128.53	\$1.27	\$129.80
	Family	\$166.49	\$1.87	\$168.36
HMO – HMSA Medical Prescription Drug – CVS Caremark RSN Chiropractic	Self	\$407.19	\$2.77	\$409.96
	Two-Party	\$1,017.86	\$5.78	\$1,023.64
	Family	\$1,318.84	\$8.44	\$1,327.28
HMO – Kaiser Comprehensive Medical Kaiser Prescription Drug RSN Chiropractic	Self	\$399.45	\$2.75	\$402.20
	Two-Party	\$997.95	\$5.77	\$1,003.72
	Family	\$1,292.71	\$8.45	\$1,301.16
HMO – Kaiser Standard Medical Kaiser Prescription Drug RSN Chiropractic	Self	\$270.37	\$2.75	\$273.12
	Two-Party	\$675.19	\$5.77	\$680.96
	Family	\$874.39	\$8.45	\$882.84
Supplemental – HMSA Medical HMSA Supplemental Prescription Drug RSN Chiropractic	Self	\$178.31	\$2.77	\$181.08
	Two-Party	\$447.81	\$5.79	\$453.60
	Family	\$587.63	\$8.45	\$596.08
Supplemental – Royal State National Supplemental Prescription Drug RSN Chiropractic	Self	\$41.48	\$2.76	\$44.24
	Two-Party	\$103.04	\$5.76	\$108.80
	Family	\$114.54	\$8.42	\$122.96
DENTAL PLAN				
HDS Dental	Self	\$30.28	\$0.32	\$30.60
	Two-Party	\$60.56	\$0.64	\$61.20
	Family	\$99.64	\$0.96	\$100.60
VISION PLAN				
VSP Vision	Self	\$5.96	\$0.08	\$6.04
	Two-Party	\$11.04	\$0.12	\$11.16
	Family	\$14.42	\$0.18	\$14.60
LIFE INSURANCE*				
Royal State National Life Insurance	Employee	\$4.12	\$0.04	\$4.16

*Employer paid

Monthly Premiums - HSTA VB Plans

BU 05, 45 FORMERLY UNDER THE HSTA VEBA HSTA VB RATES EFFECTIVE JULY 1, 2013 THROUGH JUNE 30, 2014

Benefit Plan	Type of Enrollment	Premium	Admin Fee	Total Contribution Required
MEDICAL PLANS				
HSTA VB - PPO - 90/10 Plan - HMSA Medical, CVS Drug, RSN Chiropractic, VSP Vision	Self	\$479.79	\$2.81	\$482.60
	Two-Party	\$1,160.53	\$5.91	\$1,166.44
	Family	\$1,479.65	\$8.63	\$1,488.28
HSTA VB - PPO - 80/20 Plan - HMSA Medical, CVS Drug, RSN Chiropractic, VSP Vision	Self	\$351.41	\$2.83	\$354.24
	Two-Party	\$849.01	\$5.91	\$854.92
	Family	\$1,082.33	\$8.63	\$1,090.96
HSTA VB - HMO - Kaiser Comprehensive Medical, Drug, RSN Chiropractic, VSP Vision	Self	\$415.85	\$2.83	\$418.68
	Two-Party	\$1,006.51	\$5.89	\$1,012.40
	Family	\$1,283.77	\$8.63	\$1,292.40
HSTA VB - Supplemental - HMSA Supplemental Medical, Drug, Vision RSN Chiropractic	Self	\$300.37	\$2.83	\$303.20
	Two-Party	\$725.97	\$5.91	\$731.88
	Family	\$925.63	\$8.61	\$934.24
DENTAL PLAN				
HSTA VB - HDS Dental	Self	\$30.28	\$0.32	\$30.60
	Two-Party	\$60.56	\$0.64	\$61.20
	Family	\$99.64	\$0.96	\$100.60
HSTA VB - HDS Supplemental Dental *	Self	\$16.08	\$0.32	\$16.40
	Two-Party	\$32.16	\$0.64	\$32.80
	Family	\$48.24	\$0.96	\$49.20
VISION PLAN				
HSTA VB - VSP Vision	Self	\$5.96	\$0.08	\$6.04
	Two-Party	\$11.04	\$0.12	\$11.16
	Family	\$14.42	\$0.18	\$14.60
LIFE INSURANCE**				
HSTA VB - Royal State National Life Insurance	Employee	\$4.12	\$0.04	\$4.16

*Rates may increase up to 5% effective July 1, 2013

**Employer paid

Schedule of Open Enrollment Informational Sessions for Active Employees

Date	Location	Room	Time
Apr 15	Honolulu	Neal S. Blaisdell Center ✧	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 16	Honolulu	Aloha Stadium Hospitality Room	8:30a-10a, 10:30a- 2p, 1p-2:30p, 3p-4:30p
Apr 17	Molokai	Mitchell Pauole Community Center	1p-2:30p, 3p-4:30p
Apr 18	Honolulu	Mission Memorial Auditorium	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 19	University of Hawai'i West O'ahu	University of Hawai'i – West O'ahu College	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 22	Kona	Old Kona Airport	10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 23	Honolulu	Mission Memorial Auditorium	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 24	Honolulu	Mission Memorial Auditorium	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 25	Hilo	Aunty Sally's Lu'au Hale	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 26	Windward	Windward Community College	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 29	Hilo	Aunty Sally's Lu'au Hale	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
Apr 30	Pearl City	Leeward Community College	*8:30a-10a, *10:30a-12p, 1p-2:30p, 3p-4:30p
May 1	Kauai	War Memorial Convention Center	10:30a-12p, 1p-2:30p, 3p-4:30p
May 2	Kapolei	Kapolei Hale Conference Rooms A, B & C	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
May 3	University of Hawai'i at Manoa	UH Kuykendall Auditorium	8:30a-10a, 10:30a-12p, 1p-2:30p, 3p-4:30p
May 6	Kauai	War Memorial Convention Center	10:30a-12p, 1p-2:30p, 3p-4:30p
May 7	Maui	War Memorial Gymnasium	10:30a-12p, 1p-2:30p, 3p-4:30p
May 8	Maui	War Memorial Gymnasium	10:30a-12p, 1p-2:30p, 3p-4:30p

Informational Session presentation to start promptly at the designated start time.

Informational Session Locations

HAWAII - KONA	Old Kona Airport 75-5530 Kuakini Highway Kailua-Kona, HI 96740	HAWAII - HILO	Aunty Sally's Lu'au Hale 799 Piilani Street Hilo, HI 96720
KAUAI	War Memorial Convention Center 4191 Hardy Street Lihue, HI 96766	MOLOKAI	Mitchell Pauole Community Center 90 Ainoa Street Kaunakakai, HI 96748
MAUI	War Memorial Gymnasium 700 Halia Nakoia Street Wailuku, HI 96793		
OAHU	Neal S. Blaisdell Center Pikake Room 777 Ward Avenue Honolulu, HI 96814 ✧ Parking is at your own expense	Aloha Stadium Hospitality Room 99-500 Salt Lake Boulevard Honolulu, HI 96818	Kapolei Hale Conference Rooms A, B & C 1000 Uluohia Street Kapolei, HI 96707
	Leeward Community College * General Technology Room 105 96-045 Ala Ike Street Pearl City, HI 96782	Leeward Community College Theatre 96-045 Ala Ike Street Pearl City, HI 96782	
	Mission Memorial Auditorium 550 South King Street Honolulu, HI 96813	Windward Community College Hale Kuhina Room 115 45-720 Kea'ahala Road Kaneohe, HI 96734	
	University of Hawai'i at Manoa Kuykendall Auditorium 2445 Campus Road Honolulu, HI 96822	University of Hawai'i - West O'ahu College UHWO Campus Center - C208 Multi-Purpose Ballroom 91-1001 Farrington Highway Kapolei, HI 96707	

Employee and Dependent Eligibility

Eligibility for coverage is determined by Hawaii Statute and by the 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. If you have any questions concerning eligibility provisions, you should refer to the Administrative Rules posted on the EUTF website, eutf.hawaii.gov. You can also call the EUTF Customer Service Call Center 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
- ▶ The unmarried child of an employee killed in the performance of duty, provided the child is under age 19 and has no surviving parent

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)
- ▶ Your or your spouse's or DP/CUP's children under the age of 26 (for medical and prescription drug coverage). This includes children by birth, marriage, or adoption or legal guardianship to age 18. For dental and vision coverage dependent children are covered to age 19 and from age 19 to 24 if they are unmarried and full time students
- ▶ 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
- ▶ Child covered by terms of a qualified medical child support order (QMCSO)

Group Life Insurance

Employees are eligible for the group life insurance plan offered by the EUTF.

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. 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: 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 Income Tax consequences with employer paid coverage for domestic or civil union partners: If your domestic or civil union partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic or 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, eutf.hawaii.gov) to the EUTF.

Enrollment

To enroll, you must complete an EUTF Enrollment Form for Active Employees (EC-1 or EC-1H) (see pages 50-57). If you do not enroll eligible members of your family within 30 days 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, Kaiser and CVS Caremark issue an ID card for each enrolled member of a family upon initial enrollment.
- ▶ HDS will issue two identical ID cards showing the name of the subscriber.
- ▶ VSP and RSN do not issue ID cards.

Dual Family Enrollment (Two EUTF Employees Family Enrollments) Is Not Allowed

If both you and your spouse, domestic partner or civil union partner are employee-beneficiaries, only one of you may enroll in an EUTF Family plan; or if no other dependents are involved, both may enroll in EUTF Self plans. Dual enrollment in EUTF family plans is not allowed under EUTF Administrative Rule 4.03. If your spouse or domestic partner or civil union partner has coverage outside of the EUTF that provides a family coverage through another employer, this rule does not preclude you from also enrolling in a family coverage plan to cover your spouse, domestic partner or civil union partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

Medicare Part B Premium Reimbursement

Retirees and their spouses, domestic partners or civil union partners who are enrolled in an EUTF RETIREE medical plan are eligible for Medicare Part B premium reimbursements. If you are enrolled in an EUTF active employee medical plan, you are not eligible for Medicare Part B reimbursement. However, if you are an active employee, enrolled in Medicare Part B and covered by the EUTF retiree medical plan through your spouse/DP/CUP, your spouse/DP/CUP is entitled to Medicare Part B reimbursement for you.

Change of Coverage – Special Enrollment Period due to a Qualifying Event

You are eligible to change coverage outside the Open Enrollment period for the following reasons:

1. You marry and want to enroll your spouse and/or newly eligible dependent children.
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.

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).
4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
5. You move out of your plan's service area.

To change your coverage, you should complete Form EC-1 or EC-1H and submit it through your employer representative within 30 days of the date of the change. Generally, deletion of dependents is effective on a prospective basis, depending upon receipt of the application by the EUTF. Dependent children are automatically terminated from the medical and prescription drug plans as of the end of the pay period they attain age 26 and do not require the completion of an application to delete coverage. For dental and vision, coverage for the dependent terminates at the age of 24 if the dependent is a full time student or 19 if not, or after an application has been submitted to delete coverage for the dependent. 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, Placement for Adoption (if sooner), Birth, Guardianship, New 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 on page 16.

End of Coverage

Common situations resulting in loss of coverage for you and your dependents are:

1. You voluntarily terminate coverage.
2. You do not make required premium payments (if applicable).
3. You die, subject to exceptions.
4. You fail to comply with the EUTF Administrative Rules.
5. You file fraudulent claims.

Coverage for your children, step-children, or spouse / DP / CUP will end if:

1. Your dependent is no longer eligible for coverage such as due to a divorce or legal separation with respect to step-children or your child reaches the limiting age.
2. Your surviving spouse, domestic or civil union partner remarries.

Effective Dates of Coverage for New Hires and Newly Eligible

You have a choice of when you would like your coverage to begin. You may choose either your date of hire or the first day of the first pay period from your date of hire or the first day of the second pay period from your date of hire. This rule also applies to some mid-year changes. If you become newly eligible (i.e., part time to full time employee), your effective date of coverage will be the date the change in employment status occurs.

Although your coverage begins on the date you select, 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 employer (COBRA coverage excluded), your coverage begins immediately - so you have no break in coverage. (See Transfer of Employment on page 13.)

Transfer of Employment

If you transfer from one EUTF employer to another, including transfers within State and/or County employment, coverage will be continued provided that you are still covered by the EUTF (COBRA coverage excluded) when you begin in your new position.

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. You may obtain additional information by referring to the EUTF Administrative Rules that are posted on the EUTF website, 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 rules (see Common Qualifying Events on page 16);
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) - 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>.

By electing to participate in the Premium Conversion Plan (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 (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). So 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 still 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.

Administrative Appeals

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 thirty days of the date of the 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 thirty-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 ninety 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. 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 a reasonable amount of time. 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, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

Keep this to refer to throughout the year.

Common Qualifying Events That Allow Enrollment Changes For Active Employees

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H	EFFECTIVE DATE	CAN I CHANGE PLANS (such as HMSA to Kaiser or HMSA 90/10 to 80/20)?
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	None	If coverage is gained 1 st of month, EUTF coverage ends day before 1 st . If coverage is gained 16 th of month, EUTF coverage ends 15 th	N/A
Birth (employee wishes to add newborn to EUTF plans)	Within 30 days from date of birth	Birth certificate only if child has a different last name from employee. Social Security Number within 60 days of date of birth	Employee can choose: birth date, beginning of next pay period after birth date, or 2nd pay period after birth 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
Death	As soon as reasonably practical	Death certificate or copy of obituary as soon as available	Date of death	N/A
Divorce (employee must terminate spouse's or civil union partner's coverage)	Within 30 days of 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
Guardianship (employee wishes to add child to EUTF plans)	Within 30 days from date of guardianship	Guardianship decree	Employee can choose: guardianship date, beginning of next pay period after guardianship date, or 2nd pay period after guardianship date	No

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H	EFFECTIVE DATE	CAN I CHANGE PLANS (such as HMSA to Kaiser or HMSA 90/10 to 80/20)?
Legal Separation (employee must terminate spouse's EUTF coverage)	Within 30 days from date of legal separation	Court document establishing legal separation, including any pages regarding health benefits to children	Coverage ends last day of pay period of date of legal separation	No
Leave of Absence Without Pay (employee may 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 (available on EUTF's website)	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, wishes to enroll in EUTF plans, and is currently enrolled in an EUTF plan)	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	Day following loss of coverage from other plan	N/A
Marriage (employee wishes to enroll new spouse in EUTF plans)	Within 30 days from date of marriage (effective date is date personnel office receives EC-1/EC-1H. If notification submitted prior to marriage, effective date is date of marriage)	None	Employee can choose: Date form turned into personnel, beginning of next pay period after turning in form to personnel or 2nd pay period after turning form into personnel	No
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 and 24)	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 (for dental and vision coverage). Transcripts not acceptable	Employee can choose: Date child becomes full time student, beginning of next pay period after becoming full time student, or 2nd pay period after becoming full time student	No

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H	EFFECTIVE DATE	CAN I CHANGE PLANS (such as HMSA to Kaiser or HMSA 90/10 to 80/20)?
New Hire (new employee wishes to enroll in EUTF plans)	Within 30 days of date of new hire	1) Adult children through age 25 may be included in medical and prescription drug 2) Student Certificate if enrolling a dependent 19 or older in dental and vision (on school letterhead, signed by registrar) 3) Birth certificate if enrolling a dependent with a different last name and Social Security Number within 60 days of new hire date	Employee can choose: New hire date, beginning of next pay period after new hire date, or 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, Affidavit of Dependency (notarized if IRS qualified), Premium Conversion Plan form	Employee can choose: Date of notarization of Declaration of Domestic Partnership, beginning of next pay period after notary date, or 2nd pay period after notary date	No
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, Premium Conversion Plan form	Employee can choose: Civil union date, beginning of next pay period after civil union date, or 2nd pay period after civil date	No
Termination of Domestic Partnership (employee must terminate domestic partner or civil union partner)	Within 30 days of termination of partnership	For domestic partnership, Declaration of Termination of Domestic Partnership. For civil union, see divorce	End of pay period in which the Declaration of Termination of Domestic Partnership form was received by EUTF	No
Voluntary Cancellation, including dependents (employee wishes to cancel from all EUTF plans or cancel dependents from all EUTF plans with no qualifying event)	At any time	(if enrolled in PCP, generally voluntary cancellations do not allow changes to payroll deductions)	Employee chooses date, either 1st or 16th of month	N/A

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H	EFFECTIVE DATE	CAN I CHANGE PLANS (such as HMSA to Kaiser or HMSA 90/10 to 80/20)?
<p><i>Voluntary Cancellation:</i> Although current EUTF rules allow for voluntary termination at any time, Premium Conversation Plan (PCP) enrollment cannot be terminated/changed until the next open enrollment for voluntary cancellations. Therefore, the employee contribution will continue to be collected, but health benefit plan coverage will be terminated.</p>				

Note: For termination and transfer of employment or bargaining unit changes or death the employer is required to notify EUTF immediately of the termination, transfer, BU change, or death.

Required Notices

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 these 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 (your health benefits plan administrator) 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** – 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. 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 your Employer via first class mail 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).

If you have questions about COBRA contact the EUTF Plan Administrator.

For actives enrolled in the CVS Caremark 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. Refer to page 22 for a copy of the notice.

- **Notice of Creditable and Non-Creditable Coverage** – Refer to page 49 for a description.

If you wish to have hard copies of any of the following notices, please contact Kaiser or HMSA (contact information on page 59 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 Initial 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.
- **Certificate of Creditable Coverage and Preexisting Conditions** – A certificate of creditable coverage shall be provided when your coverage ends. This notice also includes information regarding regulations on preexisting conditions.
- **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.

HIPAA Notice: Notice of Privacy Rules

Effective date of this notice is January 1, 2013.

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.

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, and
- Follow the terms of the notice that is currently in effect.

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, all of the ways the EUTF is allowed to use and disclose your medical information will 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, improvement activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, 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, Hawaii Dental Service, Vision Service Plans, ChiroPlan Hawaii or Royal State Insurance 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 claim 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.

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.

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 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.

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 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 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.

To request confidential communications, you must submit a written request to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice. The EUTF will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how and/or where you wish to be contacted.

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.

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.

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.

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 with the Secretary of the Department of Health and Human Services at:

Secretary, DHHS

Hubert H. Humphrey Building

200 Independence Avenue S.W.

Washington, D.C. 20201

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.

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
Location Address: 201 Merchant Street, Suite 1520, Honolulu, HI 96813
Local number: 808-586-7390, Toll-Free number: 1-800-295-0089

Active Benefit Plan Summaries

The following section provides condensed summaries of the health plans and life insurance coverage available for actives. 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:

- Preferred Provider Organization (PPO) 90/10 Plan
- Preferred Provider Organization (PPO) 80/20 Plan
- Preferred Provider Organization (PPO) 75/25 Plan (new)
- Prescription Drug Plan
- Health Maintenance Organization (HMO) Plans
- Supplemental Medical Plans for those who are covered under another plan, such as a spouse's plan

The HSTA VB medical plan options, including prescription drug, are:

- Preferred Provider Organization (PPO) 90/10 Plan
- Preferred Provider Organization (PPO) 80/20 Plan
- Health Maintenance Organization (HMO) Plan
- Supplemental Medical Plan for those who are covered under another plan, such as a spouse's plan

Understanding the Plan Designs

Preferred Provider Organization Plans (PPO) - EUTF 90/10, 80/20, or 75/25 or HSTA VB 90/10 or 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 70%, 75%, or 80% and you would be responsible for 30%, 25%, or 20% of the covered expense. Also, you'll often be responsible for submitting your own claims.

Health Maintenance Organization (HMO) - EUTF HMSA HMO or Kaiser Comprehensive or Standard HMO (new) or 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, HMOs don't 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. 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 Medical Plan (Dual Coverage) - EUTF or HSTA VB HMSA Supplemental or Royal State National Supplemental

If you have a medical plan through your non-State/County spouse or another source, you can choose these plans. Covered medical expenses that are not covered by the other primary medical plan such as that plan's copays or coinsurance are paid under these plans. Covered expenses include copays for prescription drugs so there is not a separate drug plan offered with the supplemental plans. You can enroll in a supplemental plan **only** if you have another medical plan coverage not provided through the State or counties.

Chiropractic Plan Benefits (Royal State National (RSN))

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 medical plans.

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 HSTAVB, 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: eutf.hawaii.gov Please refer to the plan certificate for complete information on benefits, limitations and exclusions.

Medical Plan Coverage Chart (HMSA, Kaiser, RSN)

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
Deductible Single/Family	None	\$100 per person; \$300 per family	None	
Out-of-pocket limit Single/Family	\$2,000 / \$6,000		\$2,500 / \$7,500	
Lifetime Benefit Maximum	Unlimited		Unlimited	
Policy Year Benefit Maximum	None		None	
Physician Services	YOU PAY:		YOU PAY:	
Primary Care Office Visit	10%	30%	\$14	\$14
Specialist Office Visit	10%	30%	\$14	\$14
Routine physical exams	No Charge	No Charge*	No Charge	No Charge
Screening Mammography	No Charge	30%*	No Charge	No Charge
Immunizations	No Charge	No Charge*	No Charge	No Charge
Well Baby Care Visits	No Charge	30%*	No Charge	No Charge
Maternity	Same as any other condition	Same as any other condition	10%	10%
Second opinion – surgery	10%	30%	\$14	\$14
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%	20%	20%
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:	*Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 38.		For prescription drug coverage, refer to the PPO plan on page 38.	

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – EUTF continued

Plan Type	EUTF 75/25 PPO Plan (New)		Supplemental	
	HMSA		Royal State	HMSA
Carrier				
General	In-Network	Out-of-Network		
Annual Deductible Single/Family	\$300 / \$900		None/None	None/None
Annual Out-of-pocket limit Single/Family	\$5,000 / \$15,000		None	\$10,000
Lifetime Benefit Maximum	None		None	None
Policy Year Benefit Maximum	None		Medical svcs: \$3,100; Rx: \$200/\$600	None
Physician Services	YOU PAY:		YOU PAY:	YOU PAY:
Primary Care Office Visit	\$20*	\$20*	Co-pay covered	50%
Specialist Office Visit	\$20*	\$20*	Co-pay covered	50%
Routine physical exams	No Charge	No Charge	Co-pay covered	Not covered
Screening Mammography	No Charge	No Charge	Co-pay covered	No Charge (In-network): 50% (Out-of-Network)
Immunizations	No Charge	No Charge	Co-pay covered	50%
Well Baby Care Visits	No Charge	No Charge	Co-pay covered	No Charge (In-network): 50% (Out-of-Network)
Maternity	25%	25%	Co-pay covered	Same as any other condition
Second opinion – surgery	\$20*	\$20*	Co-pay covered	50%
Emergency Room (ER care)	\$100	\$100	Co-pay covered	50%
Ambulance	25%	25%	Co-pay covered	50%
Inpatient Hospital Services				
Room & Board	25%	25%	Co-pay covered	50%
Ancillary Services	25%	25%	Co-pay covered	50%
Physician services	25%	25%	Co-pay covered	50%
Surgery	25%	25%	Co-pay covered	50%
Anesthesia	25%	25%	Co-pay covered	50%
Outpatient Services				
Chemotherapy/ Radiation Therapy	25%	25%	Co-pay covered	50%
Surgery	25%	25%	Co-pay covered	50%
Diagnostic Lab	No Charge	No Charge	Co-pay covered	50%
Diagnostic X-ray	25%	25%	Co-pay covered	50%
Anesthesia	25%	25%	Co-pay covered	50%
Mental Health Services				
Inpatient Care	25%	25%	Co-pay covered	50%
Outpatient Care	25%	25%	Co-pay covered	50%
Other Services				
Durable Medical Equipment	25%	25%	Co-pay covered	50%
Home Health Care	25%	25%	Co-pay covered	50%
Hospice Care	No Charge	No Charge	Co-pay covered	No Charge (In-network): Not Covered (Out-of-Network)
Nursing facility - Skilled Care	25%	25%	Co-pay covered	50%, 120 days / CY
Physical & Occupational Therapy	25%	25%	Co-pay covered	50%
Notes:	*Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 38		*Refer to Reimbursement information under Drug Plans on page 38	*Refer to Reimbursement information under Drug Plans on page 38

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – EUTF continued

Plan Type Plan Design	Comprehensive	HMO Standard (New)	EUTF HMO
Carrier General	Kaiser*	Kaiser*	HMSA
Deductible Single/Family	None/None	None/None	None/None
Out-of-pocket limit Single/Family	\$2,000 / \$6,000	\$2,500 /\$7,500	\$1,500 / \$4,500
Lifetime Benefit Maximum	None	None	None
Policy 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 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%	\$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
Outpatient Care	\$15	\$20	No Charge
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 38.		For prescription drug coverage, refer to the HMO plan on page 38.

*For Kaiser members only:

- 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*.
- 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.

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – HSTA VB

Plan Design Carrier General	HSTA VB 90/10 PPO Plan		HSTA VB 80/20 PPO Plan	
	HMSA		HMSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Single/Family	None	\$100 per person; \$300 per family	None	
Out-of-pocket limit Single/Family	\$2,000 / \$6,000		\$2,500 / \$7,500	
Lifetime Benefit Maximum	Unlimited		Unlimited	
Policy 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%	20%	20%
Well Baby Care Visits	No Charge	30%*	No Charge	No Charge
Maternity	Same as any other condition	Same as any other condition	20%	20%
Second opinion – surgery	10%	30%	20%	20%
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:	For prescription drug coverage, refer to the PPO plan on page 39		For prescription drug coverage, refer to the PPO plan on page 39	

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) – HSTA VB continued

Plan Type	HMO Comprehensive	Supplemental
Carrier	Kaiser*	HMSA
General		
Deductible Single/Family	None/None	None/None
Out-of-pocket limit Single/Family	\$2,000/ \$6,000	None
Annual Benefit Maximum	None	\$2,000,000
Lifetime Benefit Maximum	None	None
Policy Year Benefit Maximum	None	None
Physician Services	YOU PAY:	YOU PAY:
Primary Care Office Visit	\$15	10%
Specialist Office Visit	\$15	10%
Routine physical exams	No Charge	10%
Screening Mammography	No Charge	No Charge
Immunizations	No Charge	10%
Well Baby Care Visits	No Charge	No Charge
Maternity	No charge for routine prenatal visits and one postpartum visit	10%; plan limitations apply
Second opinion – surgery	\$15	10%
Emergency Room (ER care)	\$50	10%
Ambulance	20%	10%
Inpatient Hospital Services		
Room & Board	No Charge	10%; plan limitations apply
Ancillary Services	No Charge	10%
Physician services	No Charge	10%
Surgery	No Charge	10%
Anesthesia	No Charge	10%
Outpatient Services		
Chemotherapy/ Radiation Therapy	\$15	10%
Surgery	\$15	10%
Diagnostic Lab	\$15/ department/ day	10%
Diagnostic X-ray	\$15/ department/ day	10%
Anesthesia	\$15	10%
Mental Health Services		
Inpatient Care	No Charge	10%
Outpatient Care	\$15	10%
Other Services		
Durable Medical Equipment	20%	10%
Home Health Care	No Charge	10%
Hospice Care	No Charge	10%; participating provider only
Nursing facility - Skilled Care	No Charge, 100 days / benefit period	10%, 120 days / CY
Physical & Occupational Therapy	\$15	10%
Notes:	For prescription drug coverage, refer to the Kaiser HMO plan on page 39	Refer to Reimbursement information under Drug Plans on page 39

*For Kaiser members only:

- 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*.
- 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.

PPO and HMO Prescription Drug Plans – EUTF

COVERAGE	PPO Prescription Drug Plan Caremark*		HMO Prescription Drug Plan		
			Kaiser Comprehensive	Kaiser Standard	Caremark
RETAIL PRESCRIPTION PROGRAM (30 day supply)	Participating Pharmacy**	Nonparticipating Pharmacy**	Copayment up to	Copayment up to	In-Network
Generic	\$5 copayment	\$5 + 20% of eligible charges	\$15	\$5 maintenance; \$10 other generic	\$5
Preferred Brand Name	\$15 copayment	\$15 + 20% of eligible charges	\$15	\$35	\$15
Other Brand Name	\$30 copayment	\$30 + 20% of eligible charges	\$15	\$35	\$30
Injectables and Specialty Drug	20% of eligible charges; Up to \$250 maximum; \$2,000 out-of-pocket maximum per plan year; \$30 copay oral oncology specialty medications	Not a benefit	\$15	\$5 maintenance / \$10 other generic / \$35 brand, if requires skilled administration by medical personnel - \$20 per dose	20% of eligible charges; Up to \$250 maximum; \$2,000 out-of-pocket maximum per plan year; \$30 copay oral oncology specialty medications
Insulin					
Preferred Insulin	\$5 copayment	\$5 + 20% of eligible charges	\$15	\$35 brand insulin	\$5
Other Insulin	\$15 copayment	\$15 + 20% of eligible charges	\$15	\$10 generic insulin	\$15
Diabetic Supplies					
Preferred Diabetic Supplies	No copayment	No copayment	\$15	50% of applicable charges	No copayment
Other Diabetic Supplies	\$15 copayment	\$15	\$15	50% of applicable charges	\$15
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)					
Generic	\$10 copayment	Not a benefit	\$30	\$10	\$10
Preferred Brand Name	\$35 copayment	Not a benefit	\$30	\$20	\$35
Other Brand Name	\$60 copayment	Not a benefit	\$30	\$70	\$60
Insulin					
Preferred Insulin	\$10 copayment	Not a benefit	Not Available through Mail Order	Not Available through Mail Order	\$10
Other Insulin	\$35 copayment	Not a benefit			\$35
Diabetic Supplies					
Preferred Diabetic Supplies	No copayment	Not a benefit	\$30	50% of applicable charges	No copayment
Other Diabetic Supplies	\$35 copayment	Not a benefit	\$30	50% of applicable charges	\$35

For the Royal State Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed \$15 per prescription drug (RX) up to \$200 if enrolled in single coverage or \$600 if enrolled in family coverage per policy year. Reimbursement for prescription drugs co-payment count towards the Policy Year Maximum Benefit Payable.

For EUTF Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed \$20 per prescription drug (RX) for generic and preferred brand name. For 90-day mail order, reimbursement for prescription drug co-payments charges shall not exceed \$35 per prescription drug (RX).

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

**Member is responsible for 100% of all ineligible charges.

PPO and HMO Prescription Drug Plans – HSTA VB

COVERAGE	PPO Prescription Drug Plan Caremark		HMO Prescription Drug Plan	Supplemental Plan
	Participating Pharmacy*	Non-Participating Pharmacy*	Kaiser	HMSA
RETAIL PRESCRIPTION PROGRAM (30 day supply)	Copayment	Copayment plus charges	Copayment	Plan pays up to
Generic and Insulin	\$5 (30 days) \$10 (31-60 days) \$15 (61-90 days)	\$5 + 30% of eligible charges	\$10	\$10
Brand Name	\$15 (30 days) \$30 (31-60 days) \$45 (61-90 days)	\$15 + 30% of eligible charges	\$10	\$25
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	Caremark	Vendor other than Caremark	Kaiser	HMSA
Generic and Insulin	\$9 copayment	Not a Benefit	Generic: \$20 Insulin: Not Available through Mail Order	\$27
Preferred Brand Name	\$27 copayment	Not a Benefit	\$20	\$27

*Member is responsible for 100% of all ineligible charges.

Additional Information for CVS Caremark Prescription Drug Plans

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 efficacy and are priced lower 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 Prescription Card ready. If you are not currently a member, please visit our website at www2.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 an on-island representative.

Coordination of Benefits

Some participants may be enrolled in additional prescription coverage outside of their State of Hawaii 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 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:

- Pharmacy receipt including:
 - Patient's name
 - Date of fill
 - Prescription number
 - Name of medication
 - Metric quantity
 - Day supply
 - 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. **Generic Step Therapy Program (GSTP)** - targets single-source, non-preferred brand medications by requiring that a cost-effective generic alternative be used first before the

brand medication. When a prescription for a targeted single-source brand is presented to the pharmacy, the system will check for previous use of an appropriate generic. If the plan participant's claim history shows that a 30-day supply of an appropriate generic was dispensed within a predetermined timeframe (180 or 365 days depending on drug class), the plan will cover the single-source brand. However, if there is no evidence of prior use of an appropriate generic as identified by the plan participant's claim history, the claim will be rejected and the plan participant must obtain a new prescription for an appropriate generic or select preferred brand, pay out-of-pocket for the non-covered brand, or contact the physician to request a Prior Authorization (PA). If the PA option is requested, the physician must contact the dedicated GSTP PA team at 1-877-418-4131 and provide clinical evidence if a lower-cost alternative is not appropriate.

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

Specialty Drug Program

The EUTF coverage and management of specialty drugs is provided by CVS Caremark Specialty pharmacy. EUTF plan participants are required to obtain specialty medications through a CVS Caremark Specialty pharmacy if they are received in an outpatient office visit or a home setting.

The CVS Caremark Specialty Drug Program uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. 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 visit their website at www.caremark.com for additional information about CVS Caremark.

The following programs apply to the EUTF CVS Caremark pharmacy coverage only and not to the HSTA VB pharmacy plans.

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.

Mandatory Mail Order Program for Maintenance Medications

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. The Maintenance Mail Order Program requires participants obtain these medications through the mail service pharmacy. Mail order provides up to a 90-day supply of medication at one low co-payment. Participants are allowed three (3) 30-day fills at a retail pharmacy for each new medication or new dosage amount in order to determine if the medication or dosage is right. The mail order benefit provides cost savings through lower co-payments and the convenience of home delivery. In addition, plan participants in the EUTF & HMO CVS Caremark plans can fill maintenance medications of up to a 90-day supply at any Longs pharmacy at the lower mail order copay.

Medications requiring refrigeration such as insulin are not subject to the Mandatory Mail Order Program. Participants using drugs needing refrigeration have the option of obtaining those drugs through a local pharmacy or through this program.

The following program applies to the HSTA VB pharmacy plans not to the EUTF CVS Caremark pharmacy coverage.

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 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.

Dental Plan Benefits (Hawaii Dental Services (HDS))– EUTF and HSTA VB

Your Plan provides:

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%
<ul style="list-style-type: none"> • Diabetic Patients – four Cleanings or *Periodontal Maintenance • Expectant Mothers – three Cleanings or *Periodontal Maintenance *Periodontal Maintenance benefit level	*80%
Fluoride (once per calendar year through age 19)	
<ul style="list-style-type: none"> • Fluoride Varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions as documented by the dentist. 	100%
Space maintainers (through age 17)	100%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth 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	
Pulpal therapy	80%
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	
Periodontal scaling and root planing – once every two years	80%
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)	60%
Dentures (complete and partial – once every 5 years; ages 16 and older)	
Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth	
ORAL SURGERY	
	80%
ADJUNCTIVE GENERAL SERVICES	
Palliative treatment (for relief of pain but not to cure)	100%
ORTHODONTICS	
Maximum amount payable by HDS for an eligible patient shall be \$1,000 lifetime per case paid in 8 quarterly payments of \$125.	50%
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.

Dental Plan Benefits (Hawaii Dental Services (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 Varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions as documented by the dentist.	
Space maintainers (through age 17)	50%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth 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	
Pulpal therapy	45%
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	
Periodontal scaling and root planing – once every two years	45%
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	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.deltadentalhi.org 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.deltadentalhi.org
- 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 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
- Polycarbonate lenses 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)

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.) 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 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 1-800-877-7195, or go on-line at www.vsp.com to search for a VSP doctor near you!

Life Insurance (Royal State National (RSN))

Your life insurance benefit will be \$38,361, for active participants.

- Your benefit will reduce once you reach age 65 and continue to reduce as follows:
 - \$24,935 for participants age 65 through 69
 - \$17,262 for participants age 70 through 74
 - \$11,508 for participants age 75 through 79
 - \$7,672 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. 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 Royal State National at (808) 539-1621 or toll free at 1-888-942-2447 if you would like to change your beneficiary. You may download the beneficiary designation form from the Royal State National website at: www.royalstate.com.

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 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 Hawaii Revised Statutes;
- ▶ 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 and Bargaining Unit changes.

Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the EUTF. The notice shall be sent within thirty days of the date on which the required semi-monthly contribution payment was due. The notice shall require the employee-beneficiary to make full payment of the contribution shortage prior to the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due.

Other Actions

The EUTF shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the EUTF.

Future Retirees

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 benefit plans must enroll in Medicare Part B. Active employees considering retirement who are eligible for Medicare should enroll in Medicare Part B in order to participate in any EUTF retiree benefit plan. At the time you complete your retiree (EC-2) enrollment form, provide a copy of your Medicare Part B card as proof of enrollment. If no proof of enrollment is submitted within 60 days, your enrollment into the EUTF Retiree Benefit Plans will be cancelled back to your date of retirement.

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 considering retirement, 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 if they occur within the same calendar year.

Dental example:

On January 1, 2013, John was an active employee and incurred \$500 in dental services. He retires on July 1, 2013 and proceeds to have additional dental services totaling \$1,000. In total, John has incurred \$1,500 in dental services for 2013. Although as an active employee John's dental benefit maximum was \$2,000 per plan year, as a retiree his dental benefit maximum is now only \$1,000 per calendar year. Therefore, because he used \$500 in dental benefits as an active employee and only had \$500 remaining as a retiree, John owes the dentist \$500 because his services were all incurred within the same calendar year.

Medical Out-of-Pocket maximum example:

On January 1, 2013, Jane was an active employee enrolled in the EUTF HMSA 90/10 PPO Plan. By July 1, 2013 she had met her \$2,000 calendar year out of pocket limit under that plan. She incurs additional medical expenses in August 2013, which are paid at 100% since her out of pocket limit was satisfied. She retires on September 1, 2013 and enrolls in the EUTF HMSA Retiree PPO plan. She proceeds to have additional medical services totaling \$1,000 before the end of 2013. 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, 2013, 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 2013. She retires on June 1, 2013 and enrolls in the EUTF HMSA Retiree PPO plan. The \$100 deductible she met under the Active 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. The EUTF sponsored prescription drug plan, except for the supplemental plans, offers benefits that are as good, or better, than the standard Medicare Part D plan coverage. A summary of your Notice of Creditable Coverage appears below.

If you are enrolled in the supplemental medical plan, your prescription drug coverage is considered to be non-creditable when compared to the standard Medicare Part D plan. A summary of your Notice of Non-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 other than a supplemental 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.

Notice of Non-Creditable Coverage (available at EUTF website at eutf.hawaii.gov)

If you are enrolled in a supplemental medical plan, the EUTF has determined that your prescription drug benefits are not as good as or better than the standard Medicare Part D drug benefits. As a rule, you are enrolled in the supplemental medical plan because you are also enrolled in another prescription drug plan and you should have received a Notice of Creditable Coverage from that other plan. If your other plan's prescription drug benefits are also non-creditable coverage, you should consider enrolling in Medicare Part D when you first become eligible to do so. If you don't enroll in Part D when you are first eligible to do so, you may have to pay a penalty (a higher premium) for your Part D coverage when you later do enroll, and you may have to pay that penalty for as long as you are covered under Part D.

It is important to note that if you enroll in a Medicare Part D plan, the EUTF will not reimburse you for the premiums.

INSTRUCTIONS FOR COMPLETING FORM EC-1

EXHIBIT C

Please print or type clearly. If the EC-1 form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the EC-1 form to your Personnel Office or Department Personnel Officer (DPO) for verification, signature, and routing.

SECTION 1 - EMPLOYEE DATA

1. Enter your full legal name as recorded on your Social Security card.
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 New Hire 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 close of business date.
7. If you are enrolling with the EUTF for the first time, you are required to provide your 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 birth date.
9. Mark the Mid-Year Qualifying Event 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, 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, 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 into a Civil Union, or Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health.
11. Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her Social Security Number. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. If both you and your Spouse/Civil Union Partner/Domestic Partner are employee beneficiaries, only one of you may enroll in an EUTF Family plan, or if no other dependents are involved, both may enroll in EUTF Self 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 an 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 DEDUCTION START SELECTION

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Civil Union, Domestic Partner, New Hire, Newly Eligible, Placement for Adoption, 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 contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option selected.
3. For the following events: Marriage, Civil Union, Domestic Partner and New Eligible Student; the event date is when your Personnel Office or DPO receives proper notification. Your effective date will be based on your event date and the box you selected.
4. DPO to complete Effective Date of Coverage and Premium Contribution begins date.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in. If you do not make a selection, you will be considered as cancelling/waiving coverage.

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 an HMO, HDHP or Supplemental plan, your medical selection will include a prescription drug plan. If you select a PPO plan, you must select the prescription drug plan if you want drug coverage. If you do not make a selection, you will not have any prescription drug coverage.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you do not make a selection or check the "Cancel/Waive" box, you will be considered as waiving the selection(s). To be eligible for Supplemental medical plan coverage, you must have other medical coverage from another source, not including this employer.
3. The RSN ChiroPlan is included with all medical plans except for the EUTF High Deductible Health Plan (HDHP).
4. 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.
5. Life insurance is provided by this employer 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, Change Amount, Cancel PCP, or Do NOT Enroll.
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.

INSTRUCTIONS FOR COMPLETING FORM EC-1 (continued)

Write your name in the top right corner.

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 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 birth date 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
CU = Civil Union Partner ✓	CUCH = Civil Union Partner Child ✓	GC = Guardianship or Foster Child ✓✓
DP = Domestic Partner ✓✓✓	DPCH = Domestic Partner Child ✓✓✓	DC = Disabled Child ✓✓✓✓
3. For Relationship codes with ✓ or ✓✓ or ✓✓✓ or ✓✓✓✓, please see item #8 and #9 below for other required forms.
4. Gender – Write/type either M or F.
5. 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.
6. Dependent certification. Your initials confirm that you are certifying that all of your dependent children are eligible to be enrolled under your enrollment. 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. You also confirm that you will provide a copy of your child(ren)'s student verification letter, signed by the registrar, as required by the EUTF.
7. Civil Union Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Civil Union.
8. Domestic Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Domestic Partnership.
9. 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. You may add your Civil Union Partner or Domestic Partner at anytime outside of Open Enrollment, provided all required documents have been received by your employing office 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.
10. Other EUTF and/or DRHD forms to include with EC-1 (if applicable):
 - ✓ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable)
 - ✓ EUTF Declaration of Domestic Partnership
 - ✓ Affidavit of "Dependency" for Tax Purposes
 - ✓ DHRD Civil Union Acknowledgement Form (State Employees with PCP enrolling Domestic/Civil Partner)
 - ✓ DHRD PCP 2 form (For State Employees Only)
 - ✓✓ Legal documents for guardianship or foster child
 - ✓✓✓ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership
 - ✓✓✓ Affidavit of "Dependency" for Tax Purposes
 - ✓✓✓ DHRD Domestic Partnership Acknowledgement Form (State Employees with PCP enrolling Domestic/Civil Partner)
 - ✓✓✓ DHRD PCP 2 form (For State Employees Only)
 - ✓✓✓✓ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you or any of your dependents have health benefit coverage through another employer's health plan(s) (private / Federal), please complete this section. If you selected a supplemental medical 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).

Note: To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group plan (private / Federal).

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 employee's salary, wages, pension 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.

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

Please print or type clearly. If the EC-1H form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.

Submit the EC-1H form to the Department of Education – Health Benefits and Awards Unit (DOE – HBAU) or Hawaii Public Charter Schools (HIPCS) for verification, signature, and routing.

SECTION 1 - EMPLOYEE DATA

1. Enter your full legal name as recorded on your Social Security card.
2. Enter your contact information.
3. Enter your address information. If your mailing address differs from your residential address, you need to enter both addresses to ensure that correspondence reaches you.
4. Mark the New Hire 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 close of business date.
7. If you are enrolling with the EUTF for the first time, you are required to provide your 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 birth date.
9. Mark the Mid-Year Qualifying Event 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, 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, 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 your civil union certificate received from the Department of Health.
11. Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her Social Security Number. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. If both you and your Spouse/Civil Union Partner/Domestic Partner are employee beneficiaries, only one of you may enroll in an EUTF Family plan, or if no other dependents are involved, both may enroll in EUTF Self 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 an 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 DEDUCTION START SELECTION

1. If the “Qualifying Event” that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Civil Union, Domestic Partner, New Hire, Newly Eligible, Placement for Adoption, 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 contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option selected.
3. For the following events: Marriage, Civil Union, Domestic Partner and New Eligible Student; the event date is when DOE – HBAU / HIPCS receives proper notification. Your effective date will be based on your event date and the box you selected.
4. DOE – HBAU / HIPCS to complete Effective Date of Coverage and Premium Contribution begins date.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in. If you do not make a selection, you will be considered as cancelling/waiving coverage.

1. Carefully review each selection that you make. You can choose ONE medical, ONE dental, and ONE vision plan. Your prescription drug plan 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 do not make a selection or check the “Cancel/Waive” box, you will be considered as waiving the selection(s). To be eligible for Supplemental medical plan coverage, you must have other medical coverage from another source, not including this employer.
3. The RSN ChiroPlan is included with all medical plans.
4. If you have other health plan coverage and do not want to participate in EUTF’s HSTA VB type plans, mark the “Cancel/Waive” box for each plan that you choose not to select.
5. Life insurance is provided by this employer 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 DOE – HBAU / HIPCS or DHRD on completing a PCP-2 form.

-Mark one of the following boxes: Enroll, Change Amount, Cancel PCP, or Do NOT Enroll.

EC-1: Enrollment Form for Active Employees

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social Security numbers are required to process new hires and dependent enrollments. **

Name (Last, First, Middle)
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
New Hire Date of Hire (MM/DD/YYYY)
Mid-Year Qualifying Event (describe)
Event Date: / /
Open Enrollment
Termination Date of Termination (MM/DD/YYYY)
Employee'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)
Civil Union
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 or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN:

Section 2: COVERAGE AND DEDUCTION START SELECTION

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, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Placement for Adoption, 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

Completed by DPO -> Effective Date of Coverage: Premium Contribution begins:

SECTION 3: PLAN SELECTION

Make your selection by checking the 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 you do not make a selection, you will be considered as "waiving" coverage.

Table with columns: Medical Plan Type, Carrier Selection, Cancel/Waive, Self, 2-Party, Family. Rows include PPO, Prescription Drug, HMO, and Supplemental plans.

*** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

Table with columns: Other Plans, Cancel/Waive, Self, 2-Party, Family. Rows include Dental, Vision, and Life plans.

For STATE Employees ONLY: Premium Conversion Plan Enroll Change Amount Cancel PCP Do NOT Enroll

For COUNTY Employees ONLY: Premium Conversion Plan - Please contact your DPO for more information on available options.

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, DP=Domestic Partner, CP=Civil Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CPCH=Civil Partner's 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 SSA.

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
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.

Dependent Certification – See Section regarding Dependent Certification on “Instructions for Completing Form EC-1” for more information.

I certify that my dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ (initials)

Domestic Partner Certification – See Section regarding Domestic Partner Certification on “Instructions for Completing Form EC-1” for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ (initials)

SECTION 5: OTHER INSURANCE INFORMATION *** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage		
				Self	2-Party	Family
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6: EMPLOYEE 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 if I do not make a selection or check the “waive” box, it will be considered a “waive.” 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 employee's salary, wages, pension 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:			Date of DPO (or employer designee's) Signature / /
Remarks:			

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social Security numbers are required to process new hires and dependent enrollments. **

Name (Last, First, Middle) _____ New Hire Mid-Year Qualifying Event (describe) _____
 Date of Hire (MM/DD/YYYY) _____ / ____ / ____
 Home Phone (____) _____ Event Date: ____ / ____ / ____
 Mobile Phone (____) _____ Open Enrollment
 Work Phone (____) _____ Termination
 Email _____ Date of Termination (MM/DD/YYYY) ____ / ____ / ____
 Residence Address (Check this box if your address has changed) _____
 Street _____ Civil Union
 Line 2 _____ Employee's Social Security Number (SSN) Civil Union Date: (MM/DD/YYYY)
 City _____ State _____ Zip Code _____ or EUTF ID Number (Check this box if status change)
 Mailing Address (if different from above) _____
 Street _____ Gender Male Female Domestic Partner (DP Status)
 Line 2 _____ Birth Date: (MM/DD/YYYY) IRS Qualified Not Qualified
 City _____ State _____ Zip Code _____ DP Date: (MM/DD/YYYY)
 (Check this box if status change)

Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN: _____

Section 2: COVERAGE AND DEDUCTION START SELECTION

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, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Placement for Adoption, 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

Completed by DOE - EBU / HIPCS → Effective Date of Coverage: _____ Premium Contribution begins: _____

SECTION 3: PLAN SELECTION

Make your selection by checking the 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 you do not make a selection, you will be considered as "waiving" coverage.

Medical Plan Type	Carrier Selection	Choose only one box in each plan selection			
		Cancel/Waive	Self	2-Party	Family
PPO	PPO-80/20 HMSA Medical and Drug, Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PPO-90/10 HMSA Medical and Drug, Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HMO-Kaiser Comprehensive Medical and Drug, Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental	Supplemental-HMSA Medical, Drug and Vision, Chiro *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

Other Plans	Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Supplemental Hawaii Dental Service *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	Vision Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life	Royal State National	<input type="checkbox"/>	<input type="checkbox"/>	

For STATE Employees ONLY: Premium Conversion Plan Enroll Change Amount Cancel PCP Do NOT Enroll

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.

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, DP=Domestic Partner, CP=Civil Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CPCH=Civil Partner's 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 SSA.

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
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes. Dependent Certification – See Section regarding Dependent Certification on “Instructions for Completing Form EC-1H” for more information.

I certify that my dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ (initials)

Domestic Partner Certification – See Section regarding Domestic Partner Certification on “Instructions for Completing Form EC-1H” for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ (initials)

SECTION 5: OTHER INSURANCE INFORMATION *** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage		
				Self	2-Party	Family
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6: EMPLOYEE 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 if I do not make a selection or check the “waive” box, it will be considered a “waive.” 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 employee's salary, wages, pension 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-1H Received in DOE-EBU / HIPCS Office / /		DOE-EBU / HIPCS Phone Number	DOE-EBU / HIPCS Fax Number
DOE-EBU / HIPCS (or employer designee's) Printed Name DOE-EBU / HIPCS (or employer designee's) Signature:		Date of DOE-EBU / HIPCS (or employer designee's) Signature / /	
Remarks:			

**FORMS SUBMITTED
TO YOUR EMPLOYER'S
OPEN ENROLLMENT
DESIGNEE
AFTER FRIDAY,
MAY 10, 2013
WILL BE REJECTED**

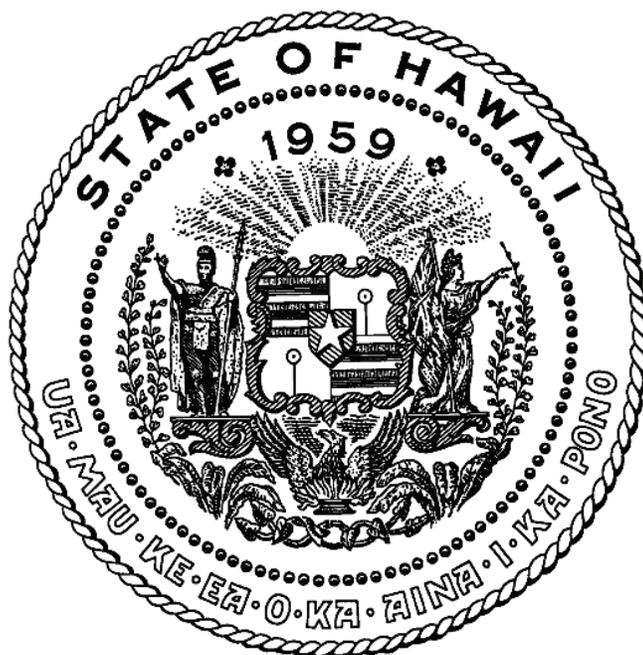
For More Information

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)
Hawaii Medical Service Association (HMSA)	www.hmsa.com 808-948-6499 or Toll Free: 1-800-776-4672 (Monday through Friday, 7:00 a.m. – 7:00 p.m. HST) Hilo: 808-935-5441, Kailua-Kona: 808-329-5291 Kahului: 808-871-6295, Lihue: 808-245-3393 (Monday through Friday, 8:00 a.m. – 4:00 p.m. HST)
Kaiser Permanente (Kaiser)	www.kp.org/hi/eutf 808-432-5955 (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)
CVS Caremark (CVS)	www.caremark.com/ www2.caremark.com/eutf/ 1-855-801-8263 (24 hours a day, 7 days a week)
Royal State National (RSN)	Chiropractic Benefit 808-621-4774 or Toll Free: 1-800-414-8845 www.chiroplanhawaii.com (Monday through Friday, 9:00 a.m. – 5:00 p.m. HST) Supplemental Medical Plan 808-539-1621 or Toll Free: 1-888-942-2447 www.royalstate.com (Monday through Friday, 8:00 a.m. – 4:30 p.m. HST) Life Insurance 808-539-1621 or Toll Free: 1-888-942-2447 www.royalstate.com (Monday through Friday, 8:00 a.m. – 4:30 p.m. HST)
Vision Service Plan (VSP)	www.vsp.com 808-532-1600 or Toll Free: 1-800-522-5162 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST) Toll Free for Mainland: 1-800-877-7195 (Monday through Friday, 5:00 a.m. – 7:00 p.m. PST Saturdays 6:00 a.m. – 2:30 p.m. PST)
Hawaii Dental Service (HDS)	www.deltadentalhi.org 808-529-9310 or Toll Free: 1-866-702-3883 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST)

Plan information can also be found online via the “Links to Carrier Web Sites” located on the EUTF website at eutf.hawaii.gov

Hawaii Employer-Union Health Benefits Trust Fund

RETIREE BENEFIT PLANS REFERENCE GUIDE (EUTF and HSTA VB)



Effective January 1, 2013 – December 31, 2013

Retirees and their dependents who are or soon will be 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 retiree plan. Please see page 24 for more information on this important topic.

October 2012

Aloha Retirees!

We are pleased to present to you the 2013 Retiree Reference Guide. Inside you will find detailed information about the health benefit plans available to you beginning January 1, 2013. The retiree benefit plans and rates contained in this Guide are for the period January 1, 2013 through December 31, 2013.

We know you worked hard as a State or County employee to earn your retirement benefits. I can assure you the EUTF Board of Trustees and EUTF staff are working hard to provide you with the best health plans possible to take care of your needs in retirement.

We hope you find the Guide helpful in meeting your informational needs. Remember, for more information on EUTF Retiree plans, the EUTF website at eutf.hawaii.gov contains links to all carrier plans.

Dean Hirata
Chair, EUTF Board of Trustees

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 assistance.

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Disclaimer: This Reference Guide offers general information on your health and other benefit plans which are exclusively governed by Hawaii 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.

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 22 through November 13, 2012.

Why is Open Enrollment special?

Now is the time when you can 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 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.

Open enrollment is your only opportunity to make these 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. So, **now is the time to think about health benefits.**

Here are the important dates:

- **Open Enrollment Election Period: October 22, 2012 through November 13, 2012**
- New coverage becomes effective: January 1, 2013
- Rates change effective: January 1, 2013
- The Base Monthly Contribution amount which sets the employer contribution maximum changes January 1, 2013.
- Plan Period: January 1, 2013 through December 31, 2013

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?
- **If you or your dependent are eligible for Medicare or will be this year:** Review the Medicare section so you are aware of how this will affect your plans and the State's 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 meeting 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 DON'T WANT TO MAKE ANY CHANGES – DO NOTHING. If you don't fill out a form, your current plan selections and covered dependents will continue into the new plan year.

Plan Administrator Changes

EUTF Prescription Drug Plans

- Effective May 1, 2012 for Non-Medicare retirees: CVS Caremark became the administrator for the prescription drug plans for the EUTF and HSTA VB* HMSA PPO plans.
- Effective July 1, 2012 for Medicare retirees: SilverScript, CVS Caremark's Medicare Part D administrator became the administrator for the prescription drug plans for the EUTF and HSTA VB* HMSA PPO Medicare Part D plans.

* HSTA VB refers to plans created for HSTA members who were previously enrolled in the HSTA VEBA plan.

Note: The enrollment of HSTA VEBA members into the health plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit was 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 has appealed the decision and reserves the right to move former 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 plans, do nothing. You are not required to complete any forms to keep your current plans.
- Step 2:** **Gather Information:** If you have questions about your plan choices, please attend an Open Enrollment Informational Session. The schedule of sessions with location information is on page 7.
- Representatives from the health plans and life insurance carrier will be on hand 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 the open enrollment. Questions regarding specific provisions such as are certain services covered 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 2013 Base Monthly Contribution Amount (BMC). The BMC amounts are not available at the time of printing and will be posted on the EUTF website as soon as they are available.
- Please check EUTF's website at eutf.hawaii.gov for BMC information and the Retiree Premium Calculation worksheet in early December.

Step 5: Who do you need to cover? You can add or drop dependents from your plan, including a spouse, domestic partner (DP), civil union partner (CUP) or eligible children. Adding a domestic or civil union partner requires additional documentation. Please contact the EUTF to obtain the appropriate forms or go to the EUTF website, eutf.hawaii.gov, to download those forms. Refer to the Employee – Dependent Eligibility section of this Guide for details on who can be enrolled as an eligible dependent.

Also, if your dependent is **eligible for Medicare**, they must be enrolled in Medicare Part B to be covered under EUTF retiree plans.

Step 6: Complete the Enrollment Form: Make your selections on the Form EC-2 or EC-2H for those eligible for HSTA VB plans and submit the completed and signed form to the EUTF, postmarked no later than November 13, 2012.

A: To make changes to your personal information, such as your address, complete Section 1, Retiree Data on the 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.

C: To change dependent information, including adding or dropping dependents or updating their data, complete Section 4, Dependent Information and Plan Selection, 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.

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.

Last Step: Submit the completed and signed form to the EUTF postmarked no later than November 13, 2012.

FORMS SUBMITTED AFTER NOVEMBER 13, 2012 WILL BE REJECTED.

The EUTF will send you an enrollment **confirmation notice** after processing is completed. The confirmation notice allows you to ensure that the changes you submitted were entered correctly. If you note an error, notify the EUTF immediately. **However, after November 13, 2012 we can only make changes if there is an error in our processing. We cannot change the selections you made on the original form submitted.**

IMPORTANT: If any of your dependents are no longer eligible due to a divorce, reaching the maximum child age or losing full-time student status, 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.

Schedule of Open Enrollment Informational Sessions for Retirees

Schedule for Retirees			
Date	Location	Room	Time *
October 22	Hilo	Aunty Sally's Luau Hale	9:00 am - 10:30 am 11:30 am - 1:00 pm
October 23	Pearl City	Leeward Community College	9:00 am - 10:30 am 11:30 am - 1:00 pm
October 25	State Capitol	State Capitol Auditorium	8:30 am - 10:00 am 1:30 pm - 3:00 pm
October 26	Maui	Kahului Community Center Annex	9:00 am - 10:30 am 11:30 am - 1:00 pm
October 29	Kona	Old Kona Airport	9:00 am - 10:30 am 11:30 am - 1:00 pm
October 30	Lanai	Lanai Community Center	10:00 am - 11:30 am
November 1	Kauai	Kauai War Memorial Convention Hall	9:00 am - 10:30 am 11:30 am - 1:00 pm
November 2	Kaneohe	Kaneohe Community & Senior Center Auditorium	9:00 am - 10:30 am 11:30 am - 1:00 pm
November 5	University of Hawaii at Manoa	Kuykendall Hall Auditorium	8:30 am - 10:00 am
November 7	Molokai	Mitchell Pauole Community Center	2:00 pm - 3:30 pm

* Informational Session presentation to start promptly at the designated start time.

Informational Session Locations

HAWAII – HILO

Aunty Sally 's Luau Hale
799 Piilani Street
Hilo, HI 96720

HAWAII - KONA

Old Kona Airport
75-5530 Kuakini Highway
Kailua-Kona, HI 96740

MAUI

Kahului Community Center Annex
275 Uhu Street
Kahului, HI 96732

KAUAI

War Memorial Convention Hall
4191 Hardy Street
Lihue, HI 96766

LANAI

Lanai Community Center
8th Street
Lanai City, HI 96763

MOLOKAI

Mitchell Pauole Community Center
90 Ainoa Street
Kaunakakai, HI 96748

OAHU

Leeward Community College
96-045 Ala Ike, General Technology, Room 105
Pearl City, HI 96782

State Capitol Auditorium
415 South Beretania Street
Honolulu, HI 96813

U.H. Kuykendall Auditorium
2445 Campus Road
Honolulu, HI 96822

Kaneohe Community & Senior Center Auditorium
45-613 Puohala Street
Kaneohe, HI 96744

Retiree and Dependent Eligibility

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

You can also call the 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 shall be eligible to enroll in the benefit plans offered or sponsored by the EUTF for Retirees:

- 4 A retired employee. You do not need to be covered under an EUTF Active Employee Plan at the time of retirement to be eligible to enroll in the EUTF retiree plans.
- 4 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
- 4 The unmarried child of a deceased retired employee, provided the child is under age 19 with no surviving parent

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

- 4 The Employee's legal Spouse, Domestic Partner or Civil Union Partner (DP/CUP).

Note: A spouse or partner who is eligible for Medicare must be enrolled in Medicare Part B to be covered by an EUTF retiree plan.

- 4 Your or your spouse's or DP/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.
- 4 Your or your spouse's or DP/CUP's unmarried children under the age of 24 provided they are full-time students attending an accredited college, university or technical school. This includes children who are away at school and dependent upon you for support.
- 4 Coverage can be continued for an unmarried child incapable of self-support due to mental/physical incapacity that existed prior to age 19.
- 4 Child covered by 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 retiree plans. For more information on this, please refer to Healthcare.gov or eutf.hawaii.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 legal civil union partnership with an employee-beneficiary which is recognized by a state government. Documentation of the civil union must be provided with the application to enroll.

NOTE: There may be Federal Income Tax consequences with employer paid coverage for domestic or 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 or 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, eutf.hawaii.gov) to the EUTF.

Enrollment

To enroll you must complete an EUTF Enrollment Form for Retirees (EC-2 or EC-2H) (see pages 44-51). If you do not enroll eligible members of your family within 30 days of when you or they first become eligible, you must wait until the next Open Enrollment period to do so. The plan year for retiree plans begins January 1 and ends December 31 of each year.

ID Cards

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

- 4 HMSA and HDS will issue two identical ID cards showing the name of the subscriber.
- 4 Kaiser, CVS Caremark, and SilverScript issue an ID card for each enrolled member of a family upon initial enrollment.
- 4 VSP does not issue ID cards.

Dual Family Enrollment (Two EUTF Retiree Family Enrollments) Is Not Allowed

If both you and your spouse are eligible to enroll in either EUTF retiree or EUTF active employee plans, only one of you may enroll in an EUTF 2 Party or Family plan. If no other dependents are involved, both may enroll in EUTF Self plans. Dual enrollment in EUTF family plans is not allowed under EUTF Administrative Rule 4.03. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF such as if your spouse has coverage outside of the EUTF through a non EUTF employer.

Change of Coverage – Special Enrollment Period Due to a Qualifying Event

You are eligible to change coverage 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.
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. You have a change in family status involving the loss of eligibility of a family member (e.g., separation, divorce, death, child marries, no longer lives with you, loses student status or turns age 19 or 24 if a student).
3. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
4. You move out of your plan's service area.

To change your coverage, you should complete Form EC-2 or EC-2H and submit it to EUTF within 30 days of the date of the change. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the EUTF. Dependent children are automatically terminated as of the end of the pay period they attain age 19 or 24 and do not require the completion of an application to delete coverage.

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. These events include: Adoption, Birth, Guardianship, New Eligible Student, Marriage, New Domestic Partner, New Civil Union Partner, Newly Eligible Student, Placement for Adoption.

End of Coverage

Common situations resulting in loss of coverage for you and your dependents are:

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

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 dependent enters the uniformed services.
3. Your surviving spouse, domestic or civil union partner remarries.

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, 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 rules;
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.

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

MEDICARE AND ENROLLMENT IN EUTF PLANS

Medicare eligible retirees must enroll in Medicare Part B to be covered or continue to be covered under an EUTF retiree plan. A spouse / domestic partner / civil union partner who is enrolled as a dependent under an EUTF Retiree plan must also enroll in Medicare Part B when they become eligible for Medicare.

Medicare Part B Premium Reimbursement

Retirees and their spouses who are enrolled in an EUTF retiree plan and who are enrolled in Medicare Part B are eligible for Medicare Part B premium reimbursements. This does not apply to active employees eligible for Medicare who are covered by EUTF active employee plans. However, if you are an active employee, enrolled in Medicare Part B and covered by an EUTF **retiree** plan through your spouse, your spouse is entitled to Medicare Part B reimbursement for you. Domestic partners or civil union partners of retirees are eligible for Medicare Part B reimbursements in the same manner as spouses.

For additional information on Medicare and EUTF 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 Medicare Part D Plans (Prescription Drug)

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:

- The date the employee was hired;
- The length of service taking into account breaks in services, and
- The Base Monthly Contribution (BMC) amount which determines the maximum amount of the employer contribution for selected EUTF plans.

Certification of the retiree's hire date and length of service is provided by ERS and determines what percentage of the Base Monthly Contribution will be available for a retiree to cover plan premiums.

The BMC amount is calculated annually and changes every January 1. The amount of change is based on the change in the Medicare Part B standard premium which is determined by the Federal government in the Fall of the preceding year.

The percentage determined by years of service is multiplied times the BMC for the year to determine the maximum monthly employer contribution. This includes premium for medical, prescription drug, dental and vision care. 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 Hawaii Revised Statute 87A.

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 maximum 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 amount.

Administrative Appeals

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 thirty days of the date of the 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 thirty-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 ninety 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. 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 a reasonable amount of time. 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 regarding the EUTF PPO Plan or EUTF Prescription Drug Plan, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

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 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 (your health benefits plan administrator) 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 prescription drug plan:

- **HIPAA Initial 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 or HMSA (contact information included on page 52 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.
- **Michelle’s Law** – If a group health plan provides coverage for a dependent child on the basis of the child being a student at a post-secondary educational institution, this federal law limits the plan’s ability to terminate coverage of such child when the child loses student status due to a medically necessary leave of absence.
- **HIPAA Initial 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.
- **Certificate of Creditable Coverage and Preexisting Conditions** – A certificate of creditable coverage shall be provided when your coverage under the Employee Modified Medical Program or the Employee Medical Program ends. This notice also includes information regarding regulations on preexisting conditions.
- **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 satisfies the individual coverage mandate of the Massachusetts Health Care Reform Law.

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 medical and prescription drug plans; therefore, there are two sections of information:

- 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 or non-Medicare retirees. The plan summaries for these plans follow the Medicare information.

Medical Plan Options

Understanding the Plan Designs

Medical coverage is important to everyone. The EUTF offers the following medical Plan options:

- Preferred Provider Organization (PPO) Plans: HMSA 90/10 PPO plan
- Health Maintenance Organization (HMO) Plans: Kaiser Comprehensive HMO

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 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 title – 90/10 – refer to the percent of eligible charges that the carrier pays for most network services – 90% - and the amount the employee is responsible for is 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. 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 70% and you would be responsible for 30% of the covered expense. Also, you'll often be responsible for submitting your own claims.

Health Maintenance Organization (HMO): Under an HMO, you agree to use the health care professionals and facilities associated with that HMO. Except in emergencies, HMOs don't 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. After a copayment for each office visit, most medical expenses are covered at 100%. You must select a Primary Care Physician to coordinate your care.

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. Therefore, 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 or county contribution for the most comparable health benefits plan.

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

During open enrollment, if you feel you need coverage outside of the State of Hawaii due to a relocation, or if you spend longer periods of time out of state, you also can enroll in the EUTF's PPO plan, administered by HMSA. The HMSA PPO provides coverage through Blue Cross's nationwide network if you reside outside of Hawaii.

Chiropractic Plan Benefits (Royal State National): HSTA VB PLAN ONLY

Royal State National Insurance Company, Ltd., through ChiroPlan Hawaii, Inc. is the provider of the chiropractic benefits. The chiropractic benefit is packaged with all HSTA VB retiree medical plans.

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. 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: eutf.hawaii.gov. Please refer to the plan certificate for complete information on benefits, limitations and exclusions.

NON-MEDICARE RETIREES

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, 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			
Deductible Single/Family	\$100 per person Maximum \$300 per family		None/None
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
Routine physical exams	Not Covered	Not Covered	\$15
Mammography	20%*	30%*	\$15
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%*	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%, some exclusions
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

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			
Deductible Single/Family	\$100 per person Maximum \$300 per family		None/None
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
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 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%	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
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 PRESCRIPTION PROGRAM (30 day supply)			
Generic	\$5 copayment	\$5 + 20% of eligible charges	\$15
Preferred Brand Name	\$15 copayment	\$15 + 20% of eligible charges	\$15
Other Brand Name	\$30 copayment	\$30 + 20% of eligible charges	\$15
Injectables and Specialty Drug	20% Up to \$250 copay maximum; \$2,000 out-of-pocket maximum per plan year	Not a benefit	\$15
Insulin			
Preferred Insulin	\$5 copayment	\$5 + 20% of eligible charges	\$15
Other Insulin	\$15 copayment	\$15 + 20% of eligible charges	\$15
Diabetic Supplies			
Preferred Diabetic Supplies	No copayment	No copayment	\$15
Other Diabetic Supplies	\$15 copayment	\$15 + 20% of eligible charges	\$15
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	CVS Caremark	Vendor other than CVS Caremark	
Generic	\$10 copayment	Not a benefit	\$30
Preferred Brand Name	\$35 copayment	Not a benefit	\$30
Other Brand Name	\$60 copayment	Not a benefit	\$30
Insulin			
Preferred Insulin	\$10 copayment	Not a benefit	\$30
Other Insulin	\$35 copayment	Not a benefit	\$30
Diabetic Supplies			
Preferred Diabetic Supplies	No copayment	Not a benefit	\$30
Other Diabetic Supplies	\$35 copayment	Not a benefit	\$30

NON-MEDICARE RETIREES

Non-Medicare Retiree Prescription Drug Plan Provisions

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 equivalent or Preferred Brand medication without compromising care as these medications have been determined to provide the same level of effectiveness. Preferred medications are usually priced lower than Non-Preferred brand name medications and have lower copayments.

Prior Authorization

The EUTF recognizes that some participants have a clinical need for a Non-Preferred product. In these cases, a prior authorization (PA) process is available for those who require Non-Preferred medications. For the PA process, the prescribing physician must document a clinical failure or drug allergy to the generic or Preferred medication in question.

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.

The following programs apply to the EUTF CVS Caremark pharmacy coverage only and not to the HSTA VB pharmacy plans.

Generic Drug Incentive Program

The Generic Drug Incentive 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.

Utilization Management Guidelines

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. ***Step Therapy*** – Requires the use of lower-cost alternatives (First-Line Agents) prior to gaining access to more costly brand name products.
3. ***Contingent Therapy Protocol*** – Medication will be covered when prescribed safely and appropriately, according to FDA approved guidelines and drug coverage protocols. Contingent therapy review often looks for one medication to be tried before another medication will be covered by the plan. This review assures medical necessity, clinical appropriateness, and safety.

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Mandatory Mail Order Program for Maintenance Medication

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. The Maintenance Mail Order Program requires participants obtain these medications through the mail service pharmacy. Mail order provides up to a 90-day supply of medication at one low co-payment. Participants are allowed three (3) 30-day fills at a retail pharmacy for each new medication or new dosage amount in order to determine if the medication or dosage is right. The mail order benefit provides cost savings through lower co-payments and the convenience of home delivery. In addition, plan participants in the EUTF CVS Caremark plan can fill maintenance medications of up to a 90-day supply at any Long's pharmacy at the lower mail order copay.

Medications requiring refrigeration such as insulin are not subject to the Mandatory Mail Order Program. Participants using drugs needing refrigeration have the option of obtaining those drugs through a local pharmacy or through this program.

Generic Step Therapy Program

The Generic Step Therapy Program targets single-source, non-preferred brand medications by requiring that a cost-effective generic alternative be used first before the brand medication. When a prescription for a targeted single-source brand is presented to the pharmacy, the system will check for previous use of an appropriate generic. If the plan participant's claim history shows that a 30-day supply of an appropriate generic was dispensed within a predetermined timeframe (180 or 365 days depending on drug class), the plan will cover the single-source brand. However, if there is no evidence of prior use of an appropriate generic as identified by the plan participant's claim history, the claim will reject and the plan participant must obtain a new prescription for an appropriate generic or select preferred brand, pay out-of-pocket for the non-covered brand, or contact the physician to request a Prior Authorization (PA). If the PA option is requested, the physician must contact the dedicated GSTP PA team at **1-877-418-4131** and provide clinical evidence if a lower-cost alternative is not appropriate.

From May 1, 2012 to July 2012, plan participants were allowed to continue taking the brand-name drug. However, starting August 1, 2012 if plan participants choose to continue using the brand-name drug that they are now taking before having tried a generic medication, the prescription may not be covered and they may need to pay the full cost of the brand medication.

Specialty Drug Program and Specialty Drug Tier

The EUTF coverage and management of self-administered injectable specialty drugs for the HMSA PPO medical plans is provided by the CVS Caremark Specialty Drug Program. EUTF plan participants are required to obtain specialty medications through the Specialty Drug Program.

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The Specialty Rx Program uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. Medications for the treatment of the following conditions are available through the Specialty Rx Program:

- Arthritic Disorders
- Blood Disorders
- Crohn's Disease
- Cystic Fibrosis
- Fabry Disease
- Gaucher's Disease
- Growth Hormone Deficiency
- Hemophilia
- Hepatitis-C
- HIV/AIDS Wasting
- Infertility
- Immune Deficiency
- Multiple Sclerosis
- Oncology (Cancer)
- Organ Transplant
- Osteoporosis
- Pompe's Disease
- Psoriasis
- Respiratory Syncytial Virus

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 plan year for specialty drug copayments.

Exception: Oral oncology medications provided under the Specialty Rx Program will have a Tier 3 copayment instead of 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 visit their website at www.caremark.com for additional information about CVS Caremark.

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 PRESCRIPTION PROGRAM (30 day supply)			
Generic and Insulin	\$5 copayment	\$5 + 30% of eligible charges	\$10
Preferred Brand Name	\$15 copayment	\$15 + 30% of eligible charges	\$10
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	CVS Caremark	Vendor other than CVS Caremark	
Generic and Insulin	\$9 copayment	Not a benefit	\$20
Preferred Brand Name	\$27 copayment	Not a benefit	\$20

Note: Specialty prescription drugs for HSTA VB plans are covered by the medical plan with HMSA.

MEDICARE RETIREES

Introduction to MEDICARE and EUTF 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 government's health insurance program for people age 65 or older. Certain people younger than age 65 can qualify for Medicare too, including those who have disabilities and those who have permanent kidney failure or amyotrophic lateral sclerosis (Lou Gehrig's disease). The program helps with the cost of health care, but it 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), some home health care and hospice care.
- Medicare Part B – Medical insurance that helps pay for doctors' services and many other medical services and supplies that are not covered by hospital insurance.
- Medicare Part C – Advantage plans are available in many areas. People with Medicare Parts A and B can choose to receive all of their health care services through one of these provider organizations under Part C.
- Medicare Part D – Prescription drug coverage that helps pay for medications doctors prescribe for treatment.

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 (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. Usually, you can sign up for Medicare Part A only during designated enrollment periods.

Medicare Part B – Medical Insurance

Medicare Part B requires a monthly premium payment.

Anyone who is eligible for Medicare Part A can enroll in Medicare Part B. If you are not eligible for free Medicare Part A, you can buy Medicare Part B if you are age 65 or older and you are –

- A U.S. citizen; or
- A lawfully admitted noncitizen who has lived in the United States for at least 5 years.

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The premium is the same whether or not you are enrolled in Medicare Part A. Some beneficiaries with higher incomes will pay a higher monthly 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 Retiree plans.

Medicare Part C – Advantage Plan

If you have enrolled for Medicare Parts A and B, you can join a Medicare Advantage plan.

Medicare Advantage plans include:

- Medicare managed care plans;
- Medicare preferred provider organization (PPO) plans;
- Medicare private fee-for-service plans; and
- Medicare specialty plans.

The EUTF Kaiser Medicare Retiree plan (Senior Advantage) is a Medicare Part C plan.

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 Retiree prescription drug plan is a Medicare Part D plan and is therefore governed by Medicare rules. Medicare requires that you can only be enrolled in one Medicare Part D plan. Therefore, if you enroll in another Medicare Part D plan, you and your dependents will be cancelled from the EUTF Retiree prescription drug plan. 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 plans are cancelled you will lose the employer premium contribution and will not be able to reenroll until the next EUTF Retiree Open Enrollment.

Signing up for Medicare

When should I apply?

Medicare eligible retirees must enroll in Medicare Part B to continue to be covered under an EUTF Retiree benefit plan. A spouse/civil union or domestic partner who is enrolled as a dependent under an EUTF Retiree plan must also enroll in Medicare Part B when they become eligible for Medicare, regardless of whether they are retired or actively employed.

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

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

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 that birthday.

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

When does my enrollment in 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 Retiree benefit plans.

Medigap & Other Medicare Plans

The EUTF Retiree plans cover many of the same benefits as a Medigap policy. Therefore, there is no need for you to enroll in a Medicare Advantage Medigap plan as long as you are enrolled in an EUTF Retiree medical and prescription drug plan. Also enrollment in a non-EUTF Medicare Advantage Plan may jeopardize your enrollment in an EUTF Retiree prescription drug plan.

Medicare enrollment and Active employment

While you are still an active employee with an EUTF employer, you are not required to enroll in Medicare. Medicare enrollment is only required for coverage under retiree plans. However, if you are enrolled in an EUTF retiree 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 Retiree plans.

Medicare Premium Payment and Reimbursement

Medicare is financed by a portion of the payroll taxes paid by workers and the employers. It is also financed in part by monthly premiums paid by the subscriber.

The Medicare Part B premium is usually deducted from the monthly Social Security pension. Retirees who are covered by EUTF retiree plans are eligible for reimbursement of Medicare Part B premiums. Please refer to page 35 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 this Reference Guide and the language 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			
Deductible Single/Family	\$100 per person Maximum \$300 per family		None/None
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
Routine physical exams	Not Covered	Not Covered	\$15
Mammography	20%*	30%*	\$15
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%*	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%, some exclusions
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.

**Contact Kaiser Permanente for questions about Senior Advantage benefits.

MEDICARE RETIREES

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

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			
Deductible Single/Family	\$100 per person Maximum \$300 per family		None/None
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
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%	\$15
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
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.

**Contact Kaiser Permanente for questions about Senior Advantage benefits.

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 the PPO 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 Silver Script)		HMO Prescription Drug Plan (Kaiser)
	Participating Pharmacy	Non-participating Pharmacy	Copayment up to
RETAIL PRESCRIPTION PROGRAM (30 day supply)			
Generic	\$5 copayment	\$5 copayment	\$15
Preferred Brand Name	\$15 copayment	\$15 copayment	\$15
Non-Preferred Brand Name	\$30 copayment	\$30 copayment	\$15
Specialty Drug	20% coinsurance Up to a \$250 copay max	20% coinsurance Up to a \$250 copay max	\$15
Insulin			
Covered Insulin Products	\$5 copayment	\$5 copayment	\$15
Diabetic Supplies			
Lancets, Strips and Meters	No copayment	No copayment	\$15
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	CVS Caremark	Vendor other than CVS Caremark	
Generic	\$10 copayment	Not a benefit	\$30
Preferred Brand Name	\$35 copayment	Not a benefit	\$30
Non-Preferred Brand Name	\$60 copayment	Not a benefit	\$30
Specialty Drug	20% coinsurance	Not a benefit	
Insulin			
Covered Insulin Products	\$10 copayment	Not a benefit	\$30
Diabetic Supplies			
Lancets, Strips and Meters	No copayment	Not a benefit	\$30
MAXIMUM ANNUAL OUT-OF-POCKET:	After a person has spent \$4,750* in eligible out-of-pocket drug costs in a year, you qualify for the catastrophic coverage. Please refer to your 2013 Evidence of Coverage booklet.		

*\$4,750 subject to change annually per CMS

MEDICARE RETIREES

Medicare Part D Prescription Drug Plans – HSTA VB

COVERAGE	PPO Prescription Drug Plan (administered Silver Script)		HMO Prescription Drug Plan (Kaiser)
	Participating Pharmacy	Non-participating Pharmacy	Copayment up to
RETAIL PRESCRIPTION PROGRAM (30 day supply)			
Generic and Covered Insulin Products	\$5 copayment	\$5 copayment	\$10
All Covered Brand Name	\$15 copayment	\$15 copayment	\$10
Diabetic Supplies			
Lancets, Strips and Meters	No copayment	Not a benefit	\$30
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	CVS Caremark	Vendor other than CVS Caremark	
Generic and Covered Insulin Products	\$9 copayment	Not a benefit	\$20
All Covered Brand Name	\$27 copayment	Not a benefit	\$20
Diabetic Supplies			
Lancets, Strips and Meters	No copayment	Not a benefit	\$30
MAXIMUM ANNUAL OUT-OF-POCKET:	After a person has spent \$4,750* in eligible out-of-pocket drug costs in a year, you qualify for the catastrophic coverage. Please refer to your 2013 Evidence of Coverage booklet.		

*\$4,750 subject to change annually per CMS

The EUTF will implement the Centers for Medicare & Medicaid Services (CMS) formulary changes to the PPO Prescription Drug's preferred product medication list for **Medicare eligible retiree** participants effective January 1, 2013. All changes are outlined in the annual notice of change (ANOC) and available online at eutf.hawaii.gov or hstavb.silverscript.com.

Prior Authorization

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "prior authorization." 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.

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 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 Part D plan, you will lose your Medicare Part D coverage through the EUTF.**

The EUTF 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 plan, your EUTF prescription drug plan 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 15)

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.

EUTF will enroll all Medicare-eligible participants into the EUTF's Medicare Part D Prescription Drug benefit 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 prescription drug plan and enroll in another Medicare Part D plan to obtain prescription drug benefits.**

If you are a Kaiser member and are Medicare eligible, you must enroll in Kaiser's Senior Advantage plan. You will be required to complete a Kaiser Permanente Senior Advantage enrollment form. All Kaiser Medicare eligible members are enrolled in the Medicare Part D plan through Kaiser Senior Advantage.

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The open enrollment period for all EUTF retirees is from October 22, 2012 through November 13, 2012. You will probably start receiving advertisements from other plans during this time. Please know that if you are happy with your coverage under the EUTF Part D plan, you do not have to take any action. Medicare only allows you to enroll in one Medicare Part D plan. Therefore, if you enroll in a non-EUTF Part D plan, you will be **terminated** from the EUTF's Medicare Part D plan.

If you do not want to enroll in a non-EUTF Part D plan, do nothing. You will automatically stay in the EUTF Medicare Part D plan.

Frequently Asked Questions and Answers:

Why will I receive communications and marketing materials for other non-EUTF Part D drug plans?

CMS allows all Part D plans to reach out to Medicare participants, beginning October 15 of each year. Other Part D plans may contact you to encourage enrollment in their plan during this time, thereby leaving (i.e., disenrolling from) the EUTF's Medicare Prescription Drug plan.

What happens if I do choose to enroll in another Part D drug plan?

If you do decide to enroll in a non-EUTF Part D plan, you will be disenrolled from the EUTF Medicare Part D plan because Medicare allows you to enroll in only one Part D plan.

Is the EUTF Medicare plan as good as other Medicare Part D plans?

All Part D plans must offer a minimum coverage to meet the Medicare Standard Part D plan requirements. The EUTF Medicare Part D plan exceeds this minimum and offers participants richer, more generous, coverage than the Medicare Standard Part D plan. The chart on page 34 provides a comparison of benefits under the EUTF Medicare Part D plan and a Standard Medicare Part D plan. Overall, there are no existing Part D plans that we know of that provide better coverage than the EUTF's.

What must I do if I choose to enroll in a non-EUTF Part D plan?

Please notify the EUTF in writing that you have enrolled in another Part D plan.

What if I have the Kaiser Permanente Senior Advantage medical plan?

All Medicare eligible members are enrolled in the Medicare Part D plan through Kaiser Senior Advantage. The EUTF enhances the Medicare Part D coverage with supplemental drug benefits that makes your current prescription drugs 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 Kaiser have committees of pharmacists who continually review drug data and studies on new and existing drugs. Based on this data they create prescription drug formularies 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.

MEDICARE RETIREES

If I enroll in a non-EUTF Part D plan, will I be reimbursed for my Medicare Part D premiums?

No.

What happens to my spouse's/domestic or civil union partner's EUTF coverage if my spouse chooses to enroll in a non-EUTF Part D plan?

If you are enrolled in the EUTF prescription drug plan and your spouse opts out of the plan, your spouse will be disenrolled from the EUTF Part D plan.

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.

I am enrolled in 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 medical plan and you will have the choice to either enroll in a PPO medical plan (HMSA) or not to enroll in any medical plan. The Medicare Part D prescription drugs plan is part of the Senior Advantage plan. You cannot have one without the other.

If I'm enrolled in the EUTF Medicare Part D drug plan, am I required to get my maintenance drugs by mail order?

No.

I am an HSTA VB retiree. 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.

However, you would be able to enroll in the EUTF (not HSTA VB) PPO medical and vision plans.

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 Part D plan but are covered under the EUTF non-Medicare retiree plan.

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 MEDICARE PART D PLAN
ANNUAL DEDUCTIBLE: \$0					
COPAYMENTS:	GENERIC	PREFERRED	NON- PREFERRED	INJECTABLES AND SPECIALTY	
RETAIL 30 DAYS	\$5	\$15	\$30	20%	\$15
RETAIL 90 DAYS	\$15	\$45	\$90	20%	\$45
MAIL ORDER 90 DAYS	\$10	\$35	\$60	NOT A BENEFIT	\$30
SPECIALTY: \$250 MAXIMUM COPAY PER FILL					
MAXIMUM ANNUAL OUT-OF-POCKET: AFTER A PERSON HAS SPENT \$4,750* IN ELIGIBLE OUT-OF-POCKET DRUG COSTS IN A YEAR, YOU QUALIFY FOR THE CATASTROPHIC COVERAGE. PLEASE REFER TO YOUR 2011 EVIDENCE OF COVERAGE BOOKLET.					
PLAN FEATURE	STANDARD CMS APPROVED MEDICARE PART D PLAN				
ANNUAL DEDUCTIBLE: \$325					
COST OF COVERED DRUGS					
CO-INSURANCE:	YOU PAY:			MEDICARE PAYS:	
UP TO \$325	100%			0%	
FROM \$326 TO \$2,969	25%			75%	
FROM \$2,970 TO \$4,749	100%			0%	
OVER \$4,750	5%			95%	
MAXIMUM ANNUAL OUT-OF-POCKET: AFTER A PERSON HAS SPENT \$4,750* IN ELIGIBLE OUT-OF-POCKET DRUG COSTS IN A YEAR, MEDICARE PAYS 95% OF THE DRUG COSTS FOR THE REMAINDER OF THE YEAR.					

*\$4,750 subject to change annually per CMS

MEDICARE RETIREES

EUTF Medicare Part B Reimbursements

WHAT: When you become eligible for Medicare, **you must enroll in Medicare Part B** to continue your retiree health 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 penalty premium payments charged by Medicare.

WHO: Applies to all retirees and their spouses enrolled in EUTF retiree plans who are eligible to enroll in Medicare Part B. Spouses who are still working but enrolled in an EUTF retiree medical plan as a dependent are required to enroll in Medicare Part B.

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

- 1) Copy of your Medicare Part B card;
- 2) Direct Deposit Agreement Form for your financial institution account, and
- 3) Copy of the letter you receive from the Social Security Administration indicating the amount of your monthly Medicare Part B premium if you pay more than the standard 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, no earlier. The Direct Deposit Agreement Form can be found 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 statute.

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;”

However, Section 87A-23(5) allows the EUTF Board to determine which retirees and dependents may continue to participate in the EUTF retiree 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 retiree 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.

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 for late enrollment). Generally, your reimbursement checks will be sent or deposited quarterly during the first week of April, July, October and January for the prior quarter.

MEDICARE RETIREES

Must I sign up for Medicare Part B if I am or my spouse is still working and covered by another non EUTF employer group health insurance?

In this situation, your active employee plan will be the primary plan and the EUTF retiree plan will be secondary. You may be advised to delay enrollment in Medicare due to your active employee plan. However, if you wish to enroll in an EUTF retiree plan, you must enroll in Medicare Part B.

What will happen if my spouse or I fail to enroll in Medicare Part B when eligible?

EUTF Administrative Rule 5.04 states “when the retiree fails to enroll in Medicare Part B, the enrollment for the retiree and family will be cancelled from all benefit plans offered or sponsored by the EUTF.” If the spouse fails to enroll, then only the spouse will be cancelled from all benefit plans offered by the EUTF. If your spouse wants to continue coverage under your retiree plan, your spouse is required to enroll in Medicare Part B even though he/she is still working. Enrollment in Medicare Part B is required to be eligible for coverage under the EUTF retiree 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 employer. What should I do?

If you missed initial enrollment (a seven-month period starting three months before your 65th birthday and ending three months after your birth month), you must wait to apply for Medicare until the general enrollment period during January and March of each year. Your coverage will start the following July. You must contact the Social Security Administration to apply for Medicare by calling 1-800-772-1213 or visit their website at SocialSecurity.gov. You will pay a 10 percent Part B premium penalty for each year you delayed signing up. Your Medicare Part B reimbursements will not include payment for any penalty amounts.

Will I be charged a higher Medicare B premium if I my 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 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 retiree plans since Medicare Part B enrollment is required.

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

If you are notified by Medicare that your Part B premium will have an income-related monthly adjustment amount, in other words your Part B premium is higher than the standard rate due to your higher income level, you will be reimbursed for 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.

EUTF automatically re-sets your 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 Medicare reimbursement deposited?

Both the retiree’s Medicare reimbursement and the spouse’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 Services [HDS]) – EUTF and HSTA VB

BENEFIT	PLAN COVERS
PLAN MAXIMUM per calendar year per member (Jan 1 – Dec 31)	\$1,000
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%
<ul style="list-style-type: none"> • 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 (once per calendar year through age 19)	100%
<ul style="list-style-type: none"> • Fluoride – high risk – once per calendar year 	
Space maintainers (through age 17)	100%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth 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	
Pulpal therapy	60%
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	
Periodontal scaling and root planing (once every two years)	60%
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)	60%
Dentures (complete and partial – once every 5 years; ages 16 and older)	
Implants (covered as alternate benefit) when one tooth is missing between two natural teeth	
ORAL SURGERY	
	60%
ADJUNCTIVE GENERAL SERVICES	
Palliative treatment (for relief of pain but not to cure)	100%

Flossing, brushing and regular visits to a dentist for checkups are critical components of every oral health program. These simple measures help prevent tooth decay and detect other oral health problems early to avoid the need for emergency dental care in the future. A dentist can also help detect diseases such as diabetes and other health conditions by examining your teeth and gums.

HDS's public website includes a section exclusively for EUTF members at www.deltadentalhi.org. This section includes a copy of the retiree dental benefits brochure, which includes a summary of the dental benefits. HDS members can also check on their eligibility, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, and view oral health and wellness information.

ALL RETIREES

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

Your coverage with VSP Doctors and Affiliate Providers:

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
- Polycarbonate lenses 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

~OR~

Contact Lenses every plan year

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

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.) 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.

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.

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 us at 1-800-877-7195, or go on-line at www.vsp.com to search for a VSP doctor near you!

ALL RETIREES

Life Insurance (Royal State National Insurance Company) – EUTF & HSTA VB

Your retiree life insurance benefit is \$2,034. Since this benefit is for all retirees and the coverage is the same for everyone, you do not need to make an election for this coverage.

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

- 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. The reimbursement amount is 10% of your life insurance benefit or approximately \$200.

Beneficiary changes: Existing beneficiary designation information is on file at Royal State National. Contact Royal State National at (808) 539-1600 or toll free at 1-888-942-2447 if you would like to change your beneficiary. Changes will be effective upon receipt by Royal State National. You may download the beneficiary designation form from their website at: www.royalstate.com.

EUTF Monthly Retiree Rates
Effective January 1, 2013 through December 31, 2013

Benefit Plan	Type of Enrollment	Premium	Admin Fee	Total Contribution Required
<i>MEDICAL PLANS - MEDICARE</i>				
HMSA PPO Medicare	Self	\$185.38	\$2.10	\$187.48
	Two-Party	\$361.26	\$4.46	\$365.72
	Family	\$535.54	\$6.54	\$542.08
Medicare Prescription Drug	Self	\$225.62	\$0.62	\$226.24
	Two-Party	\$439.33	\$1.27	\$440.60
	Family	\$651.38	\$1.86	\$653.24
Kaiser HMO Medicare Kaiser Prescription Drug	Self	\$380.28	\$2.72	\$383.00
	Two-Party	\$741.52	\$5.76	\$747.28
	Family	\$1,098.96	\$8.40	\$1,107.36
<i>MEDICAL PLANS – NON-MEDICARE</i>				
HMSA PPO Non-Medicare	Self	\$408.82	\$2.10	\$410.92
	Two-Party	\$796.62	\$4.46	\$801.08
	Family	\$1,180.94	\$6.54	\$1,187.48
Non-Medicare Prescription Drug	Self	\$121.34	\$0.62	\$121.96
	Two-Party	\$236.33	\$1.27	\$237.60
	Family	\$350.40	\$1.88	\$352.28
Kaiser HMO Non Medicare Kaiser Prescription Drug	Self	\$640.84	\$2.72	\$643.56
	Two-Party	\$1,293.52	\$5.76	\$1,299.28
	Family	\$1,907.88	\$8.40	\$1,916.28
<i>DENTAL PLAN</i>				
HDS Dental - Retiree	Self	\$30.08	\$0.32	\$30.40
	Two-Party	\$58.68	\$0.64	\$59.32
	Family	\$71.88	\$0.96	\$72.84
<i>VISION PLAN</i>				
VSP Vision - Retiree	Self	\$5.06	\$0.06	\$5.12
	Two-Party	\$10.12	\$0.12	\$10.24
	Family	\$13.59	\$0.17	\$13.76
<i>LIFE INSURANCE</i>				
Royal State National Life Insurance (Retiree only)*	Self	\$4.12	\$0.04	\$4.16

*No cost to retiree under current law

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
EUTF RETIREES
JANUARY 1, 2013

	Monthly Premium	Monthly Premium
1A MEDICAL/PRESCRIPTION DRUG	HMSA	Kaiser
A. Non-Medicare - Self	<input type="checkbox"/> \$532.88	<input type="checkbox"/> \$643.56
B. Non-Medicare - 2-Party	<input type="checkbox"/> \$1,038.68	<input type="checkbox"/> \$1,299.28
C. Non-Medicare - Family	<input type="checkbox"/> \$1,539.76	<input type="checkbox"/> \$1,916.28
D. Medicare - Self	<input type="checkbox"/> \$413.72	<input type="checkbox"/> \$383.00
E. Medicare - 2-Party	<input type="checkbox"/> \$806.32	<input type="checkbox"/> \$747.28
F. Medicare - Family	<input type="checkbox"/> \$1,195.32	<input type="checkbox"/> \$1,107.36

If you want medical and prescription drug, select one plan and enter premium amount (go to line 2)
 If you want medical only, go to line 1B; If you want prescription drug only, go to line 1C

1A \$ _____

1B MEDICAL ONLY	HMSA
A. Non-Medicare - Self	<input type="checkbox"/> \$410.92
B. Non-Medicare - 2-Party	<input type="checkbox"/> \$801.08
C. Non-Medicare - Family	<input type="checkbox"/> \$1,187.48
D. Medicare - Self	<input type="checkbox"/> \$187.48
E. Medicare - 2-Party	<input type="checkbox"/> \$365.72
F. Medicare - Family	<input type="checkbox"/> \$542.08

Select one plan and enter premium amount
 If you selected a plan in 1A, do not complete this section

1B \$ _____

1C PRESCRIPTION DRUG ONLY	
A. Non-Medicare - Self	<input type="checkbox"/> \$121.96
B. Non-Medicare - 2-Party	<input type="checkbox"/> \$237.60
C. Non-Medicare - Family	<input type="checkbox"/> \$352.28
D. Medicare - Self	<input type="checkbox"/> \$226.24
E. Medicare - 2-Party	<input type="checkbox"/> \$440.60
F. Medicare - Family	<input type="checkbox"/> \$653.24

Select one plan and enter premium amount
 If you selected a plan in 1A, do not complete this section

1C \$ _____

2 DENTAL	HDS
Non Medicare/Medicare	
Self	<input type="checkbox"/> \$30.40
2-Party	<input type="checkbox"/> \$59.32
Family	<input type="checkbox"/> \$72.84

Select one plan and enter premium amount

2 \$ _____

3 VISION	VSP
Non Medicare/Medicare	
Self	<input type="checkbox"/> \$5.12
2-Party	<input type="checkbox"/> \$10.24
Family	<input type="checkbox"/> \$13.76

Select one plan and enter premium amount

3 \$ _____

4 Add lines 1A or 1B and 1C, 2, 3 (Medical, Prescription Drug, Dental, Vision) **4** \$ _____

2013 Employer Contribution Amounts Not Available at Press Time
 See eutf.hawaii.gov for 2013 Amounts

5 EMPLOYER CONTRIBUTION		0%	50%	75%	100%
A. Non Medicare - Self	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Non Medicare - 2-Party	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Non Medicare - Family	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Medicare - Self	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Medicare - 2-Party	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Medicare - Family	<input type="checkbox"/>	\$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
Effective January 1, 2013 through December 31, 2013

Benefit Plan	Type of Enrollment	Premium	Admin Fee	Total Contribution Required
<i>MEDICAL PLANS - MEDICARE</i>				
HSTA VB Retiree - HMSA PPO Medicare Medical, Drug, RSN Chiropractic, VSP Vision	Self	\$412.00	\$2.80	\$414.80
	Two-Party	\$803.00	\$5.88	\$808.88
	Family	\$1,187.90	\$8.58	\$1,196.48
HSTA VB Retiree - Kaiser HMO Medicare Medical, Drug, RSN Chiropractic, VSP Vision	Self	\$394.67	\$2.81	\$397.48
	Two-Party	\$769.95	\$5.89	\$775.84
	Family	\$1,138.50	\$8.58	\$1,147.08
<i>MEDICAL PLANS – NON-MEDICARE</i>				
HSTA VB Retiree - HMSA PPO Non-Medicare Medical, Drug, RSN Chiropractic, VSP Vision	Self	\$530.73	\$2.79	\$533.52
	Two-Party	\$1,034.35	\$5.89	\$1,040.24
	Family	\$1,530.89	\$8.59	\$1,539.48
HSTA VB Retiree - Kaiser HMO Non-Medicare Medical, Drug, RSN Chiropractic, VSP Vision	Self	\$645.95	\$2.81	\$648.76
	Two-Party	\$1,303.67	\$5.89	\$1,309.56
	Family	\$1,921.50	\$8.58	\$1,930.08
<i>DENTAL PLAN</i>				
HDS Dental - Retiree	Self	\$30.08	\$0.32	\$30.40
	Two-Party	\$58.68	\$0.64	\$59.32
	Family	\$71.88	\$0.96	\$72.84
<i>VISION PLAN</i> <i>(Only for retirees enrolled in an out-of-state Kaiser Multi-Site or Sr. Advantage Plan - not a HSTA VEBA Plan)</i>				
VSP Vision - Retiree	Self	\$5.06	\$0.06	\$5.12
	Two-Party	\$10.12	\$0.12	\$10.24
	Family	\$13.59	\$0.17	\$13.76
<i>LIFE INSURANCE</i>				
Royal State National Life Insurance (Retiree only)*	Self	\$4.12	\$0.04	\$4.16

*No cost to retiree under current law

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
HSTA VEBA RETIREES
JANUARY 1, 2013

	Monthly Premium	Monthly Premium
1 MEDICAL/PRESCRIPTION DRUG/CHIRO/VISION	HMSA	Kaiser
A. Non-Medicare - Self	<input type="checkbox"/> \$533.52	<input type="checkbox"/> \$648.76
B. Non-Medicare - 2-Party	<input type="checkbox"/> \$1,040.24	<input type="checkbox"/> \$1,309.56
C. Non-Medicare - Family	<input type="checkbox"/> \$1,539.48	<input type="checkbox"/> \$1,930.08
D. Medicare - Self	<input type="checkbox"/> \$414.80	<input type="checkbox"/> \$397.48
E. Medicare - 2-Party	<input type="checkbox"/> \$808.88	<input type="checkbox"/> \$775.84
F. Medicare - Family	<input type="checkbox"/> \$1,196.48	<input type="checkbox"/> \$1,147.08

Select one plan and enter premium amount

1 \$ _____

2 DENTAL	HDS
Non Medicare/Medicare	
Self	<input type="checkbox"/> \$30.40
2-Party	<input type="checkbox"/> \$59.32
Family	<input type="checkbox"/> \$72.84

Select one plan and enter premium amount

2 \$ _____

3 Add lines 1 and 2

3 \$ _____

2013 Employer Amounts Not Available at Press Time
 See eutf.hawaii.gov for 2013 Amounts

4 EMPLOYER CONTRIBUTION MAXIMUM	0%	50%	75%	100%
A. Non Medicare - Self	<input type="checkbox"/> \$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Non Medicare - 2-Party	<input type="checkbox"/> \$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Non Medicare - Family	<input type="checkbox"/> \$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Medicare - Self	<input type="checkbox"/> \$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Medicare - 2-Party	<input type="checkbox"/> \$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Medicare - Family	<input type="checkbox"/> \$0.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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% or 75%).

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.

NOTES

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 full legal name as recorded on your Social Security card.
2. Enter your contact information.
3. Enter your address information. If your mailing address differs from your residential address, you need to 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. If you are enrolling with the EUTF for the first time as a retiree, you are required to provide your Social Security Number.
6. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a birth date.
7. Mark the Mid-Year Qualifying Event 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, 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 in a Domestic Partnership please be sure to check appropriate boxes and include date you were Married, or 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.
9. Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her Social Security Number. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. If both you and your Spouse/Domestic Partner are employee beneficiaries, only one of you may enroll in an EUTF Family plan, or if no other dependents are involved, both may enroll in EUTF Self 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 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. For the following events: Marriage, Civil Union, Domestic Partner and New Eligible Student; the event date is when EUTF receives proper notification. Your effective date will be based on your event date and the box you selected.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in. If you do not make a selection, you will be considered as cancelling/waiving coverage.

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 an HMO, your medical selection will include a prescription drug plan. If you select a PPO plan, you must select the prescription drug plan if you want 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 drug plans, please mark the appropriate boxes. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you do not make a selection or check the “Cancel/Waive” box, you will be considered as waiving the selection(s).
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. If enrolling your dependent for the first time, enter his/her birth date and 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 Social Security Administration. Otherwise, you may leave the birth date 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 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.

INSTRUCTIONS FOR COMPLETING FORM EC-2

2. Use the following Relationship codes:

SP = Spouse	CH = Child	SC = Step Child
CU = Civil Union Partner ✓	CUCH = Civil Union Child ✓	GC = Guardianship or Foster Child ✓✓
DP = Domestic Partner ✓✓✓	DPCH = Domestic Partner Child ✓✓✓	DC = Disabled Child ✓✓✓✓

3. For Relationship codes with ✓ or ✓✓ or ✓✓✓ or ✓✓✓✓, please see item #8 and #9 below for other required forms.

4. Gender – Write/type either M or F.

5. 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.

6. Dependent certification. Your initials confirm that you are certifying that all of your dependent children are eligible to be enrolled under your enrollment. 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.

7. Student certification. Your initials confirm that you are certifying that all of your dependent children ages 19 through 23, are eligible to be enrolled under your enrollment as full-time students. You further confirm that you will provide a copy of your child(ren)'s student verification letter, signed by the registrar, as required by the EUTF.

8. Civil Union Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Civil Union.

9. Domestic Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Domestic Partnership.

10. 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 anytime 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.

11. 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)

✓ EUTF Declaration of Domestic Partnership

✓ 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

✓✓✓ Affidavit of "Dependency" for Tax Purposes

✓✓✓✓ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

SECTION 5 – MEDICARE

IMPORTANT: If you or your dependent(s) are Medicare eligible and are enrolled in a Non-EUTF Medicare Part D prescription drug plan, please provide the name(s) of those enrolled in the Non-EUTF plan. Please ensure that you carefully read the implications of being enrolled in a Non-EUTF Medicare Part D prescription drug plan. Additional information is included in your Retiree Open Enrollment Guide. You can obtain detailed information regarding Medicare Part D at the Medicare website, www.medicare.gov.

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 a proof of enrollment (Medicare card showing Part B effective date and Direct Deposit Authorization Form) to the EUTF. Failure to comply may result in loss of all health benefits coverage. If you or your dependent(s) have recently enrolled with Medicare Part B, please complete this section and submit this EC-2 form with a copy of your Medicare card and a direct deposit agreement form to the EUTF.

SECTION 6 – OTHER INSURANCE INFORMATION

1. If you or any of your dependents have health benefit coverage through another employer's health plan(s) (private / Federal), 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).

SECTION 7 – 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, 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.

You must submit the EC-2 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.

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 full legal name as recorded on your Social Security card.
2. Enter your contact information.
3. Enter your address information. If your mailing address differs from your residential address, you need to 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. If you are enrolling with the EUTF for the first time as a retiree, you are required to provide your Social Security Number.
6. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a birth date.
7. Mark the Mid-Year Qualifying Event 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, 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 in a Domestic Partnership please be sure to check appropriate boxes and include the date you were Married, or 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.
9. Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her Social Security Number. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. If both you and your Spouse/Civil Union Partner/Domestic Partner are employee beneficiaries, only one of you may enroll in an EUTF Family plan, or if no other dependents are involved, both may enroll in EUTF Self 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 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. For the following events: Marriage, Civil Union, Domestic Partner and New Eligible Student; the event date is when EUTF receives proper notification. Your effective date will be based on your event date and the box you selected.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in. If you do not make a selection, you will be considered as cancelling/waiving coverage.

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 EUTF 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 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 is received/issued by Social Security Administration. Otherwise, you may leave the birth date 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 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.

INSTRUCTIONS FOR COMPLETING FORM EC-2H**2. Use the following Relationship codes:**

SP = Spouse	CH = Child	SC = Step Child
CU = Civil Union Partner ✓	CUCH = Civil Union Partner Child ✓	GC = Guardianship or Foster Child ✓✓
DP = Domestic Partner ✓✓✓	DPCH = Domestic Partner Child ✓✓✓	DC = Disabled Child ✓✓✓✓

3. For Relationship codes with ✓ or ✓✓ or ✓✓✓ or ✓✓✓✓, please see item #8 and #9 below for other required forms.

4. Gender – Write/type either M or F.

5. 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.

6. Dependent certification. Your initials confirm that you are certifying that all of your dependent children are eligible to be enrolled under your enrollment. 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.

7. Student certification. Your initials confirm that you are certifying that all of your dependent children ages 19 through 23, are eligible to be enrolled under your enrollment as full-time students. You further confirm that you will provide a copy of your child(ren)'s student verification letter, signed by the registrar, as required by the EUTF.

8. Civil Union Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Civil Union.

9. Domestic Partner Certification. Your initials confirm that you are certifying you have completed all the required forms in accordance with Domestic Partnership.

10. 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 anytime 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.

11. If you are adding a disabled child, domestic partner and child or an adopted 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-2H (if applicable):

✓ Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable)

✓ EUTF Declaration of Domestic Partnership

✓ 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

✓✓✓ Affidavit of "Dependency" for Tax Purposes

✓✓✓✓ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

SECTION 5 – MEDICARE

IMPORTANT: If you or your dependent(s) are Medicare eligible and are enrolled in a Non-EUTF Medicare Part D prescription drug plan, please provide the name(s) of those enrolled in the Non-EUTF plan. Please ensure that you carefully read the implications of being enrolled in a Non-EUTF Medicare Part D prescription drug plan. Additional information is included in your Retiree Open Enrollment Guide. You can obtain detailed information regarding Medicare Part D at the Medicare website, www.medicare.gov.

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 a proof of enrollment (Medicare card showing Part B effective date and Direct Deposit Authorization Form) to the EUTF. Failure to comply may result in loss of all health benefits coverage. If you or your dependent(s) have recently enrolled with Medicare Part B, please complete this section and submit this EC-2H form with a copy of your Medicare card and a direct deposit agreement form to the EUTF.

SECTION 6 – OTHER INSURANCE INFORMATION

1. If you or any of your dependents have health benefit coverage through another employer's health plan(s) (private / Federal), 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).

SECTION 7 – 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, 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.

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: 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) _____ Open Enrollment Mid-Year Qualifying Event (describe) _____

Home Phone (____) _____ Retiree's Social Security Number (SSN) or EUTF ID Number _____ Event Date: ____/____/____

Mobile Phone (____) _____ 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) ____/____/____

Other Phone (____) _____ Gender Male Female Domestic Partner (DP Status) IRS Qualified Not Qualified DP Date: (MM/DD/YYYY) (Check this box if status change) ____/____/____

Email _____ Birth Date: (MM/DD/YYYY) ____/____/____

Residence Address (Check this box if your address has changed) Marital Status Married Single Marriage Date: (MM/DD/YYYY) (Check this box if status change) ____/____/____

Street _____ Domestic Partner (DP Status) IRS Qualified Not Qualified DP Date: (MM/DD/YYYY) (Check this box if status change) ____/____/____

Line 2 _____ City _____ State _____ Zip Code _____

Mailing Address (if different from above) **If you are including your Spouse or Civil Union Partner or Domestic Partner in your health benefit plans, please complete Section 4** Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN: _____ or EUTF ID: _____

Street _____ City _____ State _____ Zip Code _____

SECTION 2: COVERAGE AND DEDUCTION 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^v following event
- Coverage and premium contributions start 1st day of the **second** pay period^v 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 you do not make a selection, you will be considered as "waiving" coverage.

Medical Plan Type	Carrier Selection	Choose only one box in each plan selection			
		Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 HMSA Medical No Prescription Drug Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Prescription Drug (Not a valid selection w/ HMO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HMO-Kaiser Medical (Includes Prescription Drug Coverage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	Vision Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life	Royal State National	<input type="checkbox"/>	<input type="checkbox"/>		

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 received/issued by SSA.

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
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ (initials)
I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. _____ (initials)
 Civil Union Partner Certification – See Section regarding Civil Union Partner Certification on “Instructions for Completing Form EC-2” for specific instructions.
I have attached all documentation as required in the Civil Union Partner Enrollment Instructions. _____ (initials)
 Domestic Partner Certification – See Section regarding Domestic Partner Certification on “Instructions for Completing Form EC-2” for specific instructions.
I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ (initials)

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires eligible beneficiaries 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) recently enrolled in Medicare Part B, or have not already done so, please submit a copy of the Medicare card and EUTF Direct Deposit Agreement Form to the EUTF without delay and complete this section to initiate quarterly reimbursement.

Name of Enrollee: _____
 Medicare Claim #: _____ (ID Number listed on the red, white and blue Medicare card)

Non-EUTF Medicare Part D

If you or your dependent(s) are enrolled in a non-EUTF Medicare Part D prescription drug plan, please read Section 5 on the instruction form and enter the name(s) of those enrolled in a non-EUTF Medicare Part D plan.
 Name(s): _____

SECTION 6: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage		
				Self	2-Party	Family
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 7: RETIREE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the “waive” box, it will be considered a “waive.” 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-2 form by mail to:
 EUTF
 P.O. Box 2121
 Honolulu, HI 96805-2121
Customer Service Call Center

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite 1520, Honolulu, HI 96813
Oahu (808) 586-7390
 Toll Free 1(800) 295-0089

EC-2H: Enrollment Form for HSTA VB 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) _____

Open Enrollment

Mid-Year Qualifying Event (describe) _____

Home Phone (____) _____

Retiree's Social Security Number (SSN) or EUTF ID Number _____

Event Date: ____/____/____

Mobile Phone (____) _____

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)

Email _____

Residence Address (Check this box if your address has changed)

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)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

If you are including your Spouse or Civil Union Partner or Domestic Partner in your health benefit plans, please complete Section 4

Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree and is **not** being enrolled in your plans, please provide his/her

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

SSN: _____ or

EUTF ID: _____

SECTION 2: COVERAGE AND DEDUCTION 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^v following event
- Coverage and premium contributions start 1st day of the **second** pay period^v following event
^v(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 you do not make a selection, you will be considered as "waiving" coverage.

Medical Plan

Choose only one box in each plan selection

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 HMSA Medical, Prescription Drug Coverage, Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HMO- Kaiser Medical, (Includes Prescription Drug Coverage), Vision, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life	Royal State National	<input type="checkbox"/>	<input type="checkbox"/>		

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.

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-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.

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
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ (initials)
I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. _____ (initials)
 Civil Union Partner Certification - See Section regarding Civil Union Partner Certification on "Instructions for Completing Form EC-2H" for specific instructions.
I have attached all documentation as required in the Civil Union Partner Enrollment Instructions. _____ (initials)
 Domestic Partner Certification - See Section regarding Domestic Partner Certification on "Instructions for Completing Form EC-2H" for specific instructions.
I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ (initials)

SECTION 5: MEDICARE

HRS Chapter 87A-23(4) requires eligible beneficiaries 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) recently enrolled in Medicare Part B, or have not already done so, please submit a copy of the Medicare card and EUTF Direct Deposit Agreement Form to the EUTF without delay and complete this section to initiate quarterly reimbursement.

Name of Enrollee: _____
 Medicare Claim #: _____ (ID Number listed on the red, white and blue Medicare card)

Non-EUTF Medicare Part D

If you or your dependent(s) are enrolled in a non-EUTF Medicare Part D prescription drug plan, please read Section 5 on the instruction form and enter the name(s) of those enrolled in a non-EUTF Medicare Part D plan.
 Name(s): _____

SECTION 6: OTHER INSURANCE INFORMATION

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage		
				Self	2-Party	Family
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 7: RETIREE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." 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

Customer Service Call Center
 Oahu (808) 586-7390
 Toll Free 1(800) 295-0089

Or you may hand deliver to: EUTF, 201 Merchant Street, Suite 1520, Honolulu, HI 96813
 EC-2H Rev. 12/11

For More Information

For Questions About...	Please Contact...
Eligibility & EUTF information	<p>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)</p>
Hawaii Medical Service Association (HMSA)	<p>www.hmsa.com 808-948-6499 or Toll Free: 1-800-776-4672 Hilo: 808-935-5441, Kailua-Kona: 808-329-5291 Kahului: 808-871-6295, Lihue: 808-245-3393 (Monday through Friday, 8:00 a.m. – 4:00 p.m. HST)</p>
Kaiser Permanente (Kaiser)	<p>www.kp.org/hi/EUTF's 808-432-5955 (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)</p>
CVS Caremark Non-Medicare Retirees: SilverScript Medicare Retirees:	<p>www.caremark.com 1-855-801-8263</p> <p>eutf.silverscript.com hstavb.silverscript.com 1-877-878-5715</p>
Vision Service Plan (VSP)	<p>www.vsp.com 808-532-1600 or Toll Free: 1-800-522-5162 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST) Toll Free for Mainland: 1-800-877-7195 (Monday through Friday, 5:00 a.m. – 7:00 p.m. PST Saturdays 6:00 a.m. – 2:30 p.m. PST)</p>
Hawaii Dental Service (HDS)	<p>www.deltadentalhi.org 808-529-9310 or Toll Free: 1-866-702-3883 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST)</p>
Royal State National	<p><u>Life Insurance</u> 808-539-1621 or Toll Free: 888-942-2447 www.royalstate.com</p> <p><u>Chiropractic Benefit (HSTA VB only)</u> 808-621-4774 or Toll Free: 1-800-414-8845 www.chioplanhawaii.com</p>
CMS Centers for Medicare and Medicaid Services	<p>cms.gov 1-800-MEDICARE</p>

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

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PERMIT NO. 1661

Attention Retiree!!

IF MAKING CHANGES TO YOUR ENROLLMENT, THE DEADLINE FOR MAILING or HAND DELIVERY OF THE ENROLLMENT FORM FOR RETIREES IS FRIDAY, NOVEMBER 13, 2012. FORMS POSTMARKED OR SUBMITTED AFTER NOVEMBER 13, 2012 WILL BE REJECTED.

CHAPTER 87A
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

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Cross References

Hawaii health authority, see chapter 322H.

Case Notes

This chapter's use of general trust language does not impose upon the trustees all of the common law fiduciary duties; although this chapter does not use "discretion" in requiring the board to decide upon the structure of the health benefits plan, the legislature clearly intended that the board have broad discretion in its design; where trustees expressed concern regarding the impact a change to a three- or four-tier structure would have on the collective bargaining process, and also determined that the two-tiered structure would have a negative impact on the smallest percentage of plan participants, trustees did not abuse their discretion. 115 H. 126, 165 P.3d 1027.

The words "similarly situated beneficiary not eligible for medicare", as those words are used in §87A-23(1), or "similarly situated employee-beneficiary not eligible for medicare", as those words are used in §87A-23(3), invoke a comparison between medicare eligible retirees and retirees who do not qualify for medicare; thus, this chapter does not require the board of the employer-union health benefits trust fund to provide health benefits plans to retirees whose benefits "reasonably approximate" those benefits provided to active employees. 122 H. 402, 228 P.3d 282.

PART I. GENERAL PROVISIONS

§87A-1 Definitions. As used in this chapter:

"Board" means the board of trustees of the Hawaii employer-union health benefits trust fund described in section 87A-5.

"Carrier" means a voluntary association, corporation, partnership, or organization engaged in providing, paying for, arranging for, or reimbursing the cost of, health benefits or long-term care benefits under group insurance contracts.

"Contribution" means money payments made to the fund by the State, the counties, an employee-beneficiary, or a qualified-beneficiary.

"County" means the counties of Hawaii, Honolulu, Kauai, and Maui, including their respective boards of water supply and other quasi-independent boards, commissions, and agencies.

"Credited service" means service as an officer or employee paid by the State or county, service during the period of leave of absence or exchange if the individual is paid by the State or county during the leave of absence or exchange, and service during the period of unpaid leave of absence or exchange if the individual is engaged in the performance of a governmental function or if the unpaid leave of absence is an approved leave of absence for professional improvement.

"Dependent-beneficiary" means an employee-beneficiary's:

- (1) Spouse;
- (2) Unmarried child deemed eligible by the board, including a legally adopted child, stepchild, foster child, or recognized natural child who lives with the employee-beneficiary; and
- (3) Unmarried child regardless of age who is incapable of self-support because of a mental or physical incapacity, which existed prior to the unmarried child's reaching the age of nineteen years.

"Employee" means an employee or officer of the State, county, or legislature,

- (1) Including:
 - (A) An elective officer;
 - (B) An officer or employee under an authorized leave of absence;
 - (C) An employee of the Hawaii national guard although paid from federal funds;
 - (D) A retired member of the employees' retirement system; the county pension system; or the police, firefighters, or bandsmen pension system of the State or county;
 - (E) A salaried and full-time member of a board, commission, or agency appointed by the governor or the mayor of a county; and
 - (F) A person employed by contract for a period not exceeding one year, where the director of human resources development, personnel services, or civil service has certified that the service is

essential or needed in the public interest and that, because of circumstances surrounding its fulfillment, personnel to perform the service cannot be obtained through normal civil service recruitment procedures,

- (2) But excluding:
 - (A) A designated beneficiary of a retired member of the employees' retirement system; the county pension system; or the police, firefighters, or bandsmen pension system of the State or county;
 - (B) Except as allowed under paragraph (1)(F), a person employed temporarily on a fee or contract basis; and
 - (C) A part-time, temporary, and seasonal or casual employee.

"Employee-beneficiary" means:

- (1) An employee;
 - (2) The beneficiary of an employee who is killed in the performance of the employee's duty;
 - (3) An employee who retired prior to 1961;
 - (4) The beneficiary of a retired member of the employees' retirement system; a county pension system; or a police, firefighters, or bandsmen pension system of the State or a county, upon the death of the retired member;
 - (5) The surviving child of a deceased retired employee, if the child is unmarried and under the age of nineteen; or
 - (6) The surviving spouse of a deceased retired employee, if the surviving spouse does not subsequently remarry;
- provided that the employee, the employee's beneficiary, or the beneficiary of the deceased retired employee is deemed eligible by the board to participate in a health benefits plan or long-term care benefits plan under this chapter.

"Fund" means the Hawaii employer-union health benefits trust fund established in section 87A-30.

"Health benefits plan" means:

- (1) A group insurance contract or service agreement that may include medical, hospital, surgical, prescribed drugs, vision, and dental services, in which a carrier agrees to provide, pay for, arrange for, or reimburse the cost of the services as determined by the board; or
- (2) A similar schedule of benefits established by the board and provided through the fund on a self-insured basis.

"Long-term care benefits plan" means:

- (1) A group insurance contract or service agreement in which a carrier agrees to provide, pay for, arrange for, or reimburse the cost of long-term care benefits as determined by the board; or
- (2) A similar schedule of benefits established by the board and provided through the fund on a self-insured basis.

"Part-time, temporary, and seasonal or casual employee" means a person employed for fewer than three months or whose employment is less than one-half of a full-time equivalent position.

"Periodic charge" means the periodic payment by the board to a carrier for any health benefits plan or long-term care benefits plan.

"Qualified-beneficiary" means, for purposes of the long-term care benefits plan, a former employee or an employee who is not eligible for benefits due to a reduction in work hours, including the spouse, divorced spouse, parents, grandparents, in-law parents, and in-law grandparents of an employee or retiree; provided that the beneficiary was enrolled in the plan before the employee or former employee became ineligible for benefits.

"State agency" includes the office of Hawaiian affairs.

"Trustee" means a trustee of the board of trustees of the Hawaii employer-union health benefits trust fund, as described in section 87A-5. [L 2001, c 88, pt of §1; am L 2003, c 152, §1; am L 2012, c 36, §1]

PART II. BOARD OF TRUSTEES

§87A-5 Composition of board. [See explanatory note below.] The board of trustees of the employer-union health benefits trust fund shall consist of ten trustees appointed by the governor in accordance with the following procedure:

- (1) Five trustees, one of whom shall represent retirees, to represent employee-beneficiaries and to be selected as follows:
 - (A) Three trustees shall be appointed from a list of two nominees per trustee selected by each of the three exclusive representative organizations that have the largest number of employee-beneficiaries;
 - (B) One trustee shall be appointed from a list of two nominees selected by mutual agreement of the remaining exclusive employee representative organizations; and

- (C) One trustee representing retirees shall be appointed from a list of two nominees selected by mutual agreement of all eligible exclusive representatives; and

- (2) Five trustees to represent public employers.

Section 26-34 shall not apply to board member selection and terms. Notwithstanding any other provision of this section, no exclusive representative of a bargaining unit that sponsors or participates in a voluntary employee beneficiary association shall be eligible to select nominees or to be represented by a trustee on the board.

As used in this section, the term "exclusive representative" shall have the same meaning as in section 89-2. [L 2001, c 88, pt of §1; am L 2005, c 250, §1]

Explanatory Note

L 2005, c 250 amendment. The legislature concluded that the governor's proclamation indicating the governor's intent to return H.B. No. 1548 was constitutionally defective and that said measure became law. On July 13, 2005, the legislature assigned Act 250 to H.B. No. 1548. The attorney general has taken the position that H.B. No. 1548 did not become law.

§87A-6 Term of a trustee; vacancy. [See explanatory note below.] The term of office of each trustee shall be four years; provided that a trustee may be reappointed for one additional consecutive four-year term.

A vacancy on the board shall be filled in the same manner as the trustee who vacated that position was nominated or appointed; provided that the criteria used for nominating or appointing the successor shall be the same criteria used for nominating or appointing the person's predecessor; provided further that vacancies on the board for each trustee position representing retirees and employee-beneficiaries appointed under section 87A-5(1)(A) and (B) shall be filled by appointment of the governor as follows:

- (1) If a vacancy occurs in one of the trustee positions described in section 87A-5(1)(A), then the vacancy shall be appointed from a list of two nominees submitted by the exclusive employee representative from among the three largest exclusive employee representatives that does not have a trustee among the three trustee positions;
- (2) If a vacancy occurs in a trustee position described in section 87A-5(1)(B), then the vacancy shall be appointed from a list of two nominees submitted by

- mutual agreement of the exclusive employee representatives described in section 87A-5(1)(B); and
- (3) If a vacancy occurs in the retiree position described in section 87A-5(1)(C), then the vacancy shall be appointed from a list of two nominees submitted by mutual agreement of all eligible exclusive employee representatives.

If by the end of a trustee's term the trustee is not reappointed or the trustee's successor is not appointed, the trustee shall serve until the trustee's successor is appointed. [L 2001, c 88, pt of §1; am L 2005, c 250, §2]

Explanatory Note

L 2005, c 250 amendment. The legislature concluded that the governor's proclamation indicating the governor's intent to return H.B. No. 1548 was constitutionally defective and that said measure became law. On July 13, 2005, the legislature assigned Act 250 to H.B. No. 1548. The attorney general has taken the position that H.B. No. 1548 did not become law.

[\$87A-7] Chair, vice-chair, and secretary-treasurer. The trustees shall elect from among the members a chair, a vice-chair, and a secretary-treasurer. [L 2001, c 88, pt of §1]

[\$87A-8] Compensation and expenses. Each trustee shall serve without compensation, but the trustees may be reimbursed from the fund for any reasonable expenses incurred in carrying out the purposes of the fund. [L 2001, c 88, pt of §1]

[\$87A-9] Legal adviser. The attorney general shall serve as legal adviser to the board and shall provide legal representation for the Hawaii employer-union health benefits trust fund. [L 2001, c 88, pt of §1]

[\$87A-10] Meetings; notice. Meetings may be scheduled, and notice of meetings shall be provided as follows:

- (1) The chairperson may call a meeting of the board at any time by giving at least six calendar days' written notice of the time and place of the meeting to all trustees; and
- (2) A majority of the trustees may call a meeting of the board by giving at least ten calendar days' written notice of the time and place to all other trustees. [L 2001, c 88, pt of §1]

[\$87A-11] Quorum; board actions; voting. (a) Six trustees, three of whom represent the public employer and three of whom represent employee-beneficiaries, shall constitute a quorum for the transaction of business.

(b) Trustees representing the public employers shall collectively have one vote. Trustees representing the employee-beneficiaries shall collectively have one vote.

For any vote of the trustees representing the public employers to be valid, three of these trustees must concur to cast such a vote. In the absence of such concurrence, the trustees representing the public employers shall be deemed to have abstained from voting.

For any vote of the trustees representing the employee-beneficiaries to be valid, three of these trustees must concur to cast such a vote. In the absence of such concurrence, the trustees representing the employee-beneficiaries shall be deemed to have abstained from voting.

An abstention shall not be counted as either a vote in favor or against a matter before the board.

(c) Any action taken by the board shall be by the concurrence of at least two votes. In the event of a tie vote on any motion, the motion shall fail. Upon the concurrence of six trustees, the board shall participate in dispute resolution. [L 2001, c 88, pt of §1]

[\$87A-12] Records and minutes. The board shall keep records and minutes of all meetings of the board. [L 2001, c 88, pt of §1]

PART III. BOARD POWERS AND DUTIES

[\$87A-15] Administration of the fund. The board shall administer and carry out the purpose of the fund. Health and other benefit plans shall be provided at a cost affordable to both the public employers and the public employees. [L 2001, c 88, pt of §1]

[\$87A-16] Health benefits plan; carriers. (a) The board shall establish the health benefits plan or plans, which shall be exempt from the minimum group requirements of chapter 431.

(b) The board may contract for health benefits plans or provide health benefits through a noninsured schedule of benefits. [L 2001, c 88, pt of §1]

[\$87A-17] Group life insurance benefits or group life insurance program. The board may provide benefits under a group life

insurance benefits program or group life insurance program to employees. [L 2001, c 88, pt of §1]

§87A-18 Long-term care benefits plan; carrier or third-party administrator.

(a) The board may establish a long-term care benefits plan or plans for employee-beneficiaries; the spouses, parents, grandparents, in-law parents, and in-law grandparents of employee-beneficiaries; and qualified-beneficiaries. The plan or plans shall be at no cost to employers and shall comply with article 10H of chapter 431.

(b) Notwithstanding any other law to the contrary, long-term care benefits shall be available only to:

- (1) Employee-beneficiaries and their spouses, parents, and grandparents;
- (2) Employee-beneficiary in-law parents and grandparents; and
- (3) Qualified-beneficiaries who enroll between the ages of twenty and eighty-five,

who comply with the plan's age, enrollment, medical underwriting, and contribution requirements.

(c) The board may contract with a carrier to provide fully insured benefits or with a third-party administrator to administer self-insured benefits. [L 2001, c 88, pt of §1; am L 2004, c 216, §14]

[§87A-19] Plans for part-time, temporary, and seasonal or casual employees.

(a) The board may offer medical, hospital, or surgical benefits plans to part-time, temporary, and seasonal or casual employees at no cost to the employers. The board may determine eligibility for part-time, temporary, and seasonal or casual employees by rules exempt from chapter 91 as provided in section 87A-26.

(b) The board shall establish the medical, hospital, or surgical benefits plan or plans, which shall be exempt from the minimum group requirements of article 10A of chapter 431. The medical, hospital, or surgical benefits plan or plans shall provide, pay for, arrange for, or reimburse the cost of medical, hospital, or surgical services, and may include prescribed hospital in-patient and out-patient service and medical benefits.

(c) The board may contract for the medical, hospital, or surgical benefits plan or plans. Each part-time, temporary, and seasonal or casual employee enrolled for medical, hospital, or surgical benefits shall pay monthly contributions directly to the board's designated carriers. The monthly contributions may include the carrier's administrative costs. [L 2001, c 88, pt of §1]

§87A-20 REPEALED. L 2004, c 216, §45.

[§87A-21] Eligibility. (a) The board shall establish eligibility criteria to determine who can qualify as an employee-beneficiary, dependent-beneficiary, or qualified-beneficiary, consistent with the provisions of this chapter.

(b) A retired member of the employees' retirement system; a county pension system; or a police, firefighters, and bandsmen pension system of the State or county, shall be eligible to qualify as an employee-beneficiary:

- (1) Regardless of whether the retired member was actively employed by the State or county at the time of the retired employee's retirement; and
- (2) Without regard to the date of the retired member's retirement.

(c) A dependent of a retired member shall be eligible to qualify as an employee-beneficiary or dependent-beneficiary:

- (1) Regardless of whether the retired member was actively employed by the State or county at the time of the retired employee's retirement; and
- (2) Without regard to the date of the retired member's retirement. [L 2001, c 88, pt of §1]

Case Notes

A retired employee's health benefits that are included in a health benefits plan falls within the constitutional protection contemplated by article XVI, §2 of the Hawaii constitution inasmuch as subsection (b) clearly and unambiguously conditions a retired state or county government employee's eligibility for health benefits on, inter alia, being a retired member of the employees' retirement system. 122 H. 402, 228 P.3d 282.

[§87A-22] Benefits plan information and enrollment. (a) The board shall make information summarizing approved benefits plans available to each employee-beneficiary. The information shall, to the extent reasonably possible, be distributed to each employee-beneficiary at the same time and in the same manner.

(b) The board shall establish conditions and procedures for benefits plan enrollment. [L 2001, c 88, pt of §1]

§87A-23 Health benefits plan supplemental to medicare. The board shall establish a health benefits plan, which takes into account benefits available to an employee-beneficiary and spouse under medicare, subject to the following conditions:

- (1) There shall be no duplication of benefits payable under medicare. The plan under this section, which shall be secondary to medicare, when combined with medicare and any other plan to which the health benefits plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall provide benefits that approximate those provided to a similarly situated beneficiary not eligible for medicare;
- (2) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a contribution equal to an amount not less than the medicare part B premium, for each of the following who are enrolled in the medicare part B medical insurance plan: (A) an employee-beneficiary who is a retired employee, (B) an employee-beneficiary's spouse while the employee-beneficiary is living, and (C) an employee-beneficiary's spouse, after the death of the employee-beneficiary, if the spouse qualifies as an employee-beneficiary. For purposes of this section, a "retired employee" means retired members of the employees' retirement system; county pension system; or a police, firefighters, or bandsmen pension system of the State or a county as set forth in chapter 88. If the amount reimbursed by the fund under this section is less than the actual cost of the medicare part B medical insurance plan due to an increase in the medicare part B medical insurance plan rate, the fund shall reimburse each employee-beneficiary and employee-beneficiary's spouse for the cost increase within thirty days of the rate change. Each employee-beneficiary and employee-beneficiary's spouse who becomes entitled to reimbursement from the fund for medicare part B premiums after July 1, 2006, shall designate a financial institution account into which the fund shall be authorized to deposit reimbursements. This method of payment may be waived by the fund if another method is determined to be more appropriate;
- (3) The benefits available under this plan, when combined with benefits available under medicare or any other coverage or plan to which this plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall approximate the benefits that would be provided to a

- similarly situated employee-beneficiary not eligible for medicare;
- (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; and
 - (5) The board shall determine which of the employee-beneficiaries and dependent-beneficiaries, who are not enrolled in the medicare part B medical insurance plan, may participate in the plans offered by the fund. [L 2001, c 88, pt of §1; am L 2003, c 111, §1; am L 2006, c 39, §1]

Case Notes

The words "similarly situated beneficiary not eligible for medicare", as those words are used in paragraph (1), or "similarly situated employee-beneficiary not eligible for medicare", as those words are used in paragraph (3), invoke a comparison between medicare eligible retirees and retirees who do not qualify for medicare; thus, this chapter does not require the board of the employer-union health benefits trust fund to provide health benefits plans to retirees whose benefits "reasonably approximate" those benefits provided to active employees. 122 H. 402, 228 P.3d 282.

§87A-24 Other powers. In addition to the power to administer the fund, the board may:

- (1) Collect, receive, deposit, and withdraw money on behalf of the fund;
- (2) Invest moneys in the same manner specified in section 88-119(1)(A), (1)(B), (1)(C), (2), (3), (4), (5), (6), and (7);
- (3) Hold, purchase, sell, assign, transfer, or dispose of any securities or other investments of the fund, as well as the proceeds of those investments and any money belonging to the fund;
- (4) Appoint, and at pleasure dismiss, an administrator and other fund staff. The administrator and staff shall be exempt from chapter 76 and shall serve under and at the pleasure of the board;

- (5) Make payments of periodic charges and pay for reasonable expenses incurred in carrying out the purposes of the fund;
- (6) Contract for the performance of financial audits of the fund and claims audits of its insurance carriers;
- (7) Retain auditors, actuaries, investment firms and managers, benefit plan consultants, or other professional advisors to carry out the purposes of this chapter;
- (8) Establish health benefits plan and long-term care benefits plan rates that include administrative and other expenses necessary to effectuate the purposes of the fund; and
- (9) Require any department, agency, or employee of the State or counties to furnish information to the board to carry out the purposes of this chapter. [L 2001, c 88, pt of §1; am L 2004, c 216, §15]

[\$87A-25] Other duties. The board shall:

- (1) Authorize charges and payments from the fund only upon vouchers countersigned by the chairperson and any other person designated by the board;
- (2) Maintain accurate records and accounts of all financial transactions of the fund that shall be audited annually and summarized in an annual report to the governor and legislature;
- (3) Maintain suitable and adequate records and provide information requested by State and county employers as necessary to carry out the purpose of the fund;
- (4) Procure fiduciary liability insurance and error and omissions coverage for all trustees; and
- (5) Procure a fidelity bond of a reasonable amount for the chairperson and any other person authorized to handle fund moneys. [L 2001, c 88, pt of §1]

[\$87A-26] Rules; policies, standards, and procedures. (a) The board may adopt rules for the purposes of this chapter. Rules shall be adopted without regard to chapter 91. Rulemaking procedures shall be adopted by the board and shall minimally provide for:

- (1) Consultation with employers and affected employee organizations with regard to proposed rules;
- (2) Adoption of rules at open meetings that permit the attendance of any interested persons;
- (3) Approval of rules by the governor; and
- (4) Filing of rules with the lieutenant governor.

(b) The board may also issue policies, standards, and procedures consistent with its rules.

(c) The board may adopt rules, without regard to chapter 91, governing dispute resolution procedures in the event of impasse in decision-making; provided that the rules shall be adopted with the concurrence of six trustees. [L 2001, c 88, pt of §1]

PART IV. TRUST FUND

§87A-30 Hawaii employer-union health benefits trust fund; establishment. There is established outside the state treasury, a trust fund to be known as the "Hawaii Employer-Union Health Benefits Trust Fund". The fund shall consist of contributions, interest, income, dividends, refunds, rate credits, and other returns. It is hereby declared that any and all sums contributed or paid from any source to the fund created by this part, and all assets of the fund including any and all interest and earnings on the same, are and shall be held in trust by the board for the exclusive use and benefit of the employee-beneficiaries and dependent-beneficiaries and shall not be subject to appropriation for any other purpose whatsoever. The fund shall be under the control of the board and placed under the department of budget and finance for administrative purposes. [L 2001, c 88, pt of §1; am L 2006, c 57, §3]

§87A-31 Trust fund; purpose. (a) The fund shall be used to provide employee-beneficiaries and dependent-beneficiaries with health and other benefit plans, and to pay administrative and other expenses of the fund. All assets of the fund are and shall be dedicated to providing health and other benefits plans to the employee-beneficiaries and dependent-beneficiaries in accordance with the terms of those plans and to pay administrative and other expenses of the fund, and shall be used for no other purposes except for those set forth in this section.

(b) The fund, including any earnings on investments, and rate credits or reimbursements from any carrier or self-insured plan and any earning or interest derived therefrom, may be used to stabilize health and other benefit plan rates; provided that the approval of the governor and the legislature shall be necessary to fund administrative and other expenses necessary to effectuate these purposes.

(c) The fund may be used to provide group life insurance benefits to employees to the extent that contributions are provided for group life insurance benefits in sections 87A-32 and 87A-37.

(d) The fund may assist the State and the counties to implement and administer cafeteria plans authorized under Title 26 United States Code section 125, the Internal Revenue Code of 1986, as amended, and section 78-30.

(e) At the discretion of the board, some or all of the fund may be used as a reserve against or to pay the fund's future costs of providing health and other benefits plans established under sections 87A-23 and 87A-37 and any other benefits plans the board establishes for retired employees and their beneficiaries. The board may create separate funds within the fund for this purpose. Each separate fund shall be subject to all of the provisions of this chapter. [L 2001, c 88, pt of §1; am L 2006, c 57, §4]

Revision Note

In subsection (d), reference to "section 78-30" substituted for "part II of chapter 78".

[\$87A-31.5] Employer contributions irrevocable.

Notwithstanding any law to the contrary, all of the monthly contributions that the State and counties make to the fund under sections 87A-32, 87A-33, 87A-34, 87A-35, 87A-36, and 87A-37, and all other contributions that the State and counties may make to the fund, shall be irrevocable; provided that this shall not preclude the fund from returning contributions or payments made by the State or any county under a mistake of fact within one year after the payment of the contributions or payments. [L 2006, c 57, §2]

[\$87A-32] State and county contributions; active employees.

(a) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a monthly contribution equal to the amount established under chapter 89C or specified in the applicable public sector collective bargaining agreements, whichever is appropriate, for each of their respective employee-beneficiaries and employee-beneficiaries with dependent-beneficiaries, which shall be used toward the payment of costs of a health benefits plan; provided that:

- (1) The monthly contribution shall be a specified dollar amount;
- (2) The monthly contribution shall not exceed the actual cost of a health benefits plan;
- (3) If both husband and wife are employee-beneficiaries, the total contribution by the State or the county shall not exceed the monthly contribution for a family plan; and
- (4) If the State or any of the counties establish cafeteria plans in accordance with Title 26, United States Code section 125, the Internal Revenue Code of 1986, as amended, and section 78-30, the monthly contribution for those employee-beneficiaries who

participate in a cafeteria plan shall be made through the cafeteria plan, and the payments made by the State or counties shall include their respective contributions to the fund and their employee-beneficiary's share of the cost of the employee-beneficiary's health benefits plan.

(b) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a monthly contribution equal to the amount established under chapter 89C or specified in the applicable public sector collective bargaining agreement, whichever is applicable, for each of their respective employees, to be used toward the payment of group life insurance benefits for each employee. [L 2001, c 88, pt of §1]

Revision Note

In subsection (a) (4), reference to "section 78-30" substituted for "part II of chapter 78".

§87A-33 State and county contributions; retired employees.

(a) Notwithstanding any law to the contrary, this section shall apply to state and county contributions to the fund for:

- (1) The dependent-beneficiary of an employee who is killed in the performance of duty;
- (2) A dependent-beneficiary, upon the death of the employee-beneficiary, except as provided in section 87A-36;
- (3) An employee-beneficiary who retired after June 30, 1984, due to a disability falling within sections 88-79 and 88-285;
- (4) An employee-beneficiary who retired before July 1, 1984;
- (5) An employee-beneficiary who:
 - (A) Was hired before July 1, 1996;
 - (B) Retired after June 30, 1984; and
 - (C) Who has ten years or more of credited service, excluding sick leave;
- (6) An employee-beneficiary who:
 - (A) Was hired after June 30, 1996; and
 - (B) Retired with twenty-five or more years of credited service, excluding sick leave, except as provided in section 87A-36; and
- (7) Employees who retired prior to 1961 and their dependent-beneficiaries.

(b) Effective July 1, 2003, there is established a base monthly contribution for health benefit plans that the State,

through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund, up to the following:

- (1) \$218 for each employee-beneficiary enrolled in supplemental medicare self plans;
- (2) \$671 for each employee-beneficiary enrolled in supplemental medicare family plans;
- (3) \$342 for each employee-beneficiary enrolled in non-medicare self plans; and
- (4) \$928 for each employee-beneficiary enrolled in non-medicare family plans.

The monthly contribution by the State or county shall not exceed the actual cost of the health benefits plan or plans. If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for a supplemental medicare family or non-medicare family plan, as appropriate.

(c) Effective July 1, 2004, there is established a base monthly contribution for health benefit plans that the State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund, up to the following:

- (1) \$254 for each employee-beneficiary enrolled in supplemental medicare self plans;
- (2) \$787 for each employee-beneficiary enrolled in supplemental medicare family plans;
- (3) \$412 for each employee-beneficiary enrolled in non-medicare self plans; and
- (4) \$1,089 for each employee-beneficiary enrolled in non-medicare family plans.

The monthly contribution by the State or county shall not exceed the actual cost of the health benefit plan or plans and shall not be required to cover increased benefits above those initially contracted for by the fund for plan year 2004-2005. If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for a supplemental medicare family or non-medicare family plan, as appropriate.

(d) The base composite monthly contribution shall be adjusted annually, beginning July 1, 2005. The adjusted base composite monthly contribution for each new plan year (July 1 until June 30) shall be calculated by increasing or decreasing the base composite monthly contribution in effect through the end of the previous plan year by the percentage increase or decrease in the medicare part B premium rate for those years, which percentage shall be calculated by dividing the medicare part B premium rate in effect at the beginning of the new plan

year by the rate in effect at the beginning of the previous plan year.

For the plan year beginning July 1, 2005, the adjusted base monthly contribution shall be computed using the actual contracted premium rate as of July 1, 2004, for medicare and non-medicare, self and family health benefits plans with the highest actual contracted premium rate as of July 1, 2004.

As used in this subsection, "medicare part B premium rate" means the rate published in the Federal Register each year on November 1 or on the business day closest to November 1 of each year after the medicare part B premium rate has been established by the Secretary of Health and Human Services and approved by the United States Congress.

(e) The base composite monthly contribution shall be adjusted annually, beginning January 1, 2013. The adjusted base composite monthly contribution for each new plan year (January 1 until December 31) shall be calculated by increasing or decreasing the base composite monthly contribution in effect through the end of the previous plan year by the percentage increase or decrease in the medicare part B premium rate for those years, which percentage shall be calculated by dividing the medicare part B premium rate in effect at the beginning of the new plan year by the rate in effect at the beginning of the previous plan year.

For the plan year beginning January 1, 2013, the adjusted base monthly contribution shall be computed using the base composite monthly contribution as of July 1, 2012.

As used in this subsection, "medicare part B premium rate" means the rate published in the Federal Register each year on November 1 or on the business day closest to November 1 of each year after the medicare part B premium rate has been established by the United States Secretary of Health and Human Services and approved by the United States Congress.

(f) If the board adopts a rate structure that provides for other than self and family rates for the health benefit plans, the base monthly contribution for the rate structure adopted by the board shall be adjusted to provide the equivalent underwriting cost as the base monthly contribution that is provided for in this section. [L 2001, c 88, pt of §1; am L 2003, c 111, §2; am L 2007, c 26, §1; am L 2012, c 38, §1]

[\$87A-33.5] State and county contribution; reimbursement for retired employees. Effective July 1, 2007, an employee-beneficiary who retires and relocates outside of the State shall be reimbursed for the premiums paid by the employee-beneficiary for a personal health insurance policy; provided that the board shall determine which employee-beneficiaries and what types of

personal health insurance policies shall be eligible for reimbursement and may set other conditions that shall be met for the employee-beneficiary to receive the reimbursements provided under this section.

The reimbursement shall be the lesser of:

- (1) The actual cost of the personal health insurance policy; or
- (2) The amount of the state or county contribution for the most comparable health benefits plan.

Reimbursements shall be paid by the fund on a quarterly basis upon the presentation of documentation that the premiums for the personal health insurance policy have been paid by the employee-beneficiary. This section shall apply to all employee-beneficiaries who retire and relocate outside of the State, regardless of their date of retirement. [L 2006, c 167, §1]

§87A-34 State and county contributions; retired employees with fewer than ten years of service. (a) This section shall apply to state and county contributions to the fund for employees specified in paragraph (1)(E) of the definition of "employee" in section 87A-1 who:

- (1) Were hired on or before June 30, 1996; and
- (2) Retired after June 30, 1984, with fewer than ten years of credited service, excluding sick leave.

(b) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a monthly contribution equal to one-half of the base monthly contribution set forth under section 87A-33(b) for retired employees enrolled in medicare or non-medicare health benefits plans. If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for supplemental medicare family or non-medicare family plan, as appropriate. [L 2001, c 88, pt of §1]

§87A-35 State and county contributions; employees hired after June 30, 1996, but before July 1, 2001, and retired with fewer than twenty-five years of service. (a) This section shall apply to state and county contributions to the fund for employees who were hired after June 30, 1996, but before July 1, 2001, and who retire with fewer than twenty-five years of credited service, excluding sick leave; provided that this section shall not apply to the following employees, for whom state and county contributions shall be made as provided by section 87A-33:

- (1) An employee hired prior to July 1, 1996, who transfers employment after June 30, 1996, and who cumulatively accrues at least ten years of credited service; and
- (2) An employee hired prior to July 1, 1996, who has at least ten years of credited service prior to a break in service.

For the purposes of this section:

"Break in service" means to leave state or county employment for more than ninety calendar days before returning to state or county employment.

"Transfer" means to leave state or county employment and return to state or county employment within ninety calendar days.

(b) For purposes of this section, if an employee leaves state or county employment and returns to state or county employment after June 30, 1996, upon retirement, the employee's years of service shall be computed in the same manner as set forth in chapter 88.

(c) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund:

- (1) For retired employees enrolled in medicare or non-medicare health benefit plans with ten or more years but fewer than fifteen years of service, a monthly contribution equal to one-half of the base monthly contribution set forth under section 87A-33(b); and
- (2) For retired employees enrolled in medicare or non-medicare health benefit plans with at least fifteen but fewer than twenty-five years of service, a monthly contribution of seventy-five per cent of the base monthly contribution set forth under section 87A-33(b).

If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for a supplemental medicare family or non-medicare family plan, as appropriate. [L 2001, c 88, pt of §1; am L 2004, c 184, §1]

§87A-36 State and county contributions; employees hired after June 30, 2001, and retired. (a) This section shall apply to state and county contributions to the fund for employees hired after June 30, 2001, and who retired, except that this section shall not apply to the following employees, for whom state and county contributions shall be made as provided by section 87A-35:

- (1) An employee hired after June 30, 1996, and prior to July 1, 2001, who transfers employment after June 30,

2001, and who cumulatively accrues at least ten years of credited service; and

- (2) An employee hired after June 30, 1996, and prior to July 1, 2001, who has at least ten years of credited service prior to a break in service.

For purposes of this section:

"Break in service" means to leave state or county employment for more than ninety calendar days before returning to state or county employment.

"Transfer" means to leave state or county employment and return to state or county employment within ninety calendar days.

(b) For purposes of this section, if an employee leaves state or county employment and returns to state or county employment after July 1, 2001, upon retirement, the employee's years of service shall be computed in the same manner as set forth in chapter 88.

(c) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund:

- (1) For retired employees based on the self plan with ten or more years but fewer than fifteen years of service, a monthly contribution equal to one-half of the base medicare or non-medicare monthly contribution set forth under section 87A-33(b);
- (2) For retired employees based on the self plan with at least fifteen but fewer than twenty-five years of service, a monthly contribution equal to seventy-five per cent of the base medicare or non-medicare monthly contribution set forth under section 87A-33(b);
- (3) For retired employees based on the self plan with twenty-five or more years of service, a monthly contribution equal to one-hundred per cent of the base medicare or non-medicare monthly contribution set forth under section 87A-33(b); and
- (4) One-half of the monthly contributions for the employee-beneficiary or employee-beneficiary with dependent-beneficiaries upon the death of the employee, as defined in paragraph (1)(E) of the definition of "employee" in section 87A-1.

If both husband and wife are employee-beneficiaries, the total contribution by the State or county shall not exceed the monthly contribution for two supplemental medicare self or non-medicare self plans, as appropriate. [L 2001, c 88, pt of §1; am L 2004, c 184, §2]

[\$87A-37] Group life insurance benefits plans for retired employees; contributions. (a) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a base monthly contribution as set forth in subsection (b) for each retired employee enrolled in the fund's group life insurance benefits plan under section 87A-34, 87A-35, and 87A-36.

(b) Effective July 1, 2003, there is established a base monthly contribution of \$4.16 for each retired employee enrolled in a group life insurance plan; provided that the monthly contribution shall not exceed the actual cost of the group life insurance benefits plan. The base composite monthly contribution shall be adjusted annually beginning July 1, 2004. The adjusted base composite monthly contribution for each new plan year shall be calculated by increasing or decreasing the base composite monthly contribution in effect through the end of the previous plan year by the percentage increase or decrease in the medicare part B premium rate for those years. The percentage shall be calculated by dividing the medicare part B premium rate in effect at the beginning of the new plan year by the rate in effect through the end of the previous plan year.

As used in this subsection, "medicare part B premium rate" means the rate published in the Federal Register each year on November 1 or on the business day closest to November 1 of each year after the medicare part B premium rate has been established by the Secretary of Health and Human Services and approved by the United States Congress. [L 2001, c 88, pt of \$1]

[\$87A-38] State and county contributions not considered wages or salary. Contributions made by the State or the counties under this part shall not be considered wages or salary of an employee-beneficiary. No employee-beneficiary shall have any vested right in or be entitled to receive any part of any contribution made to the fund. [L 2001, c 88, pt of \$1]

[\$87A-39] Reimbursement for state contributions. (a) All state agencies having control of funds other than the general fund shall reimburse the State for contributions made by the State pursuant to sections 87A-32, 87A-33, 87A-34, 87A-35, 87A-36, and 87A-37 on account of agency employees whose compensation is paid in whole or part from funds other than the general fund.

(b) All state and county agencies receiving federal funds, which may be expended for the purpose of replacing the contributions payable by the State to the fund, shall set aside a portion of the federal funds sufficient to reimburse the State for contributions made by the State pursuant to sections 87A-32,

87A-33, 87A-34, 87A-35, 87A-36, and 87A-37, on account of the employees in the agencies whose compensation is paid in whole or part from federal funds. [L 2001, c 88, pt of §1]

[\$87A-40] Employee-beneficiary contributions; health benefit plans. (a) Each employee-beneficiary shall make a monthly contribution to the fund amounting to the difference between the monthly charge of the health benefits plan selected by the employee-beneficiary and the contribution made by the State or county for the employee-beneficiary to the fund. Nothing in this section shall prohibit any employee-beneficiary from participating in a cafeteria plan authorized under Title 26 United States Code section 125, Internal Revenue Code of 1986, as amended, and section 78-30.

(b) During the period the health benefits plan selected by an employee-beneficiary is in effect, the employee-beneficiary, if allowed by law, shall authorize the employee-beneficiary's contribution to be withheld and transmitted to the fund monthly by the comptroller, employees' retirement system, or finance officer who disburses the employee-beneficiary's compensation, pension, or retirement pay. If an employee-beneficiary's contribution to the fund is not withheld and transmitted to the fund, the employee-beneficiary shall pay the monthly contribution:

- (1) In the case of an employee-beneficiary who normally receives the employee-beneficiary's compensation from the comptroller or employees' retirement system, directly to the fund by the first day of each month; or
- (2) In the case of all other employee-beneficiaries, to the respective finance officer from whom the employee-beneficiary normally receives compensation for transmittal to the fund by the first day of each month.

(c) Notwithstanding subsection (a), an employee-beneficiary's monthly contribution to the fund shall include the amount that would have been the employee-beneficiary's contribution if the employee-beneficiary had not elected to participate in the cafeteria plan. [L 2001, c 88, pt of §1]

Revision Note

In subsection (a), reference to "section 78-30" substituted for "part II of chapter 78".

[\$87A-41] Employee-beneficiary or qualified-beneficiary contributions; long-term care benefits plan. (a) During the

period the long-term care benefits plan is in effect, the employee-beneficiary, if allowed by law, shall authorize the employee-beneficiary's contribution to be withheld and transmitted to the fund monthly by the comptroller, employees' retirement system, or finance officer who disburses the employee-beneficiary's compensation, pension, or retirement pay. If an employee-beneficiary's monthly contribution to the fund is not withheld and transmitted to the fund, the employee-beneficiary shall pay the monthly contribution directly to the board's designated carrier or third-party administrator as specified by the board.

(b) Qualified-beneficiaries shall pay monthly contributions directly to the board's designated carrier or third-party administrator as specified by the board. [L 2001, c 88, pt of §1]

[§87A-42] Other post-employment benefits trust.

Notwithstanding sections 87A-31 and 87A-31.5, the board, upon terms and conditions set by the board, may establish and administer a separate trust fund for the purpose of receiving employer contributions that will prefund other post-employment health and other benefit plan costs for retirees and their beneficiaries. If a fund is established, it shall meet the requirements of the Government Accounting Standards Board regarding other post-employment benefits trusts. Employer contributions to the separate trust fund shall be irrevocable, all assets of the fund shall be dedicated exclusively to providing health and other benefits to retirees and their beneficiaries, and assets of the fund shall not be subject to appropriation for any other purpose and shall not be subject to claims by creditors of the employers or the board or plan administrator. The board's powers under section 87A-24 shall also apply to any fund established pursuant to this section. [L 2012, c 304, §1]

Note

Authorization to create fund requires Government Accounting Standards Board requirements. L 2012, c 304, §2.

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND**ADMINISTRATIVE RULES****CONTENTS**

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1.00 GENERAL PROVISIONS

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1.01 Purpose

Chapter 87A of the Hawaii Revised Statutes establishes a health trust fund known as the Hawaii Employer-Union Health Benefits Trust Fund. The Fund is to be used to provide eligible state and county employees, retirees, and their dependents with health and other benefit plans at a cost affordable to both the public employers and the public employees. The board is to administer and carry out the purposes of the Fund. These rules are adopted by the board pursuant to Section 87A-26 of the Hawaii Revised Statutes to implement the administration and purposes of the Fund.

1.02 Definitions

As used in these rules, unless otherwise indicated by the context, the following terms shall have the following meanings:

“Administrator” means the administrator of the Fund appointed by the board or the duly authorized representative of the administrator.

“Benefit plan” means a health benefit plan, a group life insurance plan that is subject to Section 79 of the Internal Revenue Code, or any other type of benefit plan except for a long-term care benefit plan.

“Board” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Carrier” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Child” means an employee’s, or where applicable, a domestic partner’s legally adopted child, a child placed for adoption, stepchild, foster child, or recognized natural child. Except for a recognized natural child of an employee or as otherwise provided by these rules, a child must live with the employee-beneficiary. A child has been placed for adoption when an adoptive parent has assumed custody of and the obligation to support a child in anticipation of adopting the child. A foster child is a child:

- (1) who lives with an employee in a regular parent-child relationship; and
- (2) for whom the employee has become the child’s guardian or has been awarded legal and physical custody of the child pursuant to a valid court order.

“Contributions” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“County” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Dependent-beneficiary” shall mean the persons described in Rule 3.01 of these rules as being eligible for coverage as dependent-beneficiaries in the health benefit plans offered or sponsored by the Fund.

“Dissolution of domestic partnership” shall occur when: (1) the employee-beneficiary no longer meets the requirements to qualify as a “domestic partner”; (2) one of the partners to the domestic partnership expressly informs the other of the end of their domestic partnership; (3) one of the partners to the domestic partnership takes actions inconsistent with the continued existence of the domestic partnership; or (4) the domestic partnership is otherwise terminated or dissolved.

“Domestic partner” shall mean a person in a spouse-like relationship with an employee-beneficiary who meets the following requirements: (1) the employee-beneficiary and the domestic partner intend to remain in a domestic partnership with each other indefinitely; (2) the employee-

beneficiary and the domestic partner have a common residence and intend to reside together indefinitely; (3) the employee-beneficiary and the domestic partner are and agree to be 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 the employee-beneficiary nor the domestic partner are married or a member of another domestic partnership; (5) the employee-beneficiary and the domestic partner are not related by blood in a way that would prevent them from being married to each other in the State of Hawaii; (6) the employee-beneficiary and the domestic partner are both at least 18 years of age and mentally competent to contract; (7) the consent of the employee-beneficiary or the domestic partner to the domestic partnership has not been obtained by force, duress or fraud; and (8) the employee-beneficiary and the domestic partner sign and file with the Fund a declaration of domestic partnership in such form as the board shall from time to time prescribe.

“Employee” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Employee-beneficiary” shall mean the persons described in Rule 3.01 of these rules as being eligible to enroll as employee-beneficiaries in the health benefit plans offered or sponsored by the Fund.

“Employer” or “public employer” shall have the meaning as set forth in Section 89-2 of the Hawaii Revised Statutes.

“Full-time student” means a student who is enrolled in an accredited school, college, or university for not less than the minimum number of credit hours required by such educational institution to have full-time student status.

“Fund” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Fund benefit plan” means a benefit plan offered or sponsored by the Fund.

“Health benefit plan” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Long-term care benefit plan” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Non-Fund benefit plan” means a benefit plan offered or sponsored by a private employer or an entity other than the Fund.

“Part-time, temporary, and seasonal or casual employee” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Periodic change” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Qualified beneficiary” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Qualified medical child support order” means any judgment, decree, or order issued by a court of competent jurisdiction that requires the provision of health benefits coverage to a child of a non-custodial parent.

“Retired member” or “retired employee” means a former employee, officer, appointed or elected official of the State or counties who is currently receiving a retirement or pension allowance from a State or county retirement system or an employee who retired prior to 1961.

“State or county retirement system” means the employees’ retirement system, the county pension system, or the police, fire, or bandsmen pension system of the State or any county.

“Trustee” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Trustee group” means the group composed of the five trustees representing public employers or the group composed of the five trustees representing employee-beneficiaries as described in Section 87A-5 of the Hawaii Revised Statutes.

1.03 Public Information

To the extent permitted by applicable federal or state law, the public records of the Fund shall be available for inspection at the Fund's office during regular business hours. All requests for inspection of public records shall be in writing and addressed to the administrator or any other person designated by the board to receive such requests. Copies of public records shall be provided upon the payment of the reasonable costs of reproduction and any fees for searching, reviewing and segregating such records. The board shall establish such costs and fees in accordance with applicable federal and state law.

Protected health information about employee-beneficiaries and dependent-beneficiaries are not public records. Employee-beneficiaries, dependent-beneficiaries, and others may have access to such information only in conformance with the Health Insurance Portability and Accountability Act of 1996 and the rules passed under that Act ("HIPAA"), and the Fund's HIPAA Privacy Policies and Procedures.

1.04 Computation of Time

Whenever a period of time is stated in these rules as a number of days from or after an event: (a) the period shall be computed in calendar days; (b) the day of the event shall not be included in the calculation; and (c) the last day of the period shall be included in the calculation.

1.05 Officers of the Board

- (a) The board shall elect a chairperson, vice-chairperson, and secretary-treasurer.
- (b) Both the chairperson and vice-chairperson shall be elected from the same trustee group. The secretary-treasurer shall be elected from the other trustee group.
- (c) Officer terms shall be for one year beginning July 1, 2002, and shall rotate between the trustee groups annually. The terms of all elected officers shall terminate on June 30 of each succeeding year and such officers shall vacate their offices at that time.

- (d) Except as otherwise provided by law or by rules or policies adopted by the board, the duties of the officers shall be as provided in the 10th Edition of *Robert's Rules of Order, Newly Revised*.
- (e) The chairperson or vice-chairperson and secretary-treasurer shall coordinate assignments to the administrator and other Fund staff, requests for information, and other matters concerning the administration and operation of the board.

1.06 Committees of the Board

- (a) Standing committees shall be established by the board to address critical issues in the major functional areas of the Fund:
 - (1) The Administrative Committee will have combined administrative and finance committee functions;
 - (2) The Benefits Committee will have benefits, communication, and appeals committee functions.
- (b) The board may establish other committees to address matters related to the operation or administration of the Fund or to investigate issues that impact the Fund.
- (c) Committees shall operate informally and shall make recommendations to the full board. Meetings of all standing committees will comply with Part I of Chapter 92 of the Hawaii Revised Statutes.
- (d) A minimum of four trustees (two trustees from each trustee group) shall be assigned to a committee. The assigned number of trustees may be larger for certain committees provided that an equal number of trustees are assigned from each trustee group.
- (e) Attendance of at least one trustee from each trustee group shall be necessary to convene a committee meeting.
- (f) Committees may select a chairperson and any other officers as deemed necessary by the board.
- (g) Committee chairpersons shall coordinate assignments to the administrator and other Fund staff for their respective committees.

- (h) Trustees in attendance shall agree within their working committees on recommendations made to the full board. When there is no agreement by the trustees in attendance, the committee shall present a summary of the disagreement(s) to the full board.

1.07 Meetings of the Board

- (a) To the extent permitted by applicable federal or state law, the meetings of the board shall be open to the public. Without limiting the foregoing, board meetings shall comply with Part I of Chapter 92 of the Hawaii Revised Statutes, including the provisions therein requiring: (1) written and electronic notice of board meetings at least six calendar days prior to each meeting; and (2) written minutes.
- (b) The board shall designate the administrator or some other member of the Fund's staff to be responsible for preparing agendas for future board meetings. Any trustee may place a question or subject on the agenda of a future board meeting by notifying the administrator or other designated staff person by 12:00 noon, seven days prior to the board meeting. All board meeting agendas shall be transmitted to the chairperson for review prior to public notice.
- (c) Unless otherwise required by the board or applicable law, the parliamentary procedure to be used by the board in the conduct of its meetings shall be in accordance with the 10th Edition of *Roberts Rules of Order, Newly Revised*.
- (d) Voting procedures for board meetings and the criteria for a quorum are established in Section 87A-11 of the Hawaii Revised Statutes. In addition, the following voting procedures shall apply:
 - (1) After a motion is made and seconded, the presiding officer shall read the motion and open the question to discussion and debate by the trustees. When ready to put the motion to a vote, the presiding officer shall call for the public employer and employee-beneficiary trustee votes to determine whether there are three votes from each trustee group in favor of the motion. If so, the motion shall be recorded as having been approved by one vote from the public employer trustees and one vote from the employee-beneficiary trustees.

- (2) For routine or procedural matters, the presiding officer may ask if there is any opposition to a motion after it has been made, and to the extent required, seconded and debated. If no opposition is voiced, the motion shall be recorded as having been unanimously approved by one vote by the public employer trustees and one vote from the employee-beneficiary trustees.
- (3) If the voting is not unanimous by each side, the names of the trustees who voted in favor of the motion, voted against the motion, or abstained from voting shall be recorded in the minutes.
- (4) In the event of a deadlock in a vote of the board on the same question or resolution at two successive meetings of the board, the board shall vote on whether or not to engage in dispute resolution. If six trustees of the board vote to engage in dispute resolution, the two trustee groups shall enter into mediation to attempt to resolve the question or resolution upon which the board has deadlocked.

The mediation shall be handled by a mediator appointed by the Federal Mediation and Conciliation Service. If the Federal Mediation and Conciliation Service fails or refuses to appoint a mediator within ten days of the date on which the six trustees voted to engage in dispute resolution, the mediation shall be handled by a mediator mutually agreeable to the two trustee groups. If the two trustee groups do not agree on a mediator within twenty days of the date on which the six trustees voted to engage in dispute resolution, either trustee group may petition the Administrative Judge of the First Circuit, Circuit Courts of the State of Hawaii, to appoint a mediator. Upon the appointment of a mediator, the two trustee groups shall in good faith enter into mediation on the question or resolution upon which the board has deadlocked. Nothing in this rule is meant to preclude the board from voting to engage in other forms of alternate dispute resolution to resolve a question or resolution upon which it has deadlocked.

- (5) Whenever any statute or other law requires a vote of a majority, two-thirds or other percentage or fraction of the trustees or members to which the board is entitled, the motion or other action shall be approved if it receives two votes in favor of the motion or

action as provided in subsection (d)(1), regardless of the total number of votes in favor of the motion or action.

For example, if a statute or other law requires a two-thirds vote of the members to which the board is entitled, the motion or other action will be approved if three trustees from each trustee group vote in favor of the motion or other action, even if the remaining four trustees vote against the motion or other action.

1.08 Appearances Before the Board

- (a) All persons shall comply with this rule when appearing before the board. Unless otherwise required by applicable federal or state law, the board shall have the discretion to prescribe additional standards and procedures for all appearances and proceedings before the board. The board may waive or suspend the provisions of this rule with respect to any particular appearance or proceeding before it.
- (b) Any person appearing before the board may appear in person, by an officer, partner or regular employee of the party, or be represented by an authorized representative. The board may at any time require any person transacting business with the board in a representative capacity to prove or authenticate the person's authority and qualification to act in such capacity.
- (c) The board shall afford all interested persons an opportunity to present oral testimony or submit data, views, or arguments, in writing, on any agenda item.
 - (1) Persons providing written testimony shall provide thirty copies of their testimony of which twenty copies shall be made available to the public. Twenty copies of materials provided to the board for or during a meeting that are determined to be disclosable shall be made available for distribution to the public.
 - (2) The board shall hear oral testimony on an agenda item after it has completed discussion of that item. At that time, the presiding officer shall invite members of the public to ask questions or provide comments on the agenda item prior to any action by the board. After the public has had an opportunity to provide input on

the agenda item, the board may discuss the agenda item further and act on the item or move on to the next agenda item.

- (3) A person may speak at a board meeting only when recognized to do so by the presiding officer. Comments are limited to three minutes per speaker. Time limitations may be adjusted at the discretion of the presiding officer or at the request of any three trustees. A person may not speak a second time on the same question unless authorized by the presiding officer to do so.
 - (4) The board may refuse to hear any testimony that is irrelevant, immaterial, or unduly repetitious and may from time to time impose additional conditions as are necessary or desirable for the orderly, efficient, and convenient presentation of oral testimony to the board. The board may request that the person providing oral testimony submit the testimony in writing to the board.
- (d) Nothing herein shall require the board to hear or receive any oral testimony or documentary evidence from a person on any matter which is the subject of another proceeding pending before the board.

1.09 Delegation of Authority

To the extent permitted by law, the board may delegate authority to act on its behalf in accordance with board policies and standards to a committee of the board, an administrator, a carrier, a third party administrator, or to such other persons and entities as it deems necessary or reasonable for the effective and efficient administration of the Fund and the provisions of Chapter 87A of the Hawaii Revised Statutes; provided, however, that nothing in this rule shall permit the board to delegate its power to adopt, amend or repeal any rules.

1.10 State Ethics Code

All trustees and employees of the Fund shall comply with Chapter 84 of the Hawaii Revised Statutes.

1.11 Controlling Law

To the extent that federal or state law governs any matter covered by these rules, the Fund and the board shall comply with and follow such federal or state law. To the extent that any matter is not completely governed by federal or state

law, the Fund and the board shall apply these rules to the extent reasonable and practicable.

1.12 Authority of the Board to Waive Rule Provisions

Subject to statutory requirements and limitations, the Board may waive an employee-beneficiary's compliance with any provision of the Fund's rules when the Board determines that: (a) good cause exists for such a waiver; (b) strict enforcement of such provision would impose a manifest injustice upon an employee-beneficiary who has substantially complied with the Fund's rules in good faith; and (c) such waiver does not involve any increase in the obligations or liabilities of the Fund beyond that which would have been involved if the employee-beneficiary had fully complied with the Fund's rules. Each waiver by the Board must be in writing and supported by documentation of the pertinent facts and grounds.

1.13 Responsibilities of Employee-Beneficiaries and Public Employers; Enforcement Actions of the Fund

- (a) Employee-beneficiaries are responsible for:
- (1) Providing current and accurate personal information as per Rules 4.06 and 4.07;
 - (2) Paying the employee's premium contributions in the amount or amounts provided by statute, an applicable bargaining unit agreement, or by the applicable Fund benefit plan;
 - (3) Paying the employee's premium contributions at the times and in the manner designated by the board; and
 - (4) Complying with the Fund's rules.
- (b) Any public employer whose current or former employees participate in Fund benefit plans is responsible for:
- (1) Providing information as requested by the Fund under section 87A-24(9) of the Hawaii Revised Statutes;
 - (2) 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;

- (3) Assisting the Fund in distributing information to and collecting information from the employee-beneficiaries; and
 - (4) Complying with the Fund's rules.
- (c) The Fund shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the Fund.

2.00 ADMINISTRATIVE PROCEDURES

- 2.01 Adoption, Amendment or Repeal of Rules
- 2.02 Policies, Standards, and Procedures
- 2.03 Declaratory Rulings
- 2.04 Administrative Appeals
- 2.05 Emergency Appeals

2.01 Adoption, Amendment or Repeal of Rules

- (a) The board may adopt, amend or repeal any rule of the Fund upon a motion of any trustee or upon the petition of an interested person or organization.
- (b) In the case of an interested person or organization, the petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain:
 - (1) The petitioner's name, address, and telephone number;
 - (2) A statement of the nature of the petitioner's interest;
 - (3) A statement of the reasons for the proposed rule, amendment or repeal;
 - (4) A draft of the proposed rule, amendment or repeal; and
 - (5) The signature of the petitioner.

The board may reject any petition that does not contain the foregoing information.

- (c) The board shall determine whether to deny or proceed with a petition within ninety days. If the petition is denied, the board shall notify the interested person or organization in writing of the denial.
- (d) If the board decides to proceed with any proposed rule change, whether by a trustee or interested person or organization, it shall consult with public employers and affected employee organizations with regard to the proposed rule change as follows. First, it shall transmit the proposed rule change to the public employers, exclusive employee organizations, exclusive representatives, retiree organizations, and all other employee organizations registered with the board for consultation prior to adoption. Second, it shall provide the employers, representatives and organizations a

reasonable amount of time for review and comment on the proposed change prior to final action by the board.

- (e) After the consultation provided for in subsection (d), the proposed rule change shall be considered for adoption at an open meeting of the board that permits the attendance of interested persons.
- (f) All proposed rule changes shall be adopted by the board in accordance with the provisions of section 87A- 26 of the Hawaii Revised Statutes.
- (g) New rules, amendments or repeals of rules that are adopted by the board shall be submitted to the governor for approval and filed with the lieutenant governor's office.
- (h) Unless some other date is expressly selected by the board, a new rule, amendment of a rule, or repeal of a rule shall be effective the first day after the rule, amendment, or repeal is filed with the lieutenant governor's office.

2.02 Policies, Standards, and Procedures

Policies, standards and procedures to be adopted amended or repealed may, at the discretion of the board, be transmitted to public employers and affected employee organizations for consultation purposes. Nothing herein shall require the board to consult with public employers or affected employee organizations concerning the board's adoption, amendment or repeal of policies, standards and procedures or to transmit any such policies, standards or procedures to public employers or affected employee organizations for consultation purposes.

2.03 Declaratory Rulings

- (a) Any interested person may petition the board for a declaratory ruling as to the applicability of any statutory provision administered by the board or of any rule or order of the Fund.
- (b) Every petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain the following:
 - (1) The petitioner's name, address, and telephone number;
 - (2) A designation of the specific statute, rule or order in question;

- (3) A statement of the nature of the petitioner's interest, including the reasons for the submittal of the petition;
- (4) A complete statement of the relevant and material facts;
- (5) A statement of the position or contentions of the petitioner; and
- (6) A full discussion of the reasons, including any legal authorities, in support of the petitioner's position or contention.

The board may reject any petition that does not contain the foregoing information.

- (c) Petitions to intervene and become a party to a declaratory ruling proceeding may be submitted in writing to the board. Such petitions shall contain the same information as required under subsection (b) and the grounds and reasons on which intervention is sought. The Board may deny intervention where the petition to intervene raises issues not reasonably pertinent to the issues already presented or the petition raises issues that would broaden the issues to be decided. If intervention is granted, the petitioner shall become a party to the proceeding to the degree permitted by the order granting intervention.
- (d) The board may dismiss any petition for a declaratory ruling for good cause. Without limiting the generality of good cause, the board may dismiss a petition if:
 - (1) The question raised is purely speculative or hypothetical;
 - (2) The petitioner's interest is not of the type or nature that would give the petitioner standing to maintain an action if the petitioner were to seek judicial relief;
 - (3) The issuance of a declaratory ruling may adversely affect the interests of the employer, the board, any of the trustees, the Fund, or any of the Fund's officers or employees in litigation which is pending or reasonably expected to arise in the future; or
 - (4) The matter is not within the jurisdiction of the board.
- (e) Subject to applicable federal and state law, the board at its discretion shall:
 - (1) Render a decision on the petition for a declaratory ruling without a hearing; or
 - (2) Hold a hearing and thereafter render its decision on the petition; or
 - (3) Refer the petition for consideration or hearing to the administrator, a special or standing committee of the board or any other person or

entity duly designated by the board. After considering the recommendation of the administrator, committee or designated person or entity, the board shall render its decision on the petition.

Where any question of law is involved, the board may seek the assistance of the state attorney general in reviewing the matter. The board may also seek the assistance of other government agencies when necessary or desirable.

Any petitioner who desires a hearing shall submit a written request for a hearing together with the petition for a declaratory ruling. The written request shall set forth in detail the reasons why the matters alleged in the petition, together with supporting affidavits or other written evidence and briefs or memoranda of legal authorities, will not permit the fair and expeditious disposition of the petition and, to the extent that the request for a hearing is dependent upon factual assertions, shall submit affidavits or certificates establishing those facts.

- (f) The petition for a declaratory ruling shall either be rejected in accordance with subsection (d) or acted upon by issuance of an order within ninety days. Upon the disposition of the petition, the board shall promptly notify the petitioner.
- (g) Orders disposing of petitions for a declaratory ruling will have the same status as other agency orders. An order shall be applicable only to the fact situation alleged in the petition or as set forth in the order. An order shall not be applicable to different fact situations or where additional facts exist that were not considered in the order.

2.04 Administrative Appeals

- (a) A person aggrieved by one of the following decisions by the Fund may appeal to the 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 Fund;

- (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 Fund; 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 Fund.
- (b) The first step in the appeal process is an appeal to the administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the Fund's office within thirty days of the date of the 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 thirty-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.
- (c) 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 ninety days of its being filed in the Fund'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 Fund'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.

- (d) 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.
- (e) The board shall grant or deny the appeal within a reasonable amount of time. 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. Nothing in these 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.
- (f) At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the Rule by submitting such a waiver in writing to the Fund's office. The board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

2.05 Emergency Appeals

- (a) An employee-beneficiary ("appellant") who is aggrieved by a plan administrator's decision denying or limiting benefits provided under a plan offered by the Fund to the employee-beneficiary or a dependent-beneficiary enrolled by the employee beneficiary may make an emergency

appeal directly to the Board where a delay in following the Fund's normal appeal process could:

- (1) Seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary;
 - (2) Seriously jeopardize the employee-beneficiary's or dependent-beneficiary's ability to regain maximum functioning; or
 - (3) In the opinion of a physician with knowledge of the medical condition of the employee-beneficiary or dependent-beneficiary, subject the employee-beneficiary or dependent-beneficiary to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.
- (b) Any appellant desiring to make an emergency appeal under this Rule shall file a written request with the Fund administrator that contains the following information:
- (1) The name, address, and telephone number of the appellant;
 - (2) A description of the decision with respect to which relief is requested;
 - (3) A statement of the relevant and material facts;
 - (4) A statement as to why the appellant is appealing the decision, including all arguments and reasons that support the appellant's position or contentions;
 - (5) A statement as to why the appellant's appeal qualifies as an emergency appeal, i.e., why the appeal meets one or more of the conditions stated in subsection (a) above;
 - (6) A statement as to exactly what relief the appellant is seeking;
 - (7) Any documents and records that support the appellant's appeal, including, but not limited to, any opinions from physicians that show that the appeal should be handled as an emergency appeal; and
 - (8) If the appellant is going to be represented by a third person on the appeal: (i) a signed authorization by the appellant designating the third person to represent him or her on the appeal; or (ii) other documentation establishing the right of the third person to represent the appellant. Such documentation may include letters of guardianship, a power of attorney, or any other document establishing that the third person may represent the appellant. Appropriate representatives may include, but are not limited to, the parent, child, spouse or domestic partner of the appellant.

Notwithstanding the foregoing, the Fund administrator may waive the foregoing requirements if the Fund administrator finds that the criteria for making an emergency appeal are present and circumstances prevent the appellant from filing a written request for an appeal.

- (c) Within two business days of receipt of a request for emergency appeal, the Fund administrator shall determine whether the request for emergency appeal qualifies as an emergency appeal under the criteria stated in this Rule. If the Fund administrator determines that the request for emergency appeal does not qualify as an emergency appeal, the appellant's appeal shall be handled as a normal appeal. Appellant may appeal the Fund administrator's denial of a request for emergency appeal by filing a written request with the Fund Administrator. No particular form is required for such a written request so long as it can be understood that the appellant is seeking to appeal the Fund administrator's decision to the Board.
- (d) Upon determining that an appeal qualifies as an emergency appeal or upon receipt of an appeal of the Fund administrator's denial of a request for emergency appeal, the Fund administrator shall take the following actions:
 - (1) Set a time and date of a hearing when a quorum of the Board can be present. Subject to quorum requirements, the hearing shall be set within five business days of: (i) the date of the Fund administrator's determination that the appeal qualifies as an emergency appeal, or (ii) the date of receipt of an appeal of the Fund administrator's denial of a request for emergency appeal;
 - (2) Notify the appellant and his or her representative, if any, of the time and date of the hearing;
 - (3) Notify the plan administrator of the time and date of the hearing, provide the plan administrator with a copy of the written request for an emergency appeal filed by the appellant, and invite the plan administrator to submit a written statement of the plan administrator's position regarding the emergency appeal. If the plan administrator submits such a written statement, a copy shall be provided by the Fund administrator to the appellant;
 - (4) In the notices to the appellant and plan administrator, the Fund administrator shall request the parties to provide the Fund administrator with copies of any documents, records, written

- testimony, or other written evidence that they wish the Board to consider at the hearing. To facilitate the hearing, the Fund administrator may request that the parties stipulate to the admission of all or any of such documents, records, written testimony, or other written evidence; and
- (5) Prior to the hearing, the Fund administrator shall provide each member of the Board that will attend the hearing with copies of the written request for an emergency appeal and any written statement of position by the plan administrator.
- (e) Unless the appellant expressly requests a public hearing, any hearing under this Rule shall be closed to the public. At the hearing, the following procedures shall apply:
- (1) The hearing shall be chaired by the EUTF chair, vice-chair, or secretary-treasurer. If none of these officers is present, the Board shall elect one of their members to chair the hearing;
 - (2) The chair shall be in charge of regulating the course and conduct of the hearing;
 - (3) The chair shall make all rulings on the admission, exclusion, or limitation of testimony and evidence. The admissibility of testimony and evidence shall not be governed by the laws of evidence. All relevant oral or documentary evidence shall be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs. Irrelevant, immaterial, or unduly repetitious material shall not be admitted into evidence. The chair shall give effect to the privileges recognized by law;
 - (4) At the outset of the hearing, the chair shall provide a brief overview of the procedures that will apply to the hearing. Following this, the Fund administrator or other representative of the Fund staff shall state the nature and background of the proceeding, including the name of the appellant, the decision being appealed, and the relief being requested;
 - (5) After the presentation by the Fund administrator or staff, the appellant shall present his or her testimony, evidence, and arguments in support of the appeal. Following the appellant, the plan administrator shall present its testimony, evidence, and argument, if any, in support of the decision being appealed. At any time during the hearing, the Board may ask questions to the appellant, plan administrator, Fund staff, and any witnesses who

- testify at the hearing. At the conclusion of the hearing, both the appellant and plan administrator may present final arguments in support of their positions;
- (6) At any time during the hearing, the Board may enter executive session to consult counsel regarding any legal issues involved in the appeal; and
 - (7) Prior to the conclusion of the hearing, the Board shall announce its decision on the appeal to the appellant and plan administrator. The Board shall subsequently issue the Board's decision in writing. A certified copy of the written decision shall be sent by certified mail, return receipt requested, to the appellant and plan administrator within a reasonable time after the hearing.
- (f) The Fund administrator may designate one or more EUTF staff members to perform any or all of the Fund administrator's duties under this Rule when the Fund administrator is unavailable or otherwise unable to perform such duties.

3.00 ELIGIBILITY FOR ENROLLMENT

- 3.01 Health Benefits
- 3.02 Long-Term Care
- 3.03 Group Life Insurance

3.01 Health Benefits

- (a) Employee-beneficiaries. The following persons shall be eligible to enroll as employee-beneficiaries in the benefit plans offered or sponsored by the Fund:
- (1) An employee;
 - (2) A retired employee;
 - (3) The surviving spouse or domestic partner of an employee who is killed in the performance of the employee's duty, provided the surviving spouse or domestic partner does not remarry or enter into a domestic partnership;
 - (4) The unmarried child of an employee who is killed in the performance of the employee's duty, provided the child is under the age of nineteen and does not have a surviving parent who is eligible to be an employee-beneficiary;
 - (5) The surviving spouse or domestic partner of a deceased retired employee, provided the surviving spouse or domestic partner does not remarry or enter into a domestic partnership; and
 - (6) The unmarried child of a deceased retired employee, provided the child is under the age of nineteen and does not have a surviving parent who is eligible to be an employee-beneficiary.

With respect to subsections (3) and (5), a surviving spouse or domestic partner ceases to be an eligible employee-beneficiary once the spouse or domestic partner remarries or enters into a domestic partnership even though the spouse or domestic partner may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of domestic partnership, or death. A surviving domestic partner shall not cease to be eligible under subsections (3) or (5) because the death of the employee or retired employee prevents him or her from further meeting the requirements of parts (1), (2), (3), (6), and (8) of the definition of "domestic partner" in Rule 1.02. With respect to subsections (4) and (6),

an unmarried child ceases to be eligible as of midnight of the child's nineteenth birthday.

Notwithstanding any other provision in these rules to the contrary, an employee-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for coverage under any benefit plan offered or sponsored by the Fund until the employee-beneficiary enrolls in the Medicare Part B medical insurance plan.

- (b) Dependent-beneficiaries. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund:
- (1) An employee-beneficiary's spouse or domestic partner;
 - (2) An employee-beneficiary's or domestic partner's unmarried child, provided the child is either under the age of nineteen or a full-time student and under the age of twenty-four;
 - (3) An employee-beneficiary's or domestic partner's unmarried child, regardless of age, who is incapable of self-support because of a mental or physical incapacity that existed prior to the child reaching the age of nineteen; and
 - (4) A child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order.

With respect to subsection (2), an unmarried child ceases to be eligible as of midnight of the child's nineteenth or twenty-fourth birthday, as applicable. With respect to subsections (2) and (3), the child of a domestic partner ceases to be eligible upon the dissolution of the domestic partnership. In addition, as a condition of eligibility for any child over the age of nineteen, the employee-beneficiary shall provide the Fund with written proof reasonably satisfactory to the Fund of the full-time student status of such child. Such written proof shall be provided at such times and in such form as the Fund may from time to time direct.

Notwithstanding any other provisions in these rules to the contrary, a dependent-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for coverage under any retiree benefit plan offered or sponsored by the Fund until the dependent-beneficiary has enrolled in the Medicare Part B medical insurance plan.

3.02 Long-Term Care

The following persons shall be eligible for any long-term care benefit plans offered or sponsored by the Fund, provided that they comply with the age, enrollment, medical underwriting and contribution requirements of such plans:

- (1) Employee-beneficiaries and their spouses, parents, and grandparents;
- (2) Employee-beneficiaries' in-law parents and grandparents; and
- (3) Qualified-beneficiaries who enroll between the ages of twenty and eighty-five.

3.03 Group Life Insurance

Employees and retired employees are eligible for any group life insurance plans offered or sponsored by the Fund, provided that they comply with the age, enrollment, underwriting, and contribution requirements of such plans.

4.00 ENROLLMENT PROCEDURES

- 4.01 Application for Enrollment
- 4.02 Rejection of an Enrollment Application
- 4.03 Dual or Multiple Enrollment
- 4.04 Date of Filing
- 4.05 Failure to File Properly Completed Enrollment Application Within the Prescribed Time; Effect on Coverage Dates
- 4.06 Notification of Changes in Personal Information
- 4.07 Verification of Eligibility
- 4.08 Exceptions to the Timely Filing of an Enrollment Application
- 4.09 Open and Special Enrollment Periods
- 4.10 Continuation of Coverage
- 4.11 Contribution Shortage
- 4.12 Cancellation of Enrollment; Effective Dates of Cancellation
- 4.13 Termination of Enrollment; Effective Dates of Termination
- 4.14 Reinstatement of Enrollment

4.01 Application for Enrollment

- (a) An employee-beneficiary shall file an enrollment application, in the form prescribed by the board or by the board's policy, to enroll, change or cancel an enrollment in any benefit plan, including long term care, offered or sponsored by the Fund. Unless otherwise provided by the board or by the board's policy, all enrollment applications shall be filed by the employee-beneficiary with: (1) in the case of an employee, the employee's employer; and (2) in all other cases, the Fund. Notwithstanding the foregoing, upon retirement, an employee-beneficiary shall file an enrollment application to enroll or change enrollment in the benefit plans offered or sponsored by the Fund with the entity that pays his or her retirement or pension allowance. Thereafter, the retired employee-beneficiary shall file any and all enrollment applications directly with the Fund.
- (b) With due consideration of appropriate federal or state laws, the board shall set the standards and procedures for filing such enrollment applications, including, but not limited to, the form of such enrollment applications, the information required to be provided by the employee-beneficiary on such enrollment applications, and the method for filing such enrollment

applications. Enrollment applications shall include the employee-beneficiary's authorization to the state comptroller or the appropriate county director of finance to assign sufficient compensation to the Fund in payment of all contributions due from such employee-beneficiary for enrollment or coverage in any and all Fund benefit plans.

- (c) A representative of an employee-beneficiary may file an enrollment application for the employee-beneficiary if:
 - (1) The representative has a written authorization signed by the employee-beneficiary that authorizes the representative to file such enrollment applications; or
 - (2) A valid court order authorizes the representative to file such enrollment applications.

4.02 Rejection of an Enrollment Application

- (a) Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.
- (b) 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 these rules;
 - (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 Fund; or
 - (5) Acceptance of the application would violate applicable federal or state law or any other provision of these rules.
- (c) Notification shall be provided to the employee-beneficiary of the rejection of any enrollment application.

4.03 Dual or Multiple Enrollment

- (a) No person may be enrolled simultaneously in any benefit plan offered or sponsored by the Fund as both an employee-beneficiary and a dependent-beneficiary, nor may unmarried children be enrolled by more than one employee-beneficiary. The Fund shall cancel such dual coverage enrollments.
- (b) Where an employee-beneficiary files more than one enrollment application, the enrollment application bearing the latest filing date shall be the one used by the Fund to process the employee-beneficiary's enrollment, provided the employee-beneficiary is eligible for such enrollment.

4.04 Date of Filing

An employee-beneficiary's enrollment application, beneficiary designation, or any other form required to be filed with the Fund shall be deemed to have been filed with the Fund on the date that the following entities, as applicable, actually receive such forms: (1) the employee-beneficiary's employer; (2) the entity that pays the employee-beneficiary's retirement or pension allowance; or (3) the Fund. However, if filed before the time or times prescribed in these rules, an enrollment application, beneficiary designation, or other form shall be deemed to have been filed on the date that the person would have been first eligible to file that document.

4.05 Failure to File Properly Completed Enrollment Application Within the Prescribed Time; Effect on Coverage Dates

Except as otherwise provided in these rules or by applicable federal or state law, the following shall apply to all applications to enroll in the benefit plans offered or sponsored by the Fund, to add or delete dependent-beneficiaries, or to change enrollments or coverages:

- (a) No enrollment of an employee-beneficiary, addition or deletion of a dependent-beneficiary, or change in an enrollment or coverage shall be effective without the filing of a properly completed enrollment application.
- (b) The effective dates of coverage, deletions of coverage, and changes in coverage shall be dependent on the filing of a properly completed

enrollment application within thirty days of the specified event that allows the filing of the application.

- (c) An employee-beneficiary who fails to file an enrollment application within the time prescribed by subsection (b) or any otherwise applicable rule shall not be permitted to file that application until the next open or special enrollment period.

4.06 Notification of Changes in Personal Information

Each employee-beneficiary shall immediately notify the Fund in writing of any changes in the employee-beneficiary's name or address or marital or domestic partnership status, of the birth or adoption of a child or any other changes in the family status of the employee-beneficiary, and any other material changes in the information previously filed by the employee-beneficiary as part of an enrollment application. Each notice to the Fund shall be submitted through the employee-beneficiary's employer or, if none, shall be submitted directly to the Fund.

4.07 Verification of Eligibility

The board may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries enrolled by an employee-beneficiary in Fund benefit plans. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the dependent-beneficiary's enrollment shall be cancelled as set forth in Rule 4.12(d).

4.08 Exceptions to the Timely Filing of an Enrollment Application

- (a) Rule 4.05 and the times for filing enrollment applications prescribed in these rules shall not apply to the following persons:
- (1) Retired members who are currently enrolled in a benefit plan offered or sponsored by the Fund;
 - (2) The surviving spouse, domestic partner, or any unmarried child under the age of nineteen of a deceased retired member who is eligible as an employee-beneficiary under Rule 3.01(a); and

- (3) The surviving spouse, domestic partner, or any unmarried child under the age of nineteen of any employee who is killed in the performance of duty who is eligible as an employee-beneficiary under Rule 3.01(a).
- (b) Coverage for the persons covered by subsection (a) shall become effective on the later of:
 - (1) The date of the event that makes the person eligible for enrollment when a properly completed enrollment application is filed within thirty days of the event; or
 - (2) The first day of the month following the date the person files a properly completed enrollment application.
- (c) Nothing in this rule shall permit an employee-beneficiary or dependent-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan to be covered under any benefit plan offered or sponsored by the Fund until enrolled in the Medicare Part B medical insurance plan. Further, nothing in this rule is meant to permit the enrollment of any person who is not otherwise eligible for enrollment in the benefit plan offered or sponsored by the Fund.

4.09 Open and Special Enrollment Periods

Except as otherwise provided by these rules, an employee-beneficiary may file an enrollment application during an open or special enrollment period to make any one or a combination of specific enrollment changes that have been approved by the board for that open or special enrollment period. The changes that the board may approve include, but are not limited to, changes from non-enrolled to enrolled status, changes between plans, changes in levels of coverage, and cancellations. All changes made shall become effective on the date approved by the board for the open or special enrollment period.

4.10 Continuation of Coverage

Subject to applicable federal and state law, coverage under the benefit plans offered or sponsored by the Fund shall continue:

- (a) Provided the employee-beneficiary meets the eligibility provisions of Rule 3.01 and pays the employee's premium contribution as provided by

statute, the employer's administrative rules, or an applicable bargaining unit agreement;

- (b) While the employee-beneficiary participates in an employee strike authorized by chapter 89, Hawaii Revised Statutes, provided that nothing in this rule shall limit the right or ability of the Fund to collect premium contributions from any public employer or employee-beneficiaries or the remedies available to the Fund to collect such premium contributions.
- (c) When an employee terminates employment and is rehired by a public employer within the same pay period or the next consecutive pay period, the employee shall be considered as having transferred employment. The employee shall be treated as if continuously enrolled in the Fund benefit plans in which the employee was enrolled at the time of termination and shall be required to pay the full cost of coverage to the extent that such is not paid by the employee's public employer. The employee shall not be allowed to change between plans unless the employee's current Fund benefit plan is unavailable at the employee's new employment location.

4.11 Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the Fund. The notice shall be sent within thirty days of the date on which the required semi-monthly contribution payment was due. Cancellation of the employee-beneficiary's enrollment due to any contribution shortage shall be as per Rule 4.12(c), and reinstatement of the employee-beneficiary's enrollment after any such cancellation shall be as per Rule 4.14(b).

4.12 Cancellation of Enrollment; Effective Dates of Cancellation

- (a) Voluntary Cancellation Requested by the Employee-Beneficiary. An employee-beneficiary may voluntarily cancel enrollment in a Fund benefit plan at any time by filing an enrollment application requesting cancellation with the employee-beneficiary's employer or, if none, directly with the Fund. The effective date of cancellation shall be the first day of the pay period following the requested cancellation date or, if no date is specified, the effective date of cancellation shall be the first day of the pay

period after which the Fund receives the employee-beneficiary's request for cancellation.

- (b) Cancellation Due to Ineligibility. The enrollment of any ineligible person who was enrolled in error or is ineligible to enroll in or be covered in a benefit plan offered or sponsored by the Fund shall be canceled:
- (1) When the person is notified of the error or ineligibility prior to the effective date of the enrollment, the person shall be treated as if the enrollment application was not submitted.
 - (2) When the person is notified after the effective date of the enrollment, the enrollment shall be canceled on the first day of the second pay period that follows the date of the Fund's notice of cancellation to the ineligible person or employee-beneficiary.
- (c) Cancellation Due to Failure to Pay Contribution Shortage. If any portion of an employee-beneficiary's required semi-monthly or monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the Fund within 30 days of the date of the notice of contribution shortage, the employee-beneficiary's enrollment and all coverages for dependent-beneficiaries under that enrollment shall be cancelled as of the first day following the last period for which full payment of the employee-beneficiary's required semi-monthly or monthly contributions were paid and transmitted to the Fund. However, the enrollment of the employee-beneficiary and his or her dependent-beneficiaries may be reinstated as provided in Rule 4.14(b). Cancellation of an employee-beneficiary's enrollment pursuant to this rule shall not affect the Fund's right to collect any and all contribution shortages from the employee-beneficiary.
- (d) Cancellation Due to Failure to Comply with Rules. If an employee-beneficiary materially fails to comply with any of the Fund's rules, the employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be canceled after notice of such has been provided to the employee-beneficiary. The board may set standards and procedures for providing notice to employee-beneficiaries under this rule. The notice shall at a minimum specify how the employee-beneficiary has failed to comply with the Fund's rules, and a date by which the employee-beneficiary must comply with the Fund's rules in order to avoid

cancellation. The effective date of the cancellation shall be the date set forth in the notice as to when the employee-beneficiary must comply with the Fund's rules in order to avoid cancellation.

4.13 Termination of Enrollment; Effective Dates of Termination

- (a) Termination Due to Change in Employment Status. An employee-beneficiary's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the employee-beneficiary's loss of eligibility to participate in such plans due to a change in employment status. The effective date of the termination shall be the first day of the pay period following the effective date of the change in employment status.

- (b) Termination Due to Filing of Fraudulent Claims. An employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be terminated if the employee-beneficiary files fraudulent claims for benefit. A dependent-beneficiary's coverage in all of the benefit plans offered or sponsored by the Fund may be terminated if the dependent-beneficiary files fraudulent claims for coverage and/or benefits. The effective date of the termination shall be the date that the Fund determines that the employee-beneficiary or dependent-beneficiary, as applicable, has filed fraudulent claims.

- (c) Notice to the Fund; Recovery of Benefits. If an event occurs that makes a person ineligible for continued enrollment or coverage in the benefit plans offered or sponsored by the Fund, that person or employee-beneficiary shall notify the Fund of the event as soon as reasonably practicable. All such notices shall be in writing and shall be sent to the Fund. The Fund shall be entitled to seek recovery of any benefits that were provided to any person after an event that terminated the person's enrollment or that otherwise made that person ineligible for continued enrollment in or coverage by the benefit plans offered or sponsored by the Fund. In seeking to recover benefits under this rule, the Fund shall have the rights of offset and set-off, including without limitation, the right to recover amounts from and out of any and all future benefits payable to the person whose enrollment was terminated or who otherwise ceased to be eligible for continued enrollment or coverage in the Fund's benefit plans.

4.14 Reinstatement of Enrollment

- (a) General Rule. Unless another rule of the Fund expressly applies, an employee-beneficiary whose enrollment in any of the Fund's benefit plans has been cancelled or terminated may not apply for reinstatement in those benefit plans. The employee-beneficiary may only apply for a new enrollment during the Fund's next open enrollment period. Any such new enrollment may be conditioned upon the employee-beneficiary meeting all the Fund's rules for eligibility and enrollment, curing any past deficiencies or failures that led to the employee-beneficiary's cancellation or termination, and providing adequate assurance that the employee-beneficiary will not further engage in the conduct that previously led to the employee-beneficiary's cancellation or termination. Nothing in this Rule shall be deemed to require the Fund to re-enroll any employee-beneficiary whose enrollment has been previously cancelled or terminated.
- (b) Contribution Shortage Cancellation. If an employee-beneficiary's enrollment in the Fund's benefit plan or plans has been cancelled under Rule 4.12 (c), the employee-beneficiary's enrollment in such benefit plan or plans may be reinstated if the employee-beneficiary makes full payment of all contributions due from the employee-beneficiary by the date specified in the contribution shortage notice provided for in Rule 4.11. The reinstatement shall be made so that the employee-beneficiary and his or her dependent-beneficiaries shall suffer no break in coverage. However, if the employee-beneficiary fails to pay all contribution shortages by the date specified in the contribution shortage notice provided for in Rule 4.11, the employee-beneficiary will suffer a break in coverage and may only apply for a new enrollment at the next open enrollment as per Rule 4.14 (a).

5.00 HEALTH AND OTHER BENEFIT PLANS

- 5.01 Enrollment; Effective Dates of Coverage
- 5.02 Changes in Enrollment; Effective Dates of Coverage
- 5.03 Mandatory Change to Medicare Supplemental Plan for Retired Employees
- 5.04 Cancellation Due to Failure to Enroll in Medicare; Effective Date of Cancellation
- 5.05 Termination of Enrollment; Effective Dates of Termination
- 5.06 Reinstatement of Enrollment; Effective Dates of Reinstatement

5.01 Enrollment; Effective Dates of Coverage

- (a) New Employee. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when the employee-beneficiary is first hired as an employee. At the option of the employee-beneficiary, the effective date of coverage shall be one of the following dates: (1) the date the employee beneficiary is first hired; (2) the first day of the first pay period following the date the employee-beneficiary is first hired; or (3) the first day of the second pay period following the date the employee-beneficiary is first hired. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the date that the employee-beneficiary is first hired. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date the employee-beneficiary is first hired.
- (b) Newly Eligible Employee. An employee-beneficiary, other than a retired member, may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when the employee-beneficiary first becomes an employee due to a change in employment status. At the option of the employee-beneficiary, the effective date of coverage shall be one of the following dates: (1) the date the change in employment status occurs; (2) the first day of the first pay period following the date the change in employment status occurs; or (3) the first day of the second pay period following the date the change in employment status occurs. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within (30) days of the date the change in employment status occurs. If the employee-

beneficiary fails to make a selection, the effective date of coverage shall be the date the change in employment status occurs.

- (c) Loss of Coverage in a Benefit Plan Offered by the Fund. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for dependent-beneficiaries when the employee-beneficiary loses coverage under the benefit plans offered or sponsored by the Fund because the employee-beneficiary's covering enrollment was terminated or the employee-beneficiary ceased to be eligible as a dependent-beneficiary. The effective date of coverage shall be the date of the employee-beneficiary's loss of coverage.
- (d) Loss of Coverage in a Non-Fund Health Benefit Plan. An employee-beneficiary who is eligible but not enrolled, may enroll in the health benefit plans offered or sponsored by the Fund, and obtain coverage for eligible dependent-beneficiaries, when the employee-beneficiary meets the conditions required for a special enrollment under 26 U.S.C. §9801(f) and the federal regulations enacted under or pursuant to that statute. These conditions are:
- (1) At the time that coverage under the Fund's health benefit plans were offered to the employee-beneficiary, the employee-beneficiary was covered by a Non-Fund health benefit plan or a COBRA continuation provision; and
 - (2) The employee-beneficiary declined coverage under the Fund's health benefit plans because of the employee-beneficiary's coverage under the Non-Fund health benefit plan or a COBRA continuation provision; and
 - (3) The employee-beneficiary's coverage under the Non-Fund health benefit plan was terminated as a result of loss of eligibility for that coverage (including as a result of legal separation, divorce, death, termination of employment or reduction of hours of employment) or because employer contributions towards such coverage was terminated; or
 - (4) The employee-beneficiary's coverage under the COBRA continuation provision was exhausted.

The effective date of the coverage under Rule 5.01(d) shall be as follows: If a properly completed enrollment application is filed within thirty (30) days of the date that the employee-beneficiary loses coverage or the date that the employee-beneficiary's COBRA continuation coverage is

exhausted, whichever event is applicable, the effective date of coverage will be the date of that event. If a properly completed enrollment application is filed more than thirty (30) days after the event, the effective date of coverage will be the first day of the pay period after the enrollment application is received.

- (e) Enrollment Due to Changes in Marital, Domestic Partnership or Family Status. An employee-beneficiary who has previously declined coverage in the health benefit plans offered or sponsored by the Fund may enroll in the Fund benefit plans when the employee-beneficiary gains a dependent through a change in marital, domestic partnership or family status, e.g., marriage, entry into domestic partnership, birth, adoption, or issuance of a qualified medical child support order. At the option of the employee-beneficiary, the effective date of enrollment shall be:
- (1) With respect to a change in marital or domestic partnership status, any of the following: (i) The date the Fund receives proper notification of the change in marital or domestic partnership status, (ii) the first day of the first pay period following the date the Fund receives such notification, or (iii) the first day of the second pay period following the date the Fund receives such notification;
 - (2) With respect to the birth, adoption, or placement for adoption of a child, any of the following: (i) the date of the child's birth, adoption, or placement for adoption; (ii) the first day of the first pay period following the date of the child's birth, adoption, or placement for adoption; or (iii) the first day of the second pay period following the date of the child's birth, adoption, or placement for adoption; and
 - (3) With respect to the issuance of a qualified medical child support order, the date specified in the order, or if no date is specified, the date that the order is issued.

The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the date of the event described in Rule 5.01(e)(1)(i) or Rule 5.01(e)(2)(i), as applicable. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date of the event described in Rule 5.01(e)(1)(i) or Rule 5.01(e)(2)(i), as applicable.

- (f) 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 Fund and obtain coverage for eligible dependent-beneficiaries when that person begins to receive a retirement allowance from a state or county retirement system. The effective date of the coverage shall be the employee-beneficiary's date of retirement.

- (g) Surviving Spouse, Domestic Partner, or Child of a Deceased Retiree or an Employee Who was Killed in the Performance of Duty. A surviving spouse, domestic partner or unmarried child who is eligible as an employee-beneficiary under Rule 3.01(a) may enroll in the health benefit plans offered or sponsored by the Fund. The effective date of coverage shall be determined under Rule 4.08, the date of the event that permits enrollment being the date that the retiree deceases or the date that the employee is killed in the performance of duty, whichever is applicable.
- (h) The public employer's premium contributions and employee-beneficiary's premium contributions, if any, shall begin as of the first day of the pay period during which the employee-beneficiary's effective date of coverage occurs. The contributions shall not be prorated based on when the employee-beneficiary's coverage begins during the pay period. For example, if an employee-beneficiary's effective date of coverage occurs on any date during the first pay period of a month (first half of a month), the public employer and employee-beneficiary shall make contributions as if the employee-beneficiary had been enrolled in the applicable health benefit plans as of the first day of that first pay period. Similarly, if there is a change in contributions due to an employee-beneficiary's change in enrollment or coverage, the change in contributions shall begin as of the first day of the pay period during which the change in enrollment or coverage occurs. For example, if an employee-beneficiary changes enrollment or coverage during any date during the second pay period of a month (second half of a month), the public employer and employee-beneficiary shall make contributions as if the change in enrollment or coverage had occurred as of the first day of that second pay period.

5.02 Changes in Enrollment; Effective Dates of Coverage

- (a) Additions of Dependents Due to Changes in Marital, Domestic Partnership or Family Status. An employee-beneficiary may change his or her enrollment to add coverage for dependent-beneficiaries in the Fund health benefit plans in which the employee-beneficiary is currently enrolled upon the occurrence of any of the following events: marriage, entry into domestic partnership, birth of a child, adoption of a child, addition of a

foster child, or the issuance of a qualified medical support order. At the option of the employee-beneficiary, the effective date of the change in enrollment shall be:

- (1) With respect to the addition of a spouse, foster child, or other dependent-eligible, any of the following dates: (i) the date that the Fund receives proper notification of the addition of the spouse, foster child, or other dependent-eligible, (ii) the first day of the first pay period following the date that the Fund receives such notification, or (iii) the first day of the second pay period following the date that the Fund receives such notification; or
- (2) With respect to the birth of a child, any of the following dates: (i) the date of the child's birth, (ii) the first day of the first pay period following the date of the child's birth, or (iii) the first day of the second pay period following the date of the child's birth; or
- (3) With respect to the adoption of a child at birth, any of the following dates: (i) the date of the child's birth, provided that the employee-beneficiary provides the Trust Fund with a written certification of intent to adopt the child (in form and content satisfactory to the Fund) and an enrollment application for the child prior to the child's birth or within thirty days thereafter, (ii) the first day of the first pay period following the date of the child's birth, subject to the same conditions set forth above, or (iii) the second day of the second pay period following the date of the child's birth, subject to the same conditions set forth above; or
- (4) With respect to the adoption of a child after birth, any of the following dates: (i) the date of the adoption, provided that the employee-beneficiary provides the Fund with satisfactory documents evidencing the adoption and an enrollment application for the child within thirty days of the date of adoption, (ii) the first day of the first pay period following the date of the adoption, subject to the same conditions set forth above, or (iii) the first day of the second pay period following the date of adoption, subject to the same conditions set forth above; or
- (5) With respect to a child placed for adoption, any of the following dates: (i) the date that the employee-beneficiary assumes custody of and an obligation to support the child in anticipation of adopting the child, provided that the employee-beneficiary provides the Fund with a written certification of intent to adopt the child (in form and content satisfactory to the Fund) and an enrollment application for the child within thirty days of the date that the

- employee-beneficiary assumes custody of and an obligation to support the child, (ii) the first day of the first pay period following the date that the employee-beneficiary assumes custody of and an obligation to support the child in anticipation of adopting the child, subject to the same conditions set forth above, or (iii) the first day of the second pay period following the date that the employee-beneficiary assumes custody of and an obligation to support the child in anticipation of adopting the child, subject to the same conditions set forth above; or
- (6) With respect to a qualified medical child support order, the date specified in the order, or if no date is specified, the date that the order is issued.

Notwithstanding Rule 5.02(a) (5), the effective date of coverage for a child placed for adoption may be any other date that is specified: in an applicable court order, by a government agency placing the child, or by a licensed child placing organization placing the child. Except as otherwise required by law or these rules, Rule 4.05 shall apply to changes of enrollment under this Rule and the employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the event described in Rule 5.02(a)(1)(i), 5.02(a)(2)(i), 5.02(a)(3)(i), 5.02(a)(4)(i), or 5.02(a)(5)(i), as applicable. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date of the event described in Rule 5.02(a)(1)(i), 5.02(a)(2)(i), 5.02(a)(3)(i), 5.02(a)(4)(i), or 5.02(a)(5)(i), as applicable.

- (b) Deletions of Dependents Due to Changes in Marital, Domestic Partner or Family Status. An employee-beneficiary shall change his or her enrollment to terminate coverage of dependent-beneficiaries who cease to be eligible for continued enrollment in the Fund health benefit plans upon the occurrence of any of the following events: divorce or dissolution; annulment; legal separation; dissolution or other act ending domestic partnership; death of a spouse, domestic partner or child; failure to complete the adoption of a child; the end of any required coverage of a child under a qualified medical support order; or a child ceases to be eligible for coverage as a dependent-beneficiary under Rule 3.01(b). The effective date of change in coverage shall be the first day of the first pay period following the occurrence of the event. Employee-beneficiaries and dependent-beneficiaries are required to provide the Fund with written notice of the occurrence of these events as soon as reasonably practicable pursuant to Rule 4.06 and Rule 4.13(c).

- (c) Loss of Spouse's or Domestic Partner's Coverage. An employee-beneficiary may change enrollment to add a spouse or domestic partner as a dependent-beneficiary in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when the employee-beneficiary's spouse or domestic partner has lost coverage in any health benefit plan due to an employment termination or other loss of eligibility. The effective date of the change in enrollment shall be the date that the employee-beneficiary's spouse or domestic partner lost coverage in the spouse's or domestic partner's health benefit plan.
- (d) Last Child Becomes Ineligible. An employee-beneficiary may change his or her enrollment in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when the last of the employee-beneficiary's children becomes ineligible for coverage as a dependent-beneficiary under the health benefit plans offered or sponsored by the Fund, e.g., when the child marries, becomes nineteen years of age and is not a full-time student, is between nineteen and twenty-four years of age and ceases to be a full-time student, or becomes twenty-four years of age. The effective date of the change in enrollment shall be the date on which the child lost eligibility.

Notwithstanding Rule 4.06, if the employee-beneficiary fails to give the appropriate notice to the Fund within thirty days of the event, the effective date of the change in coverage shall be the date on which notice was received by the Fund.

- (e) Changes Between Plans. An employee-beneficiary may change between health benefit plans offered or sponsored by the Fund when:
- (1) The employee-beneficiary moves to a residence outside of the geographic areas covered by the employee-beneficiary's present benefit plan. The effective date of the change shall be the date of the employee-beneficiary's relocation.
 - (2) The employee-beneficiary is enrolled in a supplemental health benefits plan offered or sponsored by the Fund and loses primary coverage in a Non-Fund health benefits plan. The effective date of the change shall be the date that the employee-beneficiary loses coverage in the Non-Fund health benefits plan.

- (f) Any change in the public employer's premium contributions and the employee-beneficiary's premium contributions, if any resulting from a change in enrollment or coverage shall begin as of the first day of the pay period in which the effective date of the employee-beneficiary's change in enrollment or coverage occurs. As in Rule 5.01(h), contributions shall not be prorated based on when the employee-beneficiary's change in enrollment or coverage occurs during the pay period.

5.03 Mandatory Enrollment in Medicare Part B for Retired Employees

- (a) An employee-beneficiary or a dependent-beneficiary shall submit a Notice of Enrollment along with proof of enrollment in the federal Medicare Part B medical insurance plan when the employee-beneficiary or dependent-beneficiary becomes eligible to enroll in the federal Medicare Part B medical insurance plan. Notwithstanding Rule 4.05, the effective date of coverage shall be the later of the following:
 - (1) The date that the employee-beneficiary or dependent-beneficiary becomes eligible for Medicare provided that proof of enrollment in Medicare Part B is submitted; or
 - (2) The first day of the month in which the Fund receives the employee-beneficiary or dependent-beneficiary's enrollment application and proof of enrollment in Medicare Part B.
- (b) Each public employer shall pay to the Fund a contribution equal to \$50 per month, or such other amount as is determined by the board, for voluntary medical insurance coverage under Medicare for retired members of the employees' retirement system, county pension system, or a police, firefighters, or bandsmen pension of the State or a county as set forth in Chapter 88 of the Hawaii Revised Statutes. Out of such contributions, the Fund shall reimburse the premiums paid, exclusive of any and all Medicare penalties, by the following persons for Medicare Part B medical insurance coverage in the amount of \$50 per month or such other amount as is determined by the board:
 - (1) An employee-beneficiary who is a retired employee;
 - (2) The employee-beneficiary's spouse or domestic partner while the employee-beneficiary is living; and

- (3) The employee-beneficiary's spouse or domestic partner after the death of the employee-beneficiary, if the spouse or domestic partner qualifies as an employee-beneficiary under Rule 3.01(a).

Payment of these reimbursements shall be made only for those persons who are enrolled in the Medicare Part B medical insurance plan and pay their Medicare Part B medical insurance premiums to the Social Security Administration.

5.04 Cancellation Due to Failure to Enroll in Medicare; Effective Date of Cancellation

- (a) 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 all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be cancelled.
- (b) If a dependent-beneficiary becomes eligible to enroll and fails to enroll in the federal Medicare Part B medical insurance plan, the dependent-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund shall be cancelled.
- (c) The effective date of any cancellation under this rule shall be the date upon which the employee-beneficiary or dependent-beneficiary, as applicable, first became eligible to enroll in the federal Medicare Part B medical insurance plan.

5.05 Termination of Enrollment; Effective Dates of Termination

- (a) Termination Due to Surviving Spouse's or Domestic Partner's Remarriage or Entry into Domestic Partnership. A surviving spouse's or domestic partner's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the surviving spouse's or domestic partner's remarriage or entry into a domestic partnership. The effective date of the termination shall be the first day of the pay period following the date of the surviving spouse's or domestic partner's remarriage or entry into a domestic partnership. Notwithstanding the foregoing, the child of a deceased retiree that is eligible to be an employee-beneficiary under Rules 3.01(a)(4) or Rule 3.01(a)(6) may continue his or her coverages by filing an enrollment application under Rule 5.01(g). The effective date of

coverage shall be as provided in Rule 4.08(b), the date of the event making the person eligible for enrollment being the date of termination of coverage due to the surviving spouse's or domestic partner's remarriage or entry into a domestic partnership.

- (b) Termination Due to Child's Loss of Eligibility. A child's enrollment in all benefit plans offered or sponsored by the Fund shall be terminated upon the occurrence of any of the following events:
- (1) The child marries;
 - (2) The child enters active military duty;
 - (3) The child reaches the age of nineteen and is not a full-time student;
 - (4) The child is between the ages of nineteen and twenty-four and ceases to be a full-time student;
 - (5) The child, while still a full-time student, reaches the age of twenty-four; or
 - (6) The employee-beneficiary fails to complete a legal adoption of the child within twelve months of the date that the child is covered by the Fund's benefit plans.

Notwithstanding Rule 5.05 (b) (6), the enrollment of a child placed for adoption shall not be terminated if the employee-beneficiary has custody of and an obligation to support the child under a court order or agreement with a government agency or licensed child placing organization.

With respect to subsections (1) and (2), the loss of eligibility as a dependent-beneficiary is permanent. Unless provided otherwise by these rules or applicable federal or state law, the effective date of the termination shall be the first day of the pay period following the date of the event or, in an event under Rule 5.05 (b) (6), the date stated in a written notice to the employee-beneficiary.

5.06 Reinstatement of Enrollment; Effective Dates of Reinstatement

- (a) Reinstatement in Employment. If as a result of an order or award from a court, arbitrator or other entity with proper jurisdiction over the matter, an employee-beneficiary is found to have been wrongfully terminated or suspended and is ordered to be reinstated in state or county employment, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which the employee-beneficiary's coverage was terminated. The effective date of the reinstatement shall be the date of termination so

that the employee-beneficiary's coverage is continuous, provided that the employee-beneficiary pays the full cost of such coverage less any contribution paid by the employer on behalf of the employee-beneficiary as provided by statute, the employer's administrative rules, or an applicable bargaining unit agreement.

If the full cost of such coverage is not paid, the employee-beneficiary shall have the option of having the reinstatement effective upon any of the following dates: (i) the employee-beneficiary's return to active duty, (ii) the first day of the first pay period following the employee-beneficiary's return to active duty, or (iii) the first day of the second pay period following the employee-beneficiary's return to active duty. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the date that the employee-beneficiary returns to active duty. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date the employee-beneficiary returns to active duty.

- (b) Return From an Authorized Leave of Absence. If an employee-beneficiary returns from an authorized leave of absence ("LOA") during which coverage was not provided by a Fund benefit plan, the employee-beneficiary may be reinstated in the same Fund benefit plans from which coverage was cancelled if the employee-beneficiary files a properly completed enrollment application. At the option of the employee-beneficiary, the reinstatement shall be effective upon any of the following dates: (i) the employee-beneficiary's return from the LOA provided the employee-beneficiary files an enrollment application in accordance with Rule 4.05 within thirty (30) days of his or her return from the LOA, (ii) the first day of the first pay period following the employee-beneficiary's return from the LOA, subject to the same conditions set forth above, or (iii) the first day of the second pay period following the employee-beneficiary's return from the LOA, subject to the same conditions set forth above. If the employee-beneficiary fails to timely file an enrollment application, the reinstatement shall be effective on the first day of the first pay period following the employee-beneficiary's proper filing of the enrollment application.
- (c) Return From a Leave of Absence Covered by the Family Medical Leave Act (FMLA) Or Uniform Services Employment and Reemployment Rights Act (USERRA). If an employee-beneficiary returns from a leave of absence covered under the FMLA or USERRA and the employee-

beneficiary's enrollment in the Fund benefit plans was canceled during that leave of absence, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which coverage was canceled. At the option of the employee-beneficiary, reinstatement shall be effective upon any of the following dates: (i) the date of the employee-beneficiary's return to work, (ii) the first day of the first pay period following the date of the employee-beneficiary's return to work, or (iii) the first day of the second pay period following the date of the employee-beneficiary's return to work. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the date that the employee-beneficiary returns to work. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date of the employee-beneficiary's return to work.

- (d) Enrollment in Medicare by a Retired Employee. If the enrollment of an employee-beneficiary or the coverage of a dependent-beneficiary was terminated due to the employee-beneficiary's or dependent-beneficiary's failure to enroll in the federal Medicare Part B medical insurance plan, upon the employee-beneficiary's or dependent-beneficiary's enrollment in such plan and submission of a proper and complete enrollment application to the Fund, the employee-beneficiary or dependent-beneficiary shall be enrolled in or covered by the Medicare supplemental plan offered by the Fund. The coverage shall be effective on the date specified in Rule 5.03.
- (e) The public employer's premium contributions and the employee-beneficiary's premium contributions, if any, shall begin as of the first day of the pay period during which the employee-beneficiary's effective date of coverage occurs. Similarly, if there is a change in contributions due to an employee-beneficiary's change in enrollment or coverage, the change in contributions shall begin as of the first day of the pay period during which the change in enrollment or coverage occurs. As in Rule 5.01(h), contributions shall not be prorated based on when the employee-beneficiary's coverage begins during the pay period or on when an employee-beneficiary's change in enrollment or coverage occurs during the pay period.

The Hawaii Employer-Union Health Benefits Trust Fund Board of Trustees Administrative Rules were adopted during a regular meeting of the Board of Trustees on February 19, 2003, which were amended and approved on

May 19, 2004, August 25, 2004, September 28, 2005, March 22, 2006, September 26, 2007, August 20, 2008, and August 26, 2009. The rules shall take effect on the first day after filing with the Lieutenant Governor's Office.



George Kahooahano, Chairperson
Hawaii Employer-Union Health
Benefits Trust Fund

APPROVED



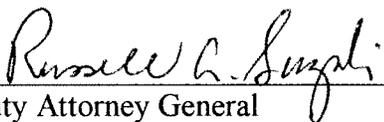
Linda Lingle
Governor
State of Hawaii

Date Filed, Office of the Lieutenant
Governor

10 JAN 21 P3:10

RECEIVED

APPROVED AS TO FORM:


Deputy Attorney General



**STATE OF HAWAII
EMPLOYER-UNION TRUST FUND**

**POSTEMPLOYMENT BENEFITS
OTHER THAN PENSIONS**

Actuarial Valuation Study

Valuation Date: July 1, 2011

Date of Report: June 30, 2012



June 30, 2012

Ms. Barbara Coriell
EUTF Administrator
P.O. Box 2121
Honolulu, Hawaii 96805-2121

Re: GASB 43 / 45 Actuarial Valuation Report

This report contains the results of the July 1, 2011 actuarial valuation of the Hawaii Employee-Union Trust Fund's (EUTF) Other Postemployment Benefits (OPEB).

The results are prepared in accordance with GASB 43 and 45, which address accounting and financial reporting requirements for OPEB plans and employers. The purpose of the report is to:

- Determine the actuarial obligations for EUTF benefits under GASB 43.
- Develop the Annual Required Contribution (ARC) and Annual OPEB Cost (AOC) for employers under GASB 45 for the fiscal year ending June 30, 2013. (Other circumstances may result in the use of this valuation to also determine the ARC for the fiscal year ending June 30, 2012.)
- Provide information needed by auditors for financial statement entries and footnote disclosures in conformity with the disclosure requirements under GASB Statements No. 43 and 45.
- Present the financial condition of the plan as measured for accounting purposes.

This report is prepared for the sole use of the EUTF and the participating employers and supplies information consistent with the stated purposes of the report. It may not be appropriate to use this report for other business applications. Accordingly, additional discussion may be helpful in understanding the assumptions, methodologies, and limitations applied in the report.

Aon Hewitt is pleased to present this report and we look forward to discussing it with you.

Respectfully submitted,

A handwritten signature in black ink that reads "Bradley Au".

Bradley J. Au, MAAA
Senior Vice President

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1. Executive Summary

For reference, a glossary of terms is provided in Exhibit 11.

Background

The State of Hawaii and its subdivisions (i.e., counties) provide healthcare benefits to public employees, retirees, and their dependents through the Hawaii Employer-Union Health Benefits Trust Fund (EUTF). As an agency of the State, the EUTF contracts with providers of medical, dental, vision, and life insurance plans.

The provisions for coverage and eligibility of benefits are set forth in Hawaii Revised Statutes (HRS) Chapter 87A. Generally, retirees and their dependents may receive health care coverage if they are eligible for their employer's public pension system. Employers make contributions to EUTF based on an employee's hire date and years of service. Retirees pay the portion of the premium not paid by the employer. These retiree healthcare benefits constitute the other postemployment benefits (OPEB) discussed in this report.

The EUTF provides coverage for all public employees in the State, including Hawaii State Teachers Association (HSTA) members. Prior to 2011, HSTA member benefits were provided through a separate VEBA trust, and a separate actuarial valuation was performed for those benefits.

GASB 43 and 45

Governmental Accounting Standards Board (GASB) Statements 43 and 45 address accounting and financial reporting for Postemployment Benefits Other Than Pensions. GASB 43 addresses financial reporting for OPEB plans and was initially effective for EUTF for the 2006-2007 fiscal year. GASB 45 addresses financial reporting for employers of OPEB plans and was initially effective for the State and other employers for the 2007-2008 fiscal year. The plan's liabilities and employer costs for the retiree benefits are calculated in this actuarial valuation in accordance with GASB 43 and 45.

It is important to note that only current active, deferred inactive and retired participants are valued in this actuarial study. To better understand GASB 45's long term effect, the State and other employers may want to further study the impact of future new entrants or any projected growth in employee population.

Health Care Reform

The liabilities and costs presented in this report consider the long term impact of the Patient Protection and Affordable Care Act (PPACA), also known as Health Care Reform (HCR). Although there is continued uncertainty on specifics and the long term application of HCR, the accounting rules require a best estimate of the impact on the valuation.

1. Executive Summary (cont.)

ARC Development

GASB requires the development of an Annual Required Contribution (ARC) each year based on a plan's assets and liabilities. The ARC is the basis for determining the Annual OPEB Cost (AOC), which is the amount employers recognize as annual expense.

Although GASB does not actually require pre-funding, the portion of the ARC that is not funded each year accumulates as a liability on an employer's financial statements.

The ARC in this report is developed under the Entry Age Normal method.

Future GASB Developments

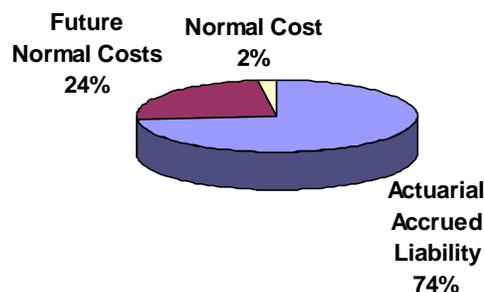
GASB is in the process of modifying employer accounting and financial reporting for pension plans. While the changes initially don't affect OPEB plans, it is anticipated that OPEB plans will soon be similarly impacted. The anticipated changes include moving unfunded liabilities from footnotes to the balance sheet, more volatile periodic expense, and a change in the discount rate basis. In order to be prepared and effectively manage plans, it is important for agencies to consider and understand the ramifications of any potential changes.

Summary of Results

Liabilities

There are a few terms to understand related to the Plan's liabilities. The Present Value of Benefits (PVB) represents the actuarial present value of all future benefits expected to be paid to current active, deferred inactive and retired employees. The Actuarial Accrued Liability (AAL) is the portion of the PVB attributable to past service. The Normal Cost is the portion of the PVB that is allocated to the current fiscal year for active employees. The chart below shows the plan's approximate allocation of these items, which varies based on assumptions.

Present Value of Benefits



1. Executive Summary (cont.)

Each liability is a present value calculated by using a selected discount rate. As requested by the EUTF and the State, results in this report are developed based on both a 4.0% and 7.0% discount rate to show costs assuming the scenarios where obligations are not prefunded or fully prefunded, respectively. The table below summarizes the liability results based on these two discount rates as of July 1, 2011:

<i>(\$ Millions)</i>	No Prefunding (4.0%)	Prefunding (7.0%)
Present Value of Benefits (PVB)	\$25,464.7	\$13,563.7
Actuarial Accrued Liability (AAL)	\$18,232.8	\$11,362.5
Normal Cost	\$603.5	\$236.7

Note: The AAL and normal cost shown above were calculated under the Entry Age Normal cost method by spreading costs as a level percentage of pay.

Discount Rate Selection

As illustrated above, the discount rate can have a considerable impact on the magnitude of the liabilities, with lower discount rates resulting in higher liabilities. As guidance in selecting an appropriate discount rate, GASB states that the discount rate should be based on the long-term yield of investments used to finance the benefits.

The no prefunding results assume employer long term general asset returns of 4%. The prefunding results are based on a 7% return, which is the EUTF's targeted return on plan investments.

If the employers want to better understand the long term advantages and disadvantages to prefunding in a trust, a study which projects cash flow, accrual amounts, and balance sheet obligations based on current and future participants should be performed.

Annual Required Contributions (ARC)

The ARC equals the normal cost plus amortization of the unfunded AAL over 30 years. The following table shows the ARC for the fiscal year ending June 30, 2013 under the scenarios where obligations are not prefunded (4.0%) and fully prefunded (7.0%):

<i>(\$ Millions)</i>	No Prefunding (4.0%)	Prefunding (7.0%)
ARC for FYE June 30, 2013	\$1,323.7	\$894.5

The ARC can be compared to the estimated pay-as-you-go funding amount of \$381.4 million.

1. Executive Summary (cont.)

Comparison to Prior Valuation Results

EUTF is considered an agent multiple employer plan under GASB rules and each employer's AOC and ARC are dependent on the respective employer's anticipated funding level.

The following tables compare total plan results to the prior valuation results:

Assuming No Prefunding of Obligations

<i>(\$ Millions)</i>	July 1, 2011 (4%)	July 1, 2011 (5%)	July 1, 2009 (5%)
Liabilities			
Present Value of Benefits (PVB)	\$25,464.7	\$20,214.6	\$21,017.4
Actuarial Accrued Liability (AAL)	\$18,232.8	\$15,420.7	\$16,153.7
Normal Cost	\$603.5	\$437.9	\$484.5
ARC	\$1,323.7	\$1,128.8	\$1,300.5
Fiscal Year Ending	June 30, 2013	June 30, 2013	June 30, 2011

Assuming Prefunding of Obligations

<i>(\$ Millions)</i>	July 1, 2011 (7%)	July 1, 2009 (7%)
Liabilities		
Present Value of Benefits (PVB)	\$13,563.7	\$14,121.2
Actuarial Accrued Liability (AAL)	\$11,362.5	\$11,864.0
Normal Cost	\$236.7	\$263.2
ARC	\$894.5	\$1,013.0
Fiscal Year Ending	June 30, 2013	June 30, 2011

1. Executive Summary (cont.)

After adjusting for the discount rate (no-pre-funding scenarios only), plan liabilities are lower than expected considering the prior valuation results. The primary factors impacting results include:

- Recognition of changes in the prescription drug plan, including carrier rebates, had a positive impact and decreased plan costs.
- Overall healthcare costs experience was favorable compared to assumed trend, resulting in liability gains.
- Future healthcare trend was revised for updated expectations, resulting in slight liability increases.
- Employer caps are anticipated to have a greater impact as the Medicare B premium index used to adjust these levels decreased from 2011 to 2012.
- Updated demographic assumptions caused a slight decrease in liabilities. The primary drivers of the differences were lower retirement rates, which were partially offset by lower mortality rates.
- The AAL grows as active participants earn additional benefits under the plan each year. Also, liabilities increase due to a decrease in the discount period for benefit payments as participants become closer to receiving benefits.

* * *

The remainder of the report shows greater details of the above results.

Appendix A, Section III shows the final results based on each employer's specific discount rate, which is determined based on the employer's funding intentions.

2. Actuarial Valuation Certificate

This report presents the results of the actuarial valuation, as of July 1, 2011, for the State of Hawaii Employer-Union Trust Fund (EUTF) under Governmental Accounting Standards Board (GASB) Statements 43 and for Employers under GASB 45.

This report was prepared using generally accepted actuarial practices and methods. The actuarial assumptions used in the calculations are individually reasonable and reasonable in aggregate.

Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following:

- Plan experience differing from that anticipated by the economic or demographic assumptions
- Changes in economic or demographic assumptions
- Increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period or additional cost or contribution requirements based on the plan's funded status)
- Changes in plan provisions or applicable law

Due to the limited scope of our assignment, we did not perform an analysis of the potential range of such future measurements.

Aon Hewitt did not audit the employee data and financial information used in this valuation. On the basis of our review of this data, we believe that the information is sufficiently complete and reliable, and that it is appropriate for the purposes intended.

Actuarial computations under GASB 43 and 45 are for purposes of fulfilling EUTF and Employer accounting requirements, respectively. The calculations reported herein have been made on a basis consistent with our understanding of these accounting standards. Determinations for purposes other than meeting EUTF and Employer financial accounting requirements may be different from these results. As required by GASB 43 and 45, this valuation assumes this will be an ongoing plan. However, this assumption does not imply any obligation by the EUTF or the Employers to continue the plan.

This report is intended for the sole use of the EUTF, the State of Hawaii, and the Employers. It is intended only to supply information to comply with the stated purpose of the report and may not be appropriate for other business purposes. Reliance on information contained in this report by anyone for other than the intended purposes, puts the relying entity at risk of being misled because of confusion or failure to understand applicable assumptions, methodologies, or limitations of the report's conclusions. Accordingly, no person or entity, including the EUTF, the State of Hawaii, or the Employers should base any representations or warranties in any business agreement on any statements or conclusions contained in this report without the written consent of Aon Hewitt.

2. Actuarial Valuation Certificate (cont.)

The actuaries whose signatures appear below are Members of either the Society of Actuaries or the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. The actuaries are available to answer any questions with regard to the matters enumerated in this report.

Aon Hewitt's relationship with the Plan and the Plan Sponsor is strictly professional. There are no aspects of the relationship that may impair or appear to impair the objectivity of our work.

Respectfully submitted,

Aon Hewitt



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June 30, 2012

3. Plan Liabilities

The liabilities shown in this exhibit were calculated as of the July 1, 2011 valuation date.

The **Present Value of Benefits (PVB)** represents the actuarial present value of all benefits ever to be paid to current employees and retirees.

The **Actuarial Accrued Liability (AAL)** is a portion of the PVB attributable to past service. For retirees and fully eligible active employees, the AAL is equal to the PVB. For other active employees, the AAL is the portion of the PVB deemed to be accrued to date. The **Normal Cost** is the portion of the PVB that is allocated to the current plan year for active employees.

The AAL in this report is based on the Entry Age Normal cost method and has been developed by spreading costs as a level percentage of payroll. It is utilized in the development of the Annual Required Contribution (ARC).

The following tables show results by retired, deferred vested, and active employee groups:

I. Assuming No Prefunding of Obligations

<i>(\$ Millions)</i>	Medical / Dental / Vision / Life	Medicare Part B	Total
Present Value of Benefits (PVB)			
Retirees	\$6,970.7	\$1,327.2	\$8,298.0
Deferred Inactives	\$1,274.9	\$181.4	\$1,456.2
Actives	\$12,578.7	\$3,131.7	\$15,710.4
Total PVB	\$20,824.3	\$4,640.3	\$25,464.7
Actuarial Accrued Liability (AAL)			
Retirees	\$6,970.7	\$1,327.2	\$8,298.0
Deferred Inactives	\$1,274.9	\$181.4	\$1,456.2
Actives	\$6,980.4	\$1,498.2	\$8,478.6
Total AAL	\$15,226.0	\$3,006.8	\$18,232.8
Normal Cost	\$467.3	\$136.3	\$603.5

3. Plan Liabilities (cont.)

II. Assuming Prefunding of Obligations

<i>(\$ Millions)</i>	Medical / Dental / Vision / Life	Medicare Part B	Total
Present Value of Benefits (PVB)			
Retirees	\$4,880.7	\$927.8	\$5,808.5
Deferred Inactives	\$664.7	\$88.8	\$753.6
Actives	\$5,683.8	\$1,317.9	\$7,001.6
Total PVB	\$11,229.2	\$2,334.5	\$13,563.7
Actuarial Accrued Liability (AAL)			
Retirees	\$4,880.7	\$927.8	\$5,808.5
Deferred Inactives	\$664.7	\$88.8	\$753.6
Actives	\$3,975.2	\$825.2	\$4,800.4
Total AAL	\$9,520.6	\$1,841.9	\$11,362.5
Normal Cost	\$182.6	\$54.0	\$236.7

4. Plan Assets

For purposes of determining the ARC, Plan assets are based on pre-funding contributions in the Hawaii EUTF account, if any, and are equal to the market value of assets, including accrued contributions, at the valuation date. The following table shows the reconciliation of Plan assets used in ARC determination.

<i>(\$ Millions)</i>	FYE 6/30/2011	FYE 6/30/2010
Plan assets, beginning of year	\$141.4	\$115.5
Employer contributions during fiscal year		
Pay-as-you-go	\$368.9	\$332.9
Pre-funding	\$25.9	\$19.5
Total employer contributions	\$394.8	\$352.4
Benefit payments (pay-as-you-go)	(\$368.9)	(\$332.9)
Investment return	\$0.1	\$0.1
Market assets, end of year	\$167.4	\$135.2
Accrued employer contributions	\$10.8	\$6.2
Plan assets, end of year	\$178.2	\$141.4

The following table summarizes the employer contributions attributable to each fiscal year:

<i>(\$ Millions)</i>	FYE 6/30/2011	FYE 6/30/2010
Pay-as-you-go	\$368.9	\$332.9
Pre-funding (during fiscal year)	\$25.9	\$19.5
Pre-funding (accrued)	\$10.8	\$6.2
Total employer contributions	\$405.6	\$358.6

The following table compares the employer contributions with the ARC:

<i>(\$ Millions)</i>	FYE 6/30/2011	FYE 6/30/2010
ARC	\$1,301.8	\$1,190.2
Employer Contributions	\$405.6	\$358.6
(Over)/Under Payment of ARC	\$896.2	\$831.6

5. Projected Benefit Payments

The following table shows the estimated projected net employer benefit payments based on the current plan provisions, current plan participants, and the valuation assumptions used in this report. The payments would be similar to funding the liabilities on a pay-as-you-go basis.

Year Ending June 30	Projected Payments (\$ Millions)		
	Medical / Dental / Vision / Life	Medicare Part B	Total
2012	\$326.0	\$55.4	\$381.4
2013	\$357.4	\$61.1	\$418.5
2014	\$392.5	\$67.2	\$459.7
2015	\$429.8	\$73.8	\$503.6
2016	\$472.3	\$80.5	\$552.8
2017	\$511.3	\$87.9	\$599.2
2018	\$548.7	\$95.6	\$644.3
2019	\$585.1	\$103.9	\$689.0
2020	\$621.2	\$112.3	\$733.5
2021	\$658.3	\$121.0	\$779.3
2022	\$695.8	\$130.0	\$825.8
2023	\$735.5	\$139.2	\$874.7
2024	\$776.3	\$148.7	\$925.0
2025	\$819.2	\$158.2	\$977.4
2026	\$862.1	\$168.2	\$1,030.3

6. Sensitivity Analysis

Impact of 1% Change to Healthcare Trend Rates

This report shows the sensitivity to discount rates by comparing results assuming no prefunding (4.0% discount rate) to results assuming prefunding (7.0% discount rate). Results are also sensitive to the healthcare trend assumptions. The following table shows the impact of a 1.0% increase or decrease in the healthcare trend rate assumption, shown for both a 4.0% and 7.0% discount rate.

I. Assuming No Prefunding of Obligations

<i>(\$ Millions)</i>	4.0% Discount Rate - Baseline Results	Impact of 1.0% Increase in the Health Trend Rate	Impact of 1.0% Decrease in the Health Trend Rate
Present Value of Benefits	\$25,464.7	\$32,361.4	\$20,373.7
Funded Status			
Actuarial Accrued Liability	\$18,232.8	\$22,259.2	\$15,133.9
Assets	\$178.2	\$178.2	\$178.2
Unfunded AAL	\$18,054.6	\$22,081.0	\$14,955.8
Annual Required Contribution (ARC) for FYE 6/30/2013			
Normal Cost plus interest	\$637.0	\$856.2	\$480.6
Amortization of Unfunded AAL	\$686.7	\$847.1	\$563.7
Total ARC	\$1,323.7	\$1,703.3	\$1,044.3

II. Assuming Prefunding of Obligations

<i>(\$ Millions)</i>	7.0% Discount Rate - Baseline Results	Impact of 1.0% Increase in the Health Trend Rate	Impact of 1.0% Decrease in the Health Trend Rate
Present Value of Benefits	\$13,563.7	\$16,263.6	\$11,460.1
Funded Status			
Actuarial Accrued Liability	\$11,362.5	\$13,321.6	\$9,793.5
Assets	\$178.2	\$178.2	\$178.2
Unfunded AAL	\$11,184.3	\$13,143.4	\$9,615.3
Annual Required Contribution (ARC) for FYE 6/30/2013			
Normal Cost plus interest	\$253.3	\$328.1	\$198.3
Amortization of Unfunded AAL	\$641.2	\$757.5	\$548.2
Total ARC	\$894.5	\$1,085.6	\$746.5

7. Participant Information

These exhibit summaries contain participant demographic information.

Active Employee Age/Service Distribution

Age	Years of Service								Total
	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35+	
<25	802	6	0	0	0	0	0	0	808
25-29	3,313	722	4	0	0	0	0	0	4,039
30-34	2,873	2,716	520	3	0	0	0	0	6,112
35-39	2,094	2,423	2,178	467	13	0	0	0	7,175
40-44	1,817	2,022	1,933	2,182	754	7	0	0	8,715
45-49	1,728	1,734	1,439	1,737	2,511	469	15	0	9,633
50-54	1,435	1,516	1,345	1,504	2,124	1,630	471	17	10,042
55-59	1,200	1,395	1,246	1,381	1,785	1,355	1,075	338	9,775
60-64	693	890	791	869	1,063	596	435	678	6,015
65-69	181	335	294	224	278	174	106	283	1,875
70-74	34	76	71	68	47	32	28	101	457
75-79	6	22	22	21	29	13	5	26	144
80+	3	6	2	2	2	0	3	6	24
Total	16,179	13,863	9,845	8,458	8,606	4,276	2,138	1,449	64,814

Inactive Age Distribution

Age	Deferred Inactives	Retirees	Total
< 35	150	36	186
35-39	315	11	326
40-44	742	37	779
45-49	1,082	166	1,248
50-54	1,275	528	1,803
55-59	1,295	2,458	3,753
60-64	886	6,523	7,409
65-69	188	8,580	8,768
70-74	59	6,691	6,750
75-79	21	5,990	6,011
80-84	4	5,266	5,270
85-89	4	3,507	3,511
90-94	0	1,533	1,533
95+	0	428	428
Total	6,021	41,754	47,775

7. Participant Information (cont.)

Participant Statistics

Retirees

Number of retirees (including surviving spouses) valued 41,754

Average age of retirees 72.8

Deferred Vested

Number of deferred vested valued 6,021

Average age of deferred vested 52.4

Actives

Number of actives valued 64,814

Average age of actives 47.3

Average past service 13.2

Participant Distribution Among Health Plans

Retirees

	Single	Two-Party	Family	Total
HMSA	18,023	11,641	1,436	31,100
HMSA (HSTA VB)	1,011	1,107	120	2,238
Kaiser	4,184	2,366	302	6,852
Kaiser (HSTA VB)	131	101	18	250
HMA	58	54	15	127
Other	87	58	0	145
Total Medical				40,712
Dental	23,468	15,094	1,766	40,328
Vision	23,411	15,449	1,899	40,759
Life				36,784

Actives

	Single	Two-Party	Family	Waived	Total
HMSA	14,957	5,126	8,253	n/a	28,336
HMSA (HSTA VB)	3,889	1,035	2,923	n/a	7,847
Kaiser	5,001	1,698	2,424	n/a	9,123
Kaiser (HSTA VB)	1,117	255	607	n/a	1,979
HMA	1,591	496	769	n/a	2,856
Other	75	85	210	n/a	370
Waived	n/a	n/a	n/a	14,303	14,303
Total Medical					64,814
Dental	25,313	11,417	17,911	10,173	64,814
Vision	25,371	10,116	16,163	13,164	64,814

8. Summary of Principal Plan Provisions

The following plan provisions are the basis for the calculations in this actuarial valuation.

1. Benefit Eligibility

The following are eligible to enroll as EUTF retirees: a) a retired member of the employees' retirement system, a county pension system, or a police, firefighters, and bandsmen pension system of the State or a county; b) the surviving spouse of a retired or deceased member; and c) the surviving child of such a retired member if the child is unmarried and under age nineteen.

2. Benefits Plans Provided (effective January 1, 2012)

Medical – PPO through HMSA, or HMO through Kaiser
 Prescription Drug – PPO through informedRx or HMSA (HSTA VB only); HMO through Kaiser
 Dental – Hawaii Dental Service
 Vision – Vision Services Plan
 Life Insurance – Royal State National
 Medicare Part B premium reimbursement

3. Monthly Base Contribution (Employer Caps)

Effective July 1, 2004, a revised monthly base contribution was established to determine the amount the employers pay to the EUTF on behalf of retirees (excluding Medicare Part B premium reimbursement). This amount is adjusted annually by the percentage change in the Medicare Part B premium.

4. Employer Contributions

Employers pay a percentage of the monthly base contribution that depends on a participant's hire date and years of service, as shown in the following table:

Hire Date	Years of Service	% of Base Contribution
Pre-7/1/96	< 10	50%
	≥ 10	100%
Post-7/1/96 (Post-7/1/01 applied to self premium only)	< 10	0%
	10-14	50%
	15-24	75%
	≥ 25	100%

5. Retiree Contributions

Retirees are required to pay the portion of the premium rate not paid by the employer.

6. Dependent and Survivor Coverage

Eligible dependents and survivors may elect coverage under the plans if they pay the portion of the premium rate not paid by the employer.

8. Summary of Principal Plan Provisions (cont.)

7. Benefit Plan Design (Effective January 1, 2012)

EUTF

Plan Provisions	HMSA PPO		Kaiser	
	Participating	Non Participating	Non-Medicare Early Retirees	Medicare Retirees ¹
Deductible Single	\$100	\$100	None	None
Family	\$300	\$300		
Office visit copay/coinsurance	10% of eligible	30% of eligible	\$15	\$15
Routine physical exams	Not Covered	Not Covered	\$15	\$15
Inpatient admission copay/coinsurance	10% of eligible	30% of eligible	No Charge	No Charge
Emergency room copay/coinsurance	10% of eligible	10% of eligible	\$50 + other applicable plan charges	\$50 + other applicable plan charges
Ambulance copay/coinsurance	20% of eligible	30% of eligible	20% of applicable charges	20% of applicable charges
Outpatient surgery copay/coinsurance	10% of eligible	30% of eligible	\$15	\$15
Out-of-pocket limit Single/Family	\$2,500/\$7,500	\$2,500/\$7,500	\$2,000/\$6,000	\$2,000
Prescriptions (30-day supply) non-mail order	informedRx		Kaiser	
Generic	\$5	\$5 + 20% of eligible charges	\$15	\$15
Preferred brand	\$15	\$15 + 20% of eligible charges	\$15	\$15
Other Brand Name	\$30	\$30 + 20% of eligible charges	\$15	\$15
Injectables and Specialty Drug	Medicare Retirees: 20%	Medicare Retirees: Co-Pay + penalty charge	\$15	\$15
	Non-Medicare Retirees: 20% Up to \$250 copay maximum, \$2,000 out-of-pocket maximum per plan year	Non-Medicare Retirees: Not a benefit	\$15	\$15
Prescriptions (90-day supply) mail order				
Generic	\$10	No benefit	\$30	\$30
Preferred brand	\$35	No benefit	\$30	\$30
Non-preferred brand	\$60	No benefit	\$30	\$30

¹ Kaiser Medicare Retirees must enroll in Kaiser's Senior Advantage plan.

8. Summary of Principal Plan Provisions (cont.)

HSTA VB

Plan Provisions	HMSA PPO		Kaiser	
	Participating	Non Participating	Non-Medicare Early Retirees	Medicare Retirees ²
Deductible Single	\$100	\$100	None	None
Family	\$300	\$300		
Office visit copay/coinsurance	10% of eligible	30% of eligible	\$15	\$15
Routine physical exams	No Charge	No Charge	No Charge	No Charge
Inpatient admission copay/coinsurance	10% of eligible	30% of eligible	No Charge	No Charge
Emergency room copay/coinsurance	10% of eligible	10% of eligible	\$50 + other applicable plan charges	\$50 + other applicable plan charges
Ambulance copay/coinsurance	10% of eligible	30% of eligible	20% of applicable charges	20% of applicable charges
Outpatient surgery copay/coinsurance	10% of eligible	30% of eligible	\$15	\$15
Out-of-pocket limit Single/Family	\$2,000/\$6,000	\$2,000/\$6,000	\$2,000/\$6,000	\$2,000
Prescriptions (30-day supply) non-mail order	HMSA		Kaiser	
Generic	\$5	\$5 + 30% of eligible charges	\$10	\$10
Preferred brand	\$15	\$15 + 30% of eligible charges	\$10	\$10
Prescriptions (90-day supply) mail order				
Generic	\$9	No benefit	\$20	\$20
Preferred brand	\$27	No benefit	\$20	\$20

² Kaiser Medicare Retirees must enroll in Kaiser's Senior Advantage plan.

9. Actuarial Methods and Assumptions

Where applicable, the Hawaii Employee Retirement System (ERS) July 1, 2011 actuarial valuation assumptions were used.

1. Actuarial Valuation Date

July 1, 2011

2. Actuarial Cost Method

The costs shown in the report were developed using the Entry Age Normal (EAN) cost method. The EAN cost method spreads plan costs for each participant from entry date (assuming the plan existed on the employee's hire date) to the expected retirement date. Under the EAN cost method, the plan's normal cost is developed as a level percentage of payroll spread over the participants' working lifetime. The AAL is the cumulative value, on the valuation date, of prior service costs. For retirees and deferred inactive participants, the AAL is the present value of all projected benefits.

The ARC under this method equals the normal cost plus the amortization of the unfunded AAL (both determined at the middle of year), based on the following:

For State of Hawaii:

- 30-year open period amortization.
- Level percentage of future payroll amounts.

For other employers:

- Initial unfunded AAL amortized over 30-year period ending June 30, 2037,
- New unfunded AAL in each subsequent valuation amortized over 30-year period beginning one year after base establishment,
- Level percentage of future payroll amounts.

The Plan costs are derived by making certain specific assumptions as to the rates of interest, mortality, turnover, and the like, which are assumed to hold for many years into the future. Actual experience may differ somewhat from the assumptions and the effect of such differences is spread over all periods. Due to these differences, the costs determined by the valuation must be regarded as estimates of the true Plan costs.

3. Asset Method

Fair value of assets, plus accrued contributions.

4. Discount Rate

4.0% - No Prefunding - This rate is based on the assumption that benefits will be paid from general employer assets.

7.0% - Prefunding - This rate is based on the assumption that employers pre-fund contributions.

9. Actuarial Methods and Assumptions (cont.)

5. Payroll Increases

3.5% - This is the annual rate at which total payroll is expected to increase and is used to amortize unfunded liabilities as a level percent of payroll.

6. Salary Increases

Used to determine AAL as a level percentage of payroll.

<u>Years of Service</u>	<u>General Employees</u>	<u>Teachers</u>	<u>Police & Fire</u>
1	8.00%	8.50%	19.00%
2	7.00%	7.75%	17.00%
3	6.00%	7.00%	5.00%
4	5.25%	6.50%	5.00%
5	5.00%	6.00%	5.00%
6	4.75%	5.50%	5.00%
7	4.50%	5.50%	5.00%
8	4.50%	5.25%	5.00%
9	4.50%	5.25%	5.00%
10	4.25%	5.25%	5.00%
11	4.25%	5.00%	5.00%
12	4.25%	5.00%	5.00%
13	4.25%	5.00%	5.00%
14	4.25%	5.00%	5.00%
15+	4.00%	4.50%	5.00%

7. Mortality

Pre-retirement non-duty mortality: ERS mortality rates were used. Below are sample rates:

Age	<u>General Employees</u>		<u>Teachers</u>		<u>Police & Fire</u>	
	Male	Female	Male	Female	Male	Female
25	0.02%	0.01%	0.02%	0.01%	0.01%	0.00%
30	0.03%	0.01%	0.02%	0.01%	0.01%	0.00%
35	0.05%	0.02%	0.04%	0.02%	0.01%	0.01%
40	0.07%	0.03%	0.05%	0.03%	0.02%	0.01%
45	0.10%	0.05%	0.08%	0.05%	0.02%	0.02%
50	0.14%	0.08%	0.11%	0.07%	0.03%	0.03%
55	0.19%	0.12%	0.15%	0.10%	0.05%	0.04%
60	0.31%	0.19%	0.24%	0.16%	0.07%	0.06%
65	0.48%	0.28%	0.38%	0.23%	0.11%	0.09%

9. Actuarial Methods and Assumptions (cont.)

Pre-retirement duty mortality: ERS mortality rates were used. Below are sample rates:

Age	General Employees		Teachers		Police & Fire	
	Male	Female	Male	Female	Male	Female
25	0.01%	0.00%	0.00%	0.00%	0.01%	0.01%
30	0.01%	0.00%	0.00%	0.00%	0.02%	0.01%
35	0.01%	0.01%	0.01%	0.00%	0.03%	0.02%
40	0.02%	0.01%	0.01%	0.00%	0.04%	0.02%
45	0.02%	0.01%	0.02%	0.01%	0.05%	0.04%
50	0.03%	0.02%	0.02%	0.01%	0.07%	0.06%
55	0.05%	0.03%	0.03%	0.01%	0.11%	0.09%
60	0.08%	0.05%	0.05%	0.02%	0.17%	0.14%
65	0.12%	0.07%	0.08%	0.03%	0.27%	0.20%

Post-retirement healthy mortality: ERS mortality rates were used. Below are sample rates:

Age	General Employees		Teachers		Police & Fire	
	Male	Female	Male	Female	Male	Female
50	0.33%	0.17%	0.18%	0.10%	0.22%	0.12%
55	1.02%	0.47%	0.31%	0.25%	0.38%	0.20%
60	1.30%	0.82%	0.29%	0.32%	0.68%	0.38%
65	1.49%	0.83%	0.37%	0.29%	1.24%	0.73%
70	1.91%	0.85%	0.97%	0.60%	2.02%	1.17%
75	2.92%	1.38%	1.62%	0.95%	3.16%	1.93%
80	4.38%	2.38%	3.21%	2.13%	5.27%	3.35%
85	7.49%	4.53%	6.36%	4.96%	8.27%	5.76%
90	12.54%	10.14%	11.13%	9.29%	13.00%	9.88%

Post-retirement disabled mortality: ERS mortality rates were used. Below are sample rates:

Age	General Employees		Teachers		Police & Fire	
	Male	Female	Male	Female	Male	Female
50	0.71%	0.39%	0.44%	0.26%	0.36%	0.19%
55	1.29%	0.76%	0.80%	0.51%	0.63%	0.34%
60	2.17%	1.27%	1.45%	0.97%	1.15%	0.67%
65	3.41%	2.04%	2.37%	1.50%	1.99%	1.18%
70	5.59%	3.54%	3.72%	2.53%	3.12%	1.83%
75	8.96%	6.10%	6.20%	4.40%	5.02%	3.17%
80	13.95%	10.46%	9.72%	7.53%	8.25%	5.49%
85	21.57%	17.07%	15.29%	12.88%	12.70%	9.38%
90	30.13%	25.67%	23.36%	20.25%	19.84%	15.59%

9. Actuarial Methods and Assumptions (cont.)

8. Termination

ERS termination rates were used in the valuation.

The following rates apply for employees with less than 6 years of service, regardless of age:

Years	General Employees		Teachers		Police & Fire	
	Male	Female	Male	Female	Male	Female
0	15.50%	18.50%	33.00%	28.00%	12.00%	12.00%
1	12.50%	16.50%	23.00%	23.00%	9.00%	9.00%
2	10.50%	12.50%	15.00%	16.00%	4.00%	4.00%
3	9.00%	10.00%	13.00%	14.00%	4.00%	4.00%
4	7.00%	8.00%	11.00%	12.00%	4.00%	4.00%
5	6.00%	7.00%	9.00%	8.00%	4.00%	4.00%

The following rates apply for employees with 6 or more years of service:

Age	General Employees		Teachers		Police & Fire	
	Male	Female	Male	Female	Male	Female
25	6.50%	7.83%	4.98%	6.72%	1.91%	1.91%
30	5.46%	5.84%	4.12%	6.15%	2.53%	2.53%
35	4.40%	4.04%	3.95%	4.99%	2.75%	2.75%
40	3.60%	3.30%	3.60%	3.70%	2.01%	2.01%
45	3.02%	2.65%	2.88%	2.88%	1.18%	1.18%
50	2.54%	2.41%	2.34%	2.36%	0.79%	0.79%
55	2.52%	2.41%	2.34%	2.36%	0.24%	0.24%
60	2.52%	2.41%	2.34%	2.36%	0.00%	0.00%
65	2.52%	2.41%	2.34%	2.36%	0.00%	0.00%

9. Actuarial Methods and Assumptions (cont.)

9. Disability

Non-Duty Disability: ERS disability rates were used in the valuation. Sample rates are as follows:

Age	General Employees		Teachers		Police & Fire	
	Male	Female	Male	Female	Male	Female
25	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
30	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
35	0.01%	0.01%	0.00%	0.00%	0.01%	0.01%
40	0.03%	0.02%	0.01%	0.01%	0.02%	0.02%
45	0.09%	0.05%	0.03%	0.03%	0.04%	0.04%
50	0.20%	0.12%	0.07%	0.06%	0.10%	0.10%
55	0.27%	0.17%	0.10%	0.08%	0.14%	0.14%
60	0.29%	0.18%	0.11%	0.08%	0.15%	0.15%
65	0.52%	0.32%	0.19%	0.15%	0.27%	0.27%

Duty Disability: ERS disability rates were used in the valuation. Sample rates are as follows:

Age	General Employees		Teachers		Police & Fire	
	Male	Female	Male	Female	Male	Female
25	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
30	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
35	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
40	0.01%	0.00%	0.00%	0.00%	0.01%	0.01%
45	0.02%	0.00%	0.00%	0.00%	0.02%	0.02%
50	0.04%	0.01%	0.01%	0.01%	0.05%	0.05%
55	0.06%	0.01%	0.01%	0.01%	0.07%	0.07%
60	0.06%	0.01%	0.01%	0.01%	0.07%	0.07%
65	0.11%	0.03%	0.02%	0.02%	0.13%	0.13%

9. Actuarial Methods and Assumptions (cont.)

10. Retirement Age

ERS retirement rates were used in the valuation. Sample rates are as follows:

For active participants in a contributory pension plan

Age	General Employees		Teachers		Police & Fire	
	Male	Female	Male	Female	Male	Female
45	2.00%	1.00%	0.00%	0.00%	13.00%	13.00%
50	2.00%	1.00%	1.00%	0.00%	15.00%	15.00%
55	16.00%	13.00%	20.00%	18.00%	20.00%	20.00%
60	14.00%	15.00%	14.00%	18.00%	30.00%	30.00%
65	25.00%	25.00%	20.00%	25.00%	100.00%	100.00%
70	20.00%	20.00%	15.00%	20.00%	100.00%	100.00%
75	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

For active participants in a non-contributory pension plan

Age	General Employees				Teachers			
	>= 30 years of Service		< 30 years of Service		>= 30 years of Service		< 30 years of Service	
	Male	Female	Male	Female	Male	Female	Male	Female
45	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
50	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
55	13.00%	12.00%	2.00%	2.00%	10.00%	13.00%	2.00%	3.00%
60	14.00%	15.00%	4.00%	4.00%	10.00%	17.00%	5.00%	5.00%
65	25.00%	22.00%	25.00%	22.00%	20.00%	30.00%	20.00%	30.00%
70	20.00%	20.00%	20.00%	20.00%	15.00%	25.00%	15.00%	25.00%
75	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

9. Actuarial Methods and Assumptions (cont.)

11. Annual Healthcare Inflation (“Trend”)

Medical and prescription drug trends were determined initially from a combination of EUTF specific trend experience and national/regional expectations. The relative weighting of the group specific versus national average trend was based on credibility theory. Applying econometric theory, trends were graded downward over several years to an ultimate rate. This assumption methodology is in line with Actuarial Standards of Practice for retiree health valuations.

A unique claim trend was developed for the Kaiser Medicare Advantage plans incorporating national expectations for these plans. The HMSA PPO trends include the impact of maximum rate guarantees from the vendor through Plan Year 2014.

The resulting trend rates are as follows:

Year	HMSA	HMSA	HMSA	HMSA
	Pre-65	Post-65	(HSTA VB) Pre-65	(HSTA VB) Post-65
2011	8.00%	8.50%	8.50%	8.50%
2012	7.50%	8.25%	8.25%	8.25%
2013	7.50%	8.00%	8.00%	8.00%
2014	13.00%	7.75%	7.75%	7.75%
2015	7.50%	7.50%	7.50%	7.50%
2016	7.00%	7.00%	7.00%	7.00%
2017	6.50%	6.50%	6.50%	6.50%
2018	6.00%	6.00%	6.00%	6.00%
2019	5.50%	5.50%	5.50%	5.50%
2020+	5.00%	5.00%	5.00%	5.00%

Year	Kaiser	Kaiser	Dental	Vision	Medicare
	Pre-65	Post-65			Part B
2011	8.50%	15.00%	4.00%	3.00%	acutal*
2012	8.25%	13.00%	4.00%	3.00%	5.00%
2013	8.00%	12.00%	4.00%	3.00%	5.00%
2014	7.75%	10.00%	4.00%	3.00%	5.00%
2015	7.50%	8.00%	4.00%	3.00%	5.00%
2016	7.00%	7.00%	4.00%	3.00%	5.00%
2017	6.50%	6.50%	4.00%	3.00%	5.00%
2018	6.00%	6.00%	4.00%	3.00%	5.00%
2019	5.50%	5.50%	4.00%	3.00%	5.00%
2020+	5.00%	5.00%	4.00%	3.00%	5.00%

* The standard 2011 Medicare Part B premium is \$96.40 for most retirees, and \$115.40 for new retirees. For 2012, the standard Part B monthly premium is \$99.90. For the Medicare Part B reimbursement valuation, \$96.40 was used from July 2011 to December 2011, and \$99.90 was used from January 2012 to June 2012. The first year trend rate is $(\$99.6*6 + \$99.6*1.05*6) / (\$96.4 * 6 + \$99.9 * 6) - 1 = 4.33\%$.

For the purpose of determining Base Contribution (Employer Caps), the first year trend rate is (13.43%).

9. Actuarial Methods and Assumptions (cont.)

12. Healthcare Premiums

Effective January 1, 2012, the total monthly premium rates for retirees follow:

	<u>Premium</u>	<u>Administrative Fee</u>	<u>Total Payment Required</u>
HMSA Non-Medicare			
Single	\$379.24	\$2.12	\$381.36
Two-Party	738.96	4.48	743.44
Family	1,095.50	6.54	1,102.04
HMSA Medicare			
Single	175.88	2.12	178.00
Two-Party	342.76	4.48	347.24
Family	508.10	6.54	514.64
Prescription Drug Non-Medicare			
Single	109.56	0.60	110.16
Two-Party	213.36	1.28	214.64
Family	316.36	1.88	318.24
Prescription Drug Medicare			
Single	203.54	0.62	204.16
Two-Party	396.31	1.29	397.60
Family	587.58	1.86	589.44
Kaiser Non-Medicare (Including Drug)			
Single	657.04	2.76	659.80
Two-Party	1,281.20	5.76	1,286.96
Family	1,898.76	8.40	1,907.16
Kaiser Medicare (Including Drug)			
Single	362.76	2.76	365.52
Two-Party	707.32	5.76	713.08
Family	1,048.24	8.40	1,056.64

9. Actuarial Methods and Assumptions (cont.)

	<u>Premium</u>	<u>Administrative Fee</u>	<u>Total Payment Required</u>
HSTA VB HMSA Non-Medicare (Including Drug)			
Single	515.56	2.80	518.36
Two-Party	1,004.77	5.91	1,010.68
Family	1,487.07	8.61	1,495.68
HSTA VB HMSA Medicare (Including Drug)			
Single	393.78	2.82	396.60
Two-Party	767.49	5.91	773.40
Family	1,135.24	8.60	1,143.84
HSTA VB Kaiser Non-Medicare (Including Drug)			
Single	677.24	2.80	680.04
Two-Party	1,320.90	5.90	1,326.80
Family	1,955.04	8.60	1,963.64
HSTA VB Kaiser Medicare (Including Drug)			
Single	376.76	2.80	379.56
Two-Party	734.98	5.90	740.88
Family	1,086.72	8.60	1,095.32
HDS (Dental)			
Single	28.56	0.32	28.88
Two-Party	55.68	0.64	56.32
Family	68.28	0.96	69.24
VSP (Vision; included in HSTA VB Medical above)			
Single	5.06	0.06	5.12
Two-Party	10.12	0.12	10.24
Family	13.59	0.17	13.76

The standard Medicare Part B monthly premium for 2011 is \$96.40 for most retirees, and is \$110.50 or \$115.40 for certain other retirees. For 2012, the standard Part B monthly premium is \$99.90.

All amounts are assumed to increase at the same rate as the applicable healthcare trend.

9. Actuarial Methods and Assumptions (cont.)

13. Monthly Base Contribution (Employer Caps)

The monthly base contribution for the fiscal years 2011/2012 and 2012/2013 follows:

Fiscal Year 7/1/11 – 6/30/12	Single	Two-Party	Family
Non-Medicare	\$771.50	\$1,555.06	\$2,276.02
Medicare	549.58	1,101.52	1,604.36
Fiscal Year 7/1/12 – 6/30/13	Single	Two-Party	Family
Non-Medicare	\$668.12	\$1,346.68	\$1,971.04
Medicare	475.94	953.92	1,389.36

This base contribution is assumed to increase at the same rate as Medicare Part B trend in following years.

14. Base Year Claims

Self Funded

The EUTF PPO prescription drug plan is self-insured. The claims development was based on 36 months of claims experience adjusted by trend and any plan design modifications. Due to data limitations, prescription drug experience was combined for both Pre-Medicare and Medicare retirees. This assumption was accounted for in our calculations.

The projected claims costs were stratified by age according to morbidity factors recognized by the Society of Actuaries as acceptable standards of practice for retiree health valuations.

Fully Insured

The claims curves developed for fully-insured plans utilized premiums rather than claims experience. The annual premiums were stratified by age using the same morbidity factors mentioned above.

9. Actuarial Methods and Assumptions (cont.)

The following table shows sample expected monthly per member claim costs for the fiscal year beginning July 1, 2011. Please note that where applicable, claims have been adjusted for carrier rebates received.

<u>Age</u>	<u>HMSA Medical & Rx</u>	<u>HMSA (HSTA VB) Medical & Rx</u>	<u>Kaiser Medical & Rx</u>	<u>Kaiser (HSTA VB) Medical & Rx</u>
42	\$271	\$247	\$337	\$328
47	313	289	394	384
52	373	346	471	459
57	441	410	557	544
62	532	497	673	658
67	313	349	285	340
72	359	401	327	391
77	401	450	367	439
82	434	488	397	475
87	452	508	413	495

Dental and vision costs are not assumed to vary by age. The monthly expected claims are \$28 for dental and \$5 for vision.

The standard Medicare Part B reimbursement is \$96.40 per month in 2011 for most retirees and \$99.90 per month in 2012 for all retirees.

15. Life Insurance

The life insurance benefit amount effective on January 1, 2012 is \$2,034.

16. Retiree Contributions

Retirees are required to pay the portion of the premium rate not paid by their employer. Future premium rates are assumed to increase by healthcare trend.

9. Actuarial Methods and Assumptions (cont.)

17. Plan Participation

The rates at which future eligible retirees are assumed to elect coverage vary based on the employer contribution percentage, as follows:

Employer Contribution	Medical & Rx	Dental/Vision	Life	Medicare Part B
0%	25%	35%	100%	99%
50%	50%	70%	100%	99%
75%	90%	85%	100%	99%
100%	99%	99%	100%	99%

An adjustment factor of 0.997 is used for EUTF HMSA and Prescription Drug participation to reflect that not all participants elect the prescription drug coverage along with HMSA.

18. Plan Election

All active and retired participants are assumed to continue coverage in the plan in which they are currently enrolled. Current actives waiving coverage and deferred inactives are assumed to elect medical coverage at the rate of 82% HMSA / 18% Kaiser, which is approximately the same proportion as current retired participants.

19. Plan Coverage

For current retirees, actual plan coverage (e.g., single, two-party and family) is used. Future retirees are assumed to elect plan coverage in the same proportion as current retirees – currently 52% single / 43% two-party / 5% family.

All participants are assumed to be eligible for Medicare upon attainment of age 65.

20. Dependent Age

Actual spouses' dates of birth are used for current retirees, if available. Otherwise, males are assumed to be 4 years older than their female spouses. Certain dependents under age 24 who are valued are assumed to be 25, 27, or 30 years younger than the retiree.

21. Participants Valued

Only current retired, deferred inactive, and active participants are valued. No future entrants are considered in this valuation.

9. Actuarial Methods and Assumptions (cont.)

22. Health Care Reform

The liabilities and costs presented in this report consider the long term impact of the Patient Protection and Affordable Care Act (PPACA), also known as Health Care Reform (HCR). Although there is continued uncertainty on specifics and the long term application of HCR, the accounting rules require a best estimate of the impact on the valuation.

23. Changes in Valuation Assumptions

The following assumptions were changed from the prior valuation:

1) Discount Rate – No Prefunding

2011 – 4.0%
2009 – 5.0%

This change was made based on the anticipated return on general employer assets.

2) Salary Increases

2011 – ERS July 1, 2011 assumptions
2009 – 4%

3) Demographic Assumptions (Mortality, Termination, Disability, and Retirement):

2011 – ERS July 1, 2011 assumptions
2009 – ERS July 1, 2009 assumptions

4) Healthcare Trend

Year	Medical & Rx Pre-65			Medical & Rx Post-65		
	2011 HMSA	2011 Kaiser & HMSA (HSTA VB)	2009	2011 HMSA	2011 Kaiser	2009
2009			10.50%			10.25%
2010			10.00			9.75
2011	8.00%	8.50%	9.50	8.50%	15.00%	9.25
2012	7.50	8.25	8.75	8.25	13.00	8.50
2013	7.50	8.00	8.00	8.00	12.00	7.75
2014	13.00	7.75	7.25	7.75	10.00	7.00
2015	7.50	7.50	6.50	7.50	8.00	6.25
2016	7.00	7.00	6.00	7.00	7.00	5.75
2017	6.50	6.50	5.50	6.50	6.50	5.25
2018	6.00	6.00	5.00	6.00	6.00	5.00
2019	5.50	5.50	5.00	5.50	5.50	5.00
2020+	5.00	5.00	5.00	5.00	5.00	5.00

9. Actuarial Methods and Assumptions (cont.)

Year	Dental		Vision		Medicare Part B	
	2011	2009	2011	2009	2011	2009
2009		6.00%		4.00%		actual
2010		5.50		3.50		6.00
2011	4.00%	5.00	3.00%	3.00	actual	5.50
2012	4.00	4.50	3.00	3.00	5.00	5.00
2013+	4.00	4.00	3.00	3.00	5.00	5.00

5) Plan Participation

Employer Contribution	Medical & Rx		Dental/Vision	
	2011	2009	2011	2009
0%	25%	50%	35%	70%
50%	50%	50%	70%	70%
75%	90%	75%	85%	85%
100%	99%	99%	99%	99%

6) Plan Coverage

2011 – 52% single / 43% two-party / 5% family

2009 – 51% single / 44% two-party / 5% family for EUTF

45% single / 55% family for HSTA

10. GASB OPEB Summary

The Government Accounting Standards Board (GASB) Statements No. 43 and 45 address recognition and disclosure for public entities sponsoring other (than pensions) post-retirement benefit plans.

This Exhibit summarizes pertinent issues from the above statements and includes comments about GASB's OPEB standard.

Why Pay-As-You-Go Accounting Will Be Unacceptable

The GASB believes, like the FASB, that other post-retirement benefits, like pensions, are a form of deferred compensation. Accordingly, GASB is saying these benefits should be recognized (in an organization's financial statement) when earned by employees, rather than when paid out. Under Accounting Standards Codification (ASC) 715, pay-as-you-go accounting is replaced with accrual accounting for these benefits. *This approach is similar to (although more restrictive than) GASB's approach under Statements No. 43 and 45.*

Allocating Costs (Attribution)

The FASB defines attribution as the process of assigning other post-retirement benefit cost to periods of employee service. ASC 715 specifies how (the attribution method) and over what accounting periods (the attribution period) the postretirement benefits promise must be allocated.

The attribution (actuarial cost) method specified by ASC 715 is the "projected unit credit actuarial cost method". This method attributes an equal amount of the total postretirement benefit to each year of service during the "attribution period".

The attribution period is the period over which the total postretirement benefit is earned. Unless the plan states that post-retirement benefits are not earned until a later date, the attribution period is from the employee's hire date until the employee is first eligible for the benefit. *The GASB Statements do not restrict entities to a single attribution method, but instead allows sponsors (and actuaries) to choose from several acceptable methods (similar to GASB 27).* GASB allows six funding methods and also allows attribution to the expected retirement age rather than the earliest eligibility age.

Defining the Plan

ASC 715 refers to the substantive plan as the basis for accounting. The substantive plan may differ from the written plan in that it reflects the employer's cost sharing policy based on past practice or communication of intended changes, or a past practice of cost increases in monetary benefits. Under ASC 715, the substantive plan is the basis for allowing recognition of potential future changes to the plan. *GASB follows FASB's lead on this issue, requiring entities to recognize the underlying promise, not just the written plan.*

10. GASB OPEB Summary (cont.)

One GASB requirement relates to the implied subsidy when retirees participate in the active healthcare plan, but are charged a rate based on composite active and retiree experience. Under the GASB standard, even if an organization does not otherwise subsidize the benefit, then the organization will have to recognize an OPEB obligation for the implied subsidy.

Actuarial Assumptions

ASC 715 says actuarial assumptions should be explicit. This means each individual assumption should represent the actuary's best estimate. GASB also, generally, requires explicit assumptions.

GASB requires the discount rate be based on the source of funds used to pay the benefits. This means the underlying expected long-term rate of return on plan assets for funded plans. However, since the source of funds for unfunded plans is usually the organization's general fund, and organizations are usually restricted by State law as to what investments they can have in their general fund, unfunded plans will need to use a relatively low discount rate.

Transition Issues

Because historical annual required contribution information will rarely be available, *GASB is taking a prospective approach on transition issues.* This means there will be no requirement for any initial transition obligation.

Effective Dates

The GASB standards have staggered effective dates, similar to GASB Statement No. 34, as follows:

	Annual Revenue	Effective for Fiscal Years Beginning After	
		GASB 43	GASB 45
Phase I	≥ \$100 million	December 15, 2005	December 15, 2006
Phase II	≥ \$10 million, but < \$100 million	December 15, 2006	December 15, 2007
Phase III	< \$10 million	December 15, 2007	December 15, 2008

11. Glossary

Actuarial Accrued Liability (AAL)

As determined by a particular Actuarial Cost Method, the portion of the Actuarial Present Value of plan benefits and expenses which is attributable to past service, and thus not provided for by future Normal Costs.

Actuarial Assumptions

Assumptions as to the occurrence of future events affecting benefit costs, such as: mortality, withdrawal, disablement and retirement; changes in compensation and employer provided benefits; rates of investment earnings and asset appreciation or depreciation; procedures used to determine the Actuarial Value of Assets; and other relevant items. The Actuarial Assumptions are used in connection with the Actuarial Cost Method to allocate plan costs over the working lifetime of plan participants.

Actuarial Cost Method

A procedure for determining the Actuarial Present Value of plan benefits and expenses and for developing an actuarially equivalent allocation of such value to time periods (e.g., past service, future service), usually in the form of a Normal Cost and an Actuarial Accrued Liability.

Actuarial Experience Gain or Loss

A measure of the difference between actual experience and that expected based upon a set of Actuarial Assumptions, during the period between two Actuarial Valuation Dates, as determined in accordance with a particular Actuarial Cost Method.

Actuarial Present Value

The value of an amount or series of amounts payable or receivable at various times, determined as of a given date by the application of a particular set of Actuarial Assumptions. For purposes of this standard, each such amount or series of amounts is:

- a. adjusted for the probable financial effect of certain intervening events (such as changes in compensation levels, Social Security, marital status, etc.).
- b. multiplied by the probability of the occurrence of an event (such as survival, death disability, termination of employment, etc.) on which the payment is conditioned, and
- c. discounted according to an assumed rate (or rates) of return to reflect the time value of money.

11. Glossary (cont.)

Actuarial Present Value of Total Projected Benefits or Present Value of Benefits (PVB)

Total projected benefits include all benefits estimated to be payable to plan members (retirees and beneficiaries, terminated employees entitled to benefits but not yet receiving them, and current active members) as a result of their service through the valuation date and their expected future service. The actuarial present value of total projected benefits as of the valuation date is the present value of the cost to finance benefits payable in the future, discounted to reflect the expected effects of the time value (present value) of money and the probabilities of payment. Expressed another way, it is the amount that would have to be invested on the valuation date so that the amount invested plus investment earnings will provide sufficient assets to pay total projected benefits when due.

Actuarial Valuation

The determination, as of a Valuation Date, of the Normal Cost, Actuarial Accrued Liability, Actuarial Value of Assets, and related Actuarial Present Values for a benefit plan.

Actuarial Valuation Date

The date as of which an actuarial valuation is performed.

Actuarial Value of Assets

The value of cash, investments, and other property belonging to a benefit plan, as used by the actuary for the purpose of an Actuarial Valuation.

Agent Multiple-Employer Plan

An aggregation of single-employer plans, with pooled administrative and investment functions. Separate accounts are maintained for each employer so that the employer's contributions provide benefits only for the employees of that employer. A separate actuarial valuation is performed for each individual employer's plan to determine the employer's periodic contribution rate and other information for the individual plan, based on the benefit formula selected by the employer and the individual plan's proportionate share of the pooled assets. The results of the individual valuations are aggregated at the administrative level.

Aggregate Actuarial Cost Method

A method under which the excess of the Actuarial Present Value of Projected Benefits of the group included in an Actuarial Valuation over the Actuarial Value of Assets is allocated on a level basis over the earnings or service of the group between the valuation date and assumed exit. This allocation is performed for the group as a whole, not as a sum of individual allocations. That portion of the Actuarial Present Value allocated to a valuation year is called the Normal Cost. The Actuarial Accrued Liability is equal to the Actuarial Value of Assets.

11. Glossary (cont.)

Amortization (of Unfunded Actuarial Accrued Liability)

The portion of benefit plan costs or contributions which is designed to pay off principal and interest on the Unfunded Actuarial Accrued Liability.

Annual OPEB Cost (AOC)

An accrual-basis measure of the periodic cost of an employer's participation in a defined benefit OPEB plan.

Annual Required Contributions of the Employer (ARC)

The employer's periodic required contributions to a Defined Benefit OPEB Plan, which is the basis for determining an employer's Annual OPEB Cost. For a Cost Sharing Multiple-Employer Plan, the Contractually Required Contributions should be used to determine an employer's Annual OPEB Cost.

Contractually Required Contributions (CRC)

The contributions assessed by a Cost Sharing Multiple-Employer Plan to the participating employer for a period, without regard for the method used to determine the amounts.

Cost Sharing Multiple-Employer Plan

A single plan with pooling (cost-sharing) arrangements for the participating employers. All risks, rewards, and costs, including benefit costs, are shared and are not attributed individually to the employers. A single actuarial valuation covers all plan members, and the same contribution rate(s) applies for each employer.

Covered Group

Plan members included in an actuarial valuation.

Deferred Inactives

Former employees, not yet receiving retirement benefits, who are eligible for plan benefits in the future.

Defined Benefit OPEB Plan

An OPEB plan having terms that specify the benefits to be provided at or after separation from employment. The benefits may be specified in dollars (for example, a flat dollar payment or an amount based on one or more factors such as age, years of service, and compensation), or as a type or level of coverage (for example, prescription drugs or a percentage of healthcare insurance premiums).

11. Glossary (cont.)

Discount Rate (Investment Return Assumption)

The rate used to adjust a series of future payments to determine the present value by reflecting the time value of money.

Employer Contributions

Contributions made in relation to the annual required contributions of the employer (ARC). An employer has made a contribution in relation to the ARC if the employer has (a) made payments of benefits directly to or on behalf of a retiree or beneficiary, (b) made premium payments to an insurer, or (c) irrevocably transferred assets to a trust, or equivalent arrangement, in which plan assets are dedicated to providing benefits to retirees and their beneficiaries in accordance with the terms of the plan and are legally protected from creditors of the employer(s) of plan administrator. Employer contributions generally do not necessarily equate to benefits paid.

Entry Age Normal Actuarial Cost Method

A method under which the Actuarial Present Value of the Projected Benefits of each individual included in an Actuarial Valuation is allocated on a level basis over the earnings or service of the individual between entry age and assumed exit age(s). The portion of this Actuarial Present Value allocated to a valuation year is called the Normal Cost. The portion of this Actuarial Present Value not provided for at a valuation date by the Actuarial Present Value of future Normal Costs is called the Actuarial Accrued Liability.

Funded Ratio

The actuarial value of assets expressed as a percentage of the Actuarial Accrued Liability.

Funding Excess

The excess of the Actuarial Value of Assets over the Actuarial Accrued Liability.

Funding Policy

The program for the amounts and timing of contributions to be made by plan members, employer(s), and other contributing entities to provide the benefits specified by an OPEB plan.

Healthcare Cost Trend Rate

The rate of change in per capita health claims costs over time as a result of factors such as medical inflation, utilization of healthcare services, plan design, and technological developments.

Implicit Rate Subsidy

The differential between utilizing a blend of active and non-Medicare retiree experience for cost of benefits, and utilizing solely the expected retiree experience. Blending a lower cost active cohort with retirees results in an implicit rate subsidy for the retirees of the entire group.

11. Glossary (cont.)

Inactives

Certain former employees with a minimum amount of years of creditable service who have benefits payable from the retirement system.

Level Percentage of Projected Payroll Amortization Method

Amortization payments are calculated so that they are a constant percentage of the projected payroll of active plan members over a given number of years. The dollar amount of the payments generally will increase over time as payroll increases (e.g., due to inflation); in dollars adjusted for inflation, the payments can be expected to remain level.

Market-Related Value of Plan Assets

A term used with reference to the actuarial value of assets. A market related value may be fair value, market value (or estimated market value), or a calculated value that recognizes changes in fair or market value over a period of, for example, three to five years.

Net OPEB Obligation (NOO)

The cumulative difference since the effective date of this Statement between Annual OPEB Cost and the employer's contributions to the plan, including the OPEB liability (asset) at transition, if any, and excluding (a) short-term differences and (b) unpaid contributions that have been converted to OPEB-related debt.

Normal Cost

The portion of the Actuarial Present Value of plan benefits and expenses that is allocated to a valuation year by the Actuarial Cost Method.

OPEB Assets

The amount recognized by an employer for contributions to an OPEB plan greater than OPEB expense.

OPEB Expenditures

The amount recognized by an employer in each accounting period for contributions to an OPEB plan on the modified accrual basis of accounting.

OPEB Expense

The amount recognized by an employer in each accounting period for contributions to an OPEB plan on the accrual basis of accounting.

11. Glossary (cont.)

OPEB Liabilities

The amount recognized by an employer for contributions to an OPEB plan less than OPEB expense/expenditures.

Other Postemployment Benefits (OPEB)

Postemployment benefits other than pension benefits. Other postemployment benefits (OPEB) include postemployment healthcare benefits, regardless of the type of plan that provides them, and all postemployment benefits provided separately from a pension plan, excluding benefits defined as termination offers and benefits.

Pay-As-You-Go

A method of financing a plan under which the contributions to the plan are generally made at about the same time and in about the same amount as benefit payments and expenses becoming due.

Plan Assets

Resources, usually in the form of stocks, bonds, and other classes of investments, that have been segregated and restricted in a trust, or equivalent arrangement, in which (a) employer contributions to the plan are irrevocable, (b) assets are dedicated to providing benefits to retirees and their beneficiaries, (c) assets are legally protected from creditors of the employers or plan administrator, for the payment of benefits in accordance with the terms of the plan.

Plan Members

The individuals covered by the terms of an OPEB plan. The plan membership generally includes employees in active service, terminated employees who have accumulated benefits but are not yet receiving them, and retired employees and beneficiaries currently receiving benefits.

Postemployment

The period between termination of employment and retirement as well as the period after retirement.

Postemployment Healthcare Benefits

Medical, dental, vision, and other health-related benefits provided to terminated or retired employees and their dependents and beneficiaries.

11. Glossary (cont.)

Postretirement Benefit Increase

An increase in the benefits of retirees or beneficiaries granted to compensate for the effects of inflation (cost-of-living adjustment) or for other reasons. Ad hoc increases may be granted periodically by a decision of the board of trustees, legislature, or other authoritative body; both the decision to grant an increase and the amount of the increase are discretionary. Automatic increases are periodic increases specified in the terms of the plan; they are nondiscretionary except to the extent that the plan terms can be changed.

Projected Benefits

Those plan benefit amounts which are expected to be paid at various future times under a particular set of Actuarial Assumptions, taking into account such items as the effect of advancement in age and past and anticipated future compensation and service credits. That portion of an individual's Projected Benefit allocated to service to date, determined in accordance with the terms of a plan and based on future compensation as projected to retirement, is called the Credited Projected Benefit.

Projected Unit Credit Actuarial Cost Method

A method under which the benefits (projected or unprojected) of each individual included in an Actuarial Valuation are allocated by a consistent formula to valuation years. The Actuarial Present Value of benefits allocated to a valuation year is called the Normal Cost. The Actuarial Present Value of benefits allocated to all periods prior to a valuation year is called the Actuarial Accrued Liability.

Under this method, the Actuarial Gains (or Losses), as they occur, generally reduce (or increase) the Unfunded Actuarial Accrued Liability.

Under this method, benefits are projected to all future points in time under the terms of the Plan and actuarial assumptions (for example, health trends). Retirees are considered to be fully attributed in their benefits. For actives, attribution is to expected retirement age; thus, benefits at each future point in time are allocated to past service based on a proration of service-to-date over total projected service.

Required Supplementary Information (RSI)

Schedules, statistical data, and other information that are an essential part of financial reporting and should be presented with, but are not part of, the basic financial statements of a governmental entity.

Single-Employer Plan

A plan that covers the current and former employees, including beneficiaries, of only one employer.

11. Glossary (cont.)

Sponsor

The entity that established the plan. The sponsor generally is the employer or one of the employers that participate in the plan to provide benefits for their employees and employees of other employers.

Substantive Plan

The terms of an OPEB plan as understood by the employer(s) and plan members.

Transition Year

The fiscal year in which this Statement is first implemented.

Unfunded Actuarial Accrued Liability (Unfunded Actuarial Liability)

The excess of the Actuarial Accrued Liability over the Actuarial Value of Assets.

Appendix A – Results by Employer

I. Assuming No Prefunding of Obligations (4%)

The ARC shown below is based on 30 year open period amortization of the Unfunded AAL as a level percent of payroll.

<i>(\$ Millions)</i>	State of Hawaii	City & County of Honolulu	County of Hawaii	County of Maui	County of Kauai	Kauai - Department of Water	Board of Water Supply - Honolulu	Hawaii Department of Water Supply	Total
Present Value of Benefits (PVB)									
Retirees	\$6,014.3	\$1,433.4	\$322.0	\$264.0	\$139.0	\$7.6	\$101.8	\$15.9	\$8,298.0
Deferred Inactives	\$1,171.1	\$174.7	\$32.9	\$43.6	\$20.9	\$0.9	\$12.2	\$0.0	\$1,456.2
Actives	\$11,711.1	\$2,345.3	\$582.9	\$604.5	\$271.8	\$18.9	\$135.6	\$40.5	\$15,710.4
Total PVB	\$18,896.5	\$3,953.3	\$937.8	\$912.1	\$431.6	\$27.4	\$249.6	\$56.3	\$25,464.7
Actuarial Accrued Liability (AAL)									
Retirees	\$6,014.3	\$1,433.4	\$322.0	\$264.0	\$139.0	\$7.6	\$101.8	\$15.9	\$8,298.0
Deferred Inactives	\$1,171.1	\$174.7	\$32.9	\$43.6	\$20.9	\$0.9	\$12.2	\$0.0	\$1,456.2
Actives	\$6,381.4	\$1,247.5	\$287.8	\$302.8	\$141.8	\$10.5	\$83.6	\$23.1	\$8,478.6
Total AAL	\$13,566.8	\$2,855.6	\$642.8	\$610.4	\$301.6	\$18.9	\$197.6	\$39.0	\$18,232.8
Normal Cost	\$449.5	\$89.2	\$22.8	\$23.9	\$10.8	\$0.7	\$5.0	\$1.5	\$603.5
Assets	\$0.0	\$40.2	\$61.9	\$25.1	\$29.7	\$2.3	\$14.6	\$4.5	\$178.2
Unfunded AAL as of 7/1/2011	\$13,566.8	\$2,815.4	\$580.9	\$585.3	\$272.0	\$16.7	\$183.1	\$34.5	\$18,054.6
Interest on Unfunded AAL	\$542.7	\$112.6	\$23.2	\$23.4	\$10.9	\$0.7	\$7.3	\$1.4	\$722.2
Normal Cost plus interest	\$467.5	\$92.7	\$23.8	\$24.9	\$11.2	\$0.7	\$5.2	\$1.6	\$627.6
Contribution with interest	\$289.0	\$159.1	\$36.9	\$33.5	\$17.4	\$1.1	\$11.0	\$2.4	\$550.4
Unfunded AAL as of 7/1/2012	\$14,288.0	\$2,861.6	\$591.0	\$600.1	\$276.7	\$17.0	\$184.6	\$35.1	\$18,854.0
Annual Required Contribution for FYE 6/30/2013									
Normal Cost plus interest	\$474.5	\$94.1	\$24.1	\$25.2	\$11.4	\$0.8	\$5.3	\$1.6	\$637.0
Amortization of Unfunded AAL	\$520.4	\$104.2	\$21.5	\$21.9	\$10.1	\$0.6	\$6.7	\$1.3	\$686.7
Total ARC	\$994.9	\$198.3	\$45.6	\$47.1	\$21.5	\$1.4	\$12.0	\$2.9	\$1,323.7
% of Pay	36.0%	34.2%	33.6%	34.2%	31.5%	25.0%	29.7%	33.0%	35.4%

Appendix A Results by Employer (cont.)

II. Assuming Prefunding of Obligations (7%)

The ARC shown below for the State of Hawaii is based on 30 year open period amortization of the Unfunded AAL. For the other employers, separate amortization of Unfunded AAL developed each year is used.

(\$ Millions)	State of Hawaii	City & County of Honolulu	County of Hawaii	County of Maui	County of Kauai	Kauai - Department of Water	Board of Water Supply - Honolulu	Hawaii Department of Water Supply	Total
Present Value of Benefits (PVB)									
Retirees	\$4,244.3	\$984.0	\$216.9	\$179.3	\$95.2	\$5.2	\$72.2	\$11.3	\$5,808.5
Deferred Inactives	\$611.7	\$86.7	\$16.8	\$21.8	\$10.4	\$0.4	\$5.8	\$0.0	\$753.6
Actives	\$5,233.5	\$1,041.7	\$252.1	\$261.4	\$121.2	\$8.5	\$64.6	\$18.7	\$7,001.6
Total PVB	\$10,089.5	\$2,112.4	\$485.8	\$462.5	\$226.8	\$14.2	\$142.6	\$30.0	\$13,563.7
Actuarial Accrued Liability (AAL)									
Retirees	\$4,244.3	\$984.0	\$216.9	\$179.3	\$95.2	\$5.2	\$72.2	\$11.3	\$5,808.5
Deferred Inactives	\$611.7	\$86.7	\$16.8	\$21.8	\$10.4	\$0.4	\$5.8	\$0.0	\$753.6
Actives	\$3,614.5	\$707.3	\$160.9	\$168.7	\$80.6	\$5.9	\$49.1	\$13.2	\$4,800.4
Total AAL	\$8,470.6	\$1,778.0	\$394.6	\$369.8	\$186.3	\$11.6	\$127.2	\$24.5	\$11,362.5
Normal Cost	\$176.5	\$34.5	\$9.1	\$9.5	\$4.3	\$0.3	\$1.8	\$0.6	\$236.7
Assets	\$0.0	\$40.2	\$61.9	\$25.1	\$29.7	\$2.3	\$14.6	\$4.5	\$178.2
Unfunded AAL as of 7/1/2011	\$8,470.6	\$1,737.8	\$332.7	\$344.6	\$156.6	\$9.3	\$112.6	\$20.0	\$11,184.3
Annual Required Contribution for FYE 6/30/2013									
Normal Cost plus interest	\$189.0	\$36.9	\$9.7	\$10.1	\$4.7	\$0.3	\$2.0	\$0.6	\$253.3
Amortization of Unfunded AAL	\$480.2	\$103.1	\$19.8	\$20.3	\$9.3	\$0.6	\$6.7	\$1.2	\$641.2
Total ARC	\$669.2	\$140.0	\$29.5	\$30.5	\$14.0	\$0.9	\$8.7	\$1.8	\$894.5
% of Pay	24.2%	24.1%	21.7%	22.1%	20.5%	15.5%	21.5%	20.8%	23.9%

Appendix A Results by Employer (cont.)

III. Actual Final Results Based on Employers' Funding Intentions

The following exhibit shows the results based on each employer's specific discount rate, which is determined based on the employer's funding intentions. This exhibit also reflects different amortization methods of the Unfunded AAL to develop the ARC. The results were provided in separate employer reports and in some cases figures are slightly different than in earlier sections of this report due to rounding. *Please note that Honolulu Authority for Rapid Transportation (HART) requested their results shown as a separate employer, as shown in this exhibit. All other exhibits include HART with City & County of Honolulu based on the breakdown provided in preliminary results.*

(\$ Millions)	State of Hawaii	City & County of Honolulu	Honolulu Authority for Rapid Transportation	County of Hawaii	County of Maui	County of Kauai	Kauai - Department of Water	Board of Water Supply - Honolulu	Hawaii Department of Water Supply	Total
<i>Employer Specific Discount Rate</i>	4%	7%	7%	7%	7%	7%	7%	7%	7%	
Present Value of Benefits (PVB)										
Retirees	\$6,014.3	\$984.0	\$0.0	\$216.9	\$179.3	\$95.2	\$5.2	\$72.2	\$11.3	\$7,578.5
Deferred Inactives	\$1,171.1	\$86.7	\$0.0	\$16.8	\$21.8	\$10.4	\$0.4	\$5.8	\$0.0	\$1,313.0
Actives	\$11,711.1	\$1,038.5	\$3.3	\$252.1	\$261.4	\$121.2	\$8.5	\$64.6	\$18.7	\$13,479.3
Total PVB	\$18,896.5	\$2,109.1	\$3.3	\$485.8	\$462.5	\$226.8	\$14.2	\$142.6	\$30.0	\$22,370.8
Actuarial Accrued Liability (AAL)										
Retirees	\$6,014.3	\$984.0	\$0.0	\$216.9	\$179.3	\$95.2	\$5.2	\$72.2	\$11.3	\$7,578.5
Deferred Inactives	\$1,171.1	\$86.7	\$0.0	\$16.8	\$21.8	\$10.4	\$0.4	\$5.8	\$0.0	\$1,313.0
Actives	\$6,381.4	\$705.4	\$2.0	\$160.9	\$168.7	\$80.6	\$5.9	\$49.1	\$13.2	\$7,567.3
Total AAL	\$13,566.8	\$1,776.1	\$2.0	\$394.6	\$369.8	\$186.3	\$11.6	\$127.2	\$24.5	\$16,458.8
Normal Cost	\$449.5	\$34.3	\$0.2	\$9.1	\$9.5	\$4.3	\$0.3	\$1.8	\$0.6	\$509.7
Assets	\$0.0	\$40.2	\$0.0	\$61.9	\$25.1	\$29.7	\$2.3	\$14.6	\$4.5	\$178.2
Unfunded AAL as of 7/1/2011	\$13,566.8	\$1,735.9	\$2.0	\$332.7	\$344.6	\$156.6	\$9.3	\$112.6	\$20.0	\$16,280.6
Annual Required Contribution for FYE 6/30/2013										
Normal Cost plus interest	\$474.5	\$36.7	\$0.2	\$9.7	\$10.1	\$4.7	\$0.3	\$2.0	\$0.6	\$538.8
Amortization of Unfunded AAL	\$520.4	\$103.0	\$0.1	\$19.8	\$20.3	\$9.3	\$0.6	\$6.7	\$1.2	\$681.4
Total ARC	\$994.9	\$139.7	\$0.3	\$29.5	\$30.5	\$14.0	\$0.9	\$8.7	\$1.8	\$1,220.3
% of Pay	36.0%	24.5%	3.0%	21.7%	22.1%	20.5%	15.5%	21.5%	20.8%	32.6%

Appendix A Results by Employer (cont.)

IV. Additional Information

The following exhibit shows the 2012 ARC. This ARC was developed based on the July 1, 2009 actuarial valuation for all employers except for the State, for which the ARC was developed based on the July 1, 2011 actuarial valuation.

(\$ Millions)	State of Hawaii	City & County of Honolulu	County of Hawaii	County of Maui	County of Kauai	Kauai - Department of Water	Board of Water Supply - Honolulu	Hawaii Department of Water Supply	Total
<i>Employer Specific Discount Rate</i>	4%	7%	7%	7%	7%	7%	7%	7%	
Normal Cost plus interest	\$458.4	\$44.0	\$11.8	\$11.6	\$5.6	\$0.4	\$2.5	\$0.9	\$535.3
Amortization of Unfunded AAL	\$494.1	\$112.0	\$24.4	\$21.2	\$11.5	\$0.7	\$8.2	\$1.5	\$673.7
Total 6/30/2012 ARC	\$952.6	\$156.0	\$36.2	\$32.9	\$17.1	\$1.1	\$10.8	\$2.4	\$1,209.0
% of Pay	36.7%	28.4%	27.8%	24.8%	25.7%	21.7%	36.0%	30.0%	34.4%

The following exhibit shows the change in the ARC from FY 2012 to FY 2013 by source.

(\$ Millions)	State of Hawaii	City & County of Honolulu	County of Hawaii	County of Maui	County of Kauai	Kauai - Department of Water	Board of Water Supply - Honolulu	Hawaii Department of Water Supply	Total
<i>Employer Specific Discount Rate</i>	4%	7%	7%	7%	7%	7%	7%	7%	
6/30/2012 ARC	\$952.6	\$156.0	\$36.2	\$32.9	\$17.1	\$1.1	\$10.8	\$2.4	\$1,209.0
Anticipated growth*	\$42.3	\$5.5	\$1.3	\$1.2	\$0.6	\$0.0	\$0.4	\$0.1	\$51.3
Contribution Shortfall / (Excess) vs. ARC	N/A	\$8.3	\$0.0	\$1.9	(\$0.0)	(\$0.0)	(\$0.1)	(\$0.0)	\$10.1
Asset (Gain) / Loss	N/A	\$0.3	\$0.3	\$0.2	\$0.1	\$0.0	\$0.1	\$0.0	\$1.0
Liability (Gain) / Loss - Amortization of AAL	N/A	(\$21.3)	(\$5.8)	(\$3.8)	(\$2.7)	(\$0.2)	(\$1.8)	(\$0.4)	(\$36.0)
Liability (Gain) / Loss - Normal Cost	N/A	(\$8.7)	(\$2.5)	(\$1.9)	(\$1.1)	(\$0.1)	(\$0.7)	(\$0.2)	(\$15.1)
6/30/2013 ARC	\$994.9	\$140.0	\$29.5	\$30.5	\$14.0	\$0.8	\$8.7	\$1.8	\$1,220.2

* The anticipated growth is 3.5% for pre-funding employers.

Appendix B – Results for the State

The following exhibit compares results for the State to the prior valuation results, both at 4.0% discount rate.

(\$ Millions)	July 1, 2011			July 1, 2009		
	Non-HSTA (EUTF)	HSTA	State of Hawaii Total	Non-HSTA (EUTF)	HSTA	State of Hawaii Total
Present Value of Benefits (PVB)						
Retirees	\$5,227.8	\$786.5	\$6,014.3	\$5,221.0	\$507.7	\$5,728.8
Deferred Inactives	\$931.6	\$239.5	\$1,171.1	\$1,019.6	\$263.5	\$1,283.1
Actives	\$8,295.6	\$3,415.6	\$11,711.1	\$9,283.4	\$2,985.2	\$12,268.5
Total PVB	\$14,455.0	\$4,441.5	\$18,896.5	\$15,524.0	\$3,756.4	\$19,280.4
Actuarial Accrued Liability (AAL)						
Retirees	\$5,227.8	\$786.5	\$6,014.3	\$5,221.0	\$507.7	\$5,728.8
Deferred Inactives	\$931.6	\$239.5	\$1,171.1	\$1,019.6	\$263.5	\$1,283.1
Actives	\$4,575.7	\$1,805.7	\$6,381.4	\$5,282.7	\$1,712.9	\$6,995.6
Total AAL	\$10,735.2	\$2,831.6	\$13,566.8	\$11,523.3	\$2,484.2	\$14,007.5
Normal Cost	\$327.0	\$122.6	\$449.5	\$379.8	\$108.5	\$488.2
Assets	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Unfunded AAL as of 7/1/2011	\$10,735.2	\$2,831.6	\$13,566.8	\$11,523.3	\$2,484.2	\$14,007.5
Annual Required Contribution	For FYE June 30, 2013			For FYE June 30, 2011		
Normal Cost plus interest	\$345.1	\$129.4	\$474.5	\$400.8	\$114.5	\$515.3
Amortization of Unfunded AAL	\$409.5	\$110.8	\$520.4	\$441.4	\$97.4	\$538.8
Total ARC	\$754.7	\$240.2	\$994.9	\$842.3	\$211.9	\$1,054.1

Appendix B – Results for the State (cont.)

HSTA liabilities are slightly lower than expected considering the prior valuation results. The primary factors impacting results include:

- Overall healthcare costs experience was less favorable compared to assumed trend, resulting in liability losses.
- Updated demographic assumptions caused a decrease in liabilities. The primary drivers of the differences were lower retirement rates, which were partially offset by lower mortality rates.
- Future healthcare trend was revised for updated expectations, resulting in slight liability increases.
- Employer caps are anticipated to have a greater impact as the Medicare B premium index used to adjust these levels decreased from 2011 to 2012.
- Some new retirees elected coverage under the EUTF medical plans, and their liabilities are not included under HSTA.
- The AAL grows as active participants earn additional benefits under the plan each year. Also, liabilities increase due to a decrease in the discount period for benefit payments as participants become closer to receiving benefits.



EXECUTIVE CHAMBERS
HONOLULU

NEIL ABERCROMBIE
GOVERNOR

July 3, 2013

GOV. MSG. NO. 1371

The Honorable Donna Mercado Kim,
President
and Members of the Senate
Twenty-Seventh State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

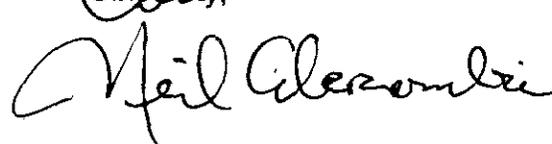
The Honorable Joseph M. Souki,
Speaker and Members of the
House of Representatives
Twenty-Seventh State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kim, Speaker Souki, and Members of the Legislature:

This is to inform you that on July 3, 2013, the following bill was signed into law:

HB546 HD2 SD2 CD1

RELATING TO THE HAWAII EMPLOYER-UNION
HEALTH BENEFITS TRUST FUND
ACT 268 (13)

Sincerely,


NEIL ABERCROMBIE
Governor, State of Hawaii

Approved by the Governor
on JUL 3 2013

EXHIBIT G

ACT 268

HOUSE OF REPRESENTATIVES
TWENTY-SEVENTH LEGISLATURE, 2013
STATE OF HAWAII

H.B. NO. 546
H.D. 2
S.D. 2
C.D. 1

A BILL FOR AN ACT

RELATING TO THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST
FUND.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

PART I

SECTION 1. The purpose of this part is to convene a task force in the department of budget and finance to examine the unfunded liability of the Hawaii employer-union health benefits trust fund.

SECTION 2. (a) There is established a Hawaii employer-union health benefits trust fund task force within the department of budget and finance for administrative purposes to consist of the following members:

- (1) Two members from the house of representatives selected by the speaker of the house of representatives;
- (2) Two members from the senate selected by the senate president;
- (3) The director of finance, or the director's designee;
- (4) One member from the Hawaii Council of Mayors;
- (5) One member from the Hawaii State Association of Counties;



- 1 (6) Four members representing public sector unions who
2 shall be invited to participate by the director of
3 finance;
- 4 (7) One member representing public employee retirees who
5 shall be invited to participate by the director of
6 finance; and
- 7 (8) Four members representing the respective interests of
8 the four counties who shall be selected by the
9 governor.

10 The director of finance, or the director's designee, shall
11 serve as the chairperson of the task force. The task force
12 shall cease to exist on June 30, 2014.

13 (b) The members of the task force shall serve without
14 compensation, but shall be reimbursed for expenses, including
15 travel expenses, necessary for the performance of their duties.
16 No member shall be made subject to chapter 84, Hawaii Revised
17 Statutes, solely because of that member's participation as a
18 member of that task force.

19 SECTION 3. The Hawaii employer-union health benefits trust
20 fund task force shall examine the unfunded liability of the
21 Hawaii employer-union health benefits trust fund (trust fund),
22 including:



- 1 (1) The current and projected unfunded actuarial accrued
2 liability of the trust fund;
- 3 (2) The availability of medical benefits plans other than
4 plans that pay or reimburse medical services providers
5 under a fee-for-service model;
- 6 (3) The costs and benefits of alternative medical benefits
7 plans in relation to the medical benefits plans
8 currently offered by the trust fund;
- 9 (4) An evaluation of the costs and process of
10 transitioning from the current medical benefits plans
11 to an alternative medical benefits plan, including
12 recommended proposed legislation;
- 13 (5) An evaluation of the current structure of state and
14 county public employers paying a percentage of health
15 insurance policy premiums and providing
16 recommendations for a benefits plan for prospective
17 employees; and
- 18 (6) Any other matters that are relevant to gaining a full
19 and meaningful understanding of the circumstance of
20 the trust fund.

21 SECTION 4. The director of finance, in consultation with
22 the task force, shall submit a report to the legislature,



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H.D. 2
S.D. 2
C.D. 1

1 including findings, recommendations, and proposed legislation,
2 no later than twenty days prior to the convening of the regular
3 session of 2014.

4 SECTION 5. There is appropriated out of the general
5 revenues of the State of Hawaii the sum of \$185,750 or so much
6 thereof as may be necessary for fiscal year 2013-2014 to support
7 the work of the Hawaii employer-union health benefits trust fund
8 task force, including necessary travel expenses for task force
9 members who reside outside of Oahu and consulting services of
10 persons knowledgeable in relevant issues.

11 The sum appropriated shall be expended by the department of
12 budget and finance for the purposes of this part.

13 PART II

14 SECTION 6. Chapter 87A, Hawaii Revised Statutes, is
15 amended by adding two new sections to part IV to be
16 appropriately designated and to read as follows:

17 "§87A-A Public employers; defined. For the purposes of
18 this part, "public employer" means a governmental entity whose
19 employees', beneficiaries', and retirees' health benefits
20 coverage is provided through the fund.

21 §87A-B Payment of public employer contributions to the
22 other post-employment benefits trust. (a) Commencing with



1 fiscal year 2018-2019, each of the counties and all other public
2 employers shall make annual required contributions in accordance
3 with section 87A-42 for the benefit of their retirees and
4 beneficiaries.

5 (b) The board shall determine the annual required
6 contribution owed by each public employer under this part for
7 each fiscal year, beginning with fiscal year 2018-2019."

8 SECTION 7. Section 87A-24, Hawaii Revised Statutes, is
9 amended to read as follows:

10 "§87A-24 Other powers. In addition to the power to
11 administer the fund, the board may:

- 12 (1) Collect, receive, deposit, and withdraw money on
13 behalf of the fund;
- 14 (2) Invest moneys in the same manner specified in section
15 88-119(1)(A), (1)(B), (1)(C), (2), (3), (4), (5), (6),
16 and (7);
- 17 (3) Hold, purchase, sell, assign, transfer, or dispose of
18 any securities or other investments of the fund, as
19 well as the proceeds of those investments and any
20 money belonging to the fund;
- 21 (4) Appoint, and at pleasure dismiss, an administrator and
22 other fund staff. The administrator and staff shall



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S.D. 2
C.D. 1

- 1 be exempt from chapter 76 and shall serve under and at
2 the pleasure of the board;
- 3 (5) Make payments of periodic charges and pay for
4 reasonable expenses incurred in carrying out the
5 purposes of the fund;
- 6 (6) Contract for the performance of financial audits of
7 the fund and claims audits of its insurance carriers;
- 8 (7) Retain auditors, actuaries, investment firms and
9 managers, benefit plan consultants, or other
10 professional advisors to carry out the purposes of
11 this chapter[→], including the retaining of an actuary
12 to determine the annual required public employer
13 contribution for the separate trust fund established
14 under section 87A-42;
- 15 (8) Establish health benefits plan and long-term care
16 benefits plan rates that include administrative and
17 other expenses necessary to effectuate the purposes of
18 the fund; and
- 19 (9) Require any department, agency, or employee of the
20 State or counties to furnish information to the board
21 to carry out the purposes of this chapter."



1 SECTION 8. Section 87A-42, Hawaii Revised Statutes, is
2 amended to read as follows:

3 "[~~§~~87A-42~~§~~] Other post-employment benefits trust. (a)

4 Notwithstanding sections 87A-31 and 87A-31.5, the board, upon
5 terms and conditions set by the board, [~~may~~] shall establish and
6 administer a separate trust fund for the purpose of receiving
7 employer contributions that will prefund other post-employment
8 health and other benefit plan costs for retirees and their
9 beneficiaries. [~~If a fund is established, it~~] The separate
10 trust fund shall meet the requirements of the Government
11 Accounting Standards Board regarding other post-employment
12 benefits trusts. The board shall establish and maintain a
13 separate account for each public employer within the separate
14 trust fund to accept and account for each public employer's
15 contributions. Employer contributions to the separate trust
16 fund shall be irrevocable, all assets of the fund shall be
17 dedicated exclusively to providing health and other benefits to
18 retirees and their beneficiaries, and assets of the fund shall
19 not be subject to appropriation for any other purpose and shall
20 not be subject to claims by creditors of the employers or the
21 board or plan administrator. The board's powers under section



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1 87A-24 shall also apply to ~~any~~ the fund established pursuant
2 to this section.

3 (b) Public employer contributions shall be paid into the
4 fund in each fiscal year, and commencing with the 2018-2019
5 fiscal year, the amount of the annual public employer
6 contribution shall be equal to the amount of the annual required
7 contribution, as determined by an actuary retained by the board.

8 (c) In any fiscal year subsequent to the 2017-2018 fiscal
9 year in which the state public employer's contributions into the
10 fund are less than the amount of the annual required
11 contribution, the amount that represents the excess of the
12 annual required contribution over the state public employer's
13 contributions shall be deposited into the appropriate account of
14 the separate trust fund from a portion of all general excise tax
15 revenues collected by the department of taxation under section
16 237-31.

17 If any general excise tax revenues are deposited into the
18 separate trust fund in any fiscal year as a result of this
19 subsection, the director of finance shall notify the legislature
20 and governor whether the general fund expenditure ceiling for
21 that fiscal year would have been exceeded if those revenues had
22 been legislatively appropriated instead of deposited without .



1 appropriation into the trust fund. The notification shall be
2 submitted within thirty days following the end of the applicable
3 fiscal year.

4 (d) In any fiscal year subsequent to the 2017-2018 fiscal
5 year in which a county public employer's contributions into the
6 fund are less than the amount of the annual required
7 contribution, the amount that represents the excess of the
8 annual required contribution over the county public employer's
9 contributions shall be deposited into the fund from a portion of
10 all transient accommodations tax revenues collected by the
11 department of taxation under section 237D-6.5(b)(3). The
12 director of finance shall deduct the amount necessary to meet
13 the county public employer's annual required contribution from
14 the revenues derived under section 237D-6.5(b)(3) and transfer
15 the amount to the board for deposit into the appropriate account
16 of the separate trust fund.

17 (e) In any fiscal year subsequent to fiscal year 2017-2018
18 in which a public employer's contributions into the fund are
19 less than the amount of the annual required contribution and the
20 public employer is not entitled to transient accommodations tax
21 revenues sufficient to satisfy the total amount of the annual
22 required contribution, the public employer's contributions shall



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1 be deposited into the fund from portions of any other revenues
2 collected on behalf of the public employer or held by the State.
3 The director of finance shall deduct the amount necessary to
4 meet the public employer's annual required contribution from any
5 revenues collected on behalf of the public employer held by the
6 State and transfer the amount to the board for deposit into the
7 appropriate account of the separate trust fund.

8 (f) For the purposes of this section, "annual required
9 contribution" means a public employer's required contribution to
10 the trust fund established in this section that is sufficient to
11 cover:

12 (1) The normal cost, which is the cost of other post-
13 employment benefits attributable to the current year
14 of service; and

15 (2) An amortization payment, which is a catch-up payment
16 for past service costs to fund the unfunded actuarial
17 accrued liability over the next thirty years."

18 SECTION 9. Section 237-31, Hawaii Revised Statutes, is
19 amended to read as follows:

20 "§237-31 Remittances. All remittances of taxes imposed by
21 this chapter shall be made by money, bank draft, check,
22 cashier's check, money order, or certificate of deposit to the



1 office of the department of taxation to which the return was
2 transmitted. The department shall issue its receipts therefor
3 to the taxpayer and shall pay the moneys into the state treasury
4 as a state realization, to be kept and accounted for as provided
5 by law; provided that:

- 6 (1) The sum from all general excise tax revenues realized
7 by the State that represents the difference between
8 \$45,000,000 and the proceeds from the sale of any
9 general obligation bonds authorized for that fiscal
10 year for the purposes of the state educational
11 facilities improvement special fund shall be deposited
12 in the state treasury in each fiscal year to the
13 credit of the state educational facilities improvement
14 special fund;
- 15 (2) A sum, not to exceed \$5,000,000, from all general
16 excise tax revenues realized by the State shall be
17 deposited in the state treasury in each fiscal year to
18 the credit of the compound interest bond reserve fund;
19 [and]
- 20 (3) A sum from all general excise tax revenues realized by
21 the State that is equal to one-half of the total
22 amount of funds appropriated or transferred out of the



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1 hurricane reserve trust fund under sections 4 and 5 of
2 Act 62, Session Laws of Hawaii 2011, shall be
3 deposited into the hurricane reserve trust fund in
4 fiscal year 2013-2014 and in fiscal year 2014-2015;
5 provided that the deposit required in each fiscal year
6 shall be made by October 1 of that fiscal year[-]; and
7 (4) Commencing with fiscal year 2018-2019, a sum from all
8 general excise tax revenues realized by the State that
9 represents the difference between the state public
10 employer's annual required contribution for the
11 separate trust fund established under section 87A-42
12 and the amount of the state public employer's
13 contributions into that trust fund shall be deposited
14 to the credit of the State's annual required
15 contribution into that trust fund in each fiscal year,
16 as provided in section 87A-42."

17 SECTION 10. Section 237D-6.5, Hawaii Revised Statutes, is
18 amended by amending subsection (b) to read as follows:

19 "(b) Revenues collected under this chapter, except for
20 revenues collected under section 237D-2(b), shall be distributed
21 as follows, with the excess revenues to be deposited into the
22 general fund:



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1 (1) 17.3 per cent of the revenues collected under this
2 chapter shall be deposited into the convention center
3 enterprise special fund established under section
4 201B-8; provided that beginning January 1, 2002, if
5 the amount of the revenue collected under this
6 paragraph exceeds \$33,000,000 in any fiscal year,
7 revenues collected in excess of \$33,000,000 shall be
8 deposited into the general fund;

9 (2) 34.2 per cent of the revenues collected under this
10 chapter shall be deposited into the tourism special
11 fund established under section 201B-11 for tourism
12 promotion and visitor industry research; provided that
13 for any period beginning on July 1, 2012, and ending
14 on June 30, 2015, no more than \$71,000,000 per fiscal
15 year shall be deposited into the tourism special fund
16 established under section 201B-11; provided further
17 that beginning on July 1, 2012, and ending on June 30,
18 2015, \$2,000,000 shall be expended from the tourism
19 special fund for development and implementation of
20 initiatives to take advantage of expanded visa
21 programs and increased travel opportunities for
22 international visitors to Hawaii; and provided further



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1 that beginning on July 1, 2002, of the first
2 \$1,000,000 in revenues deposited:

3 (A) Ninety per cent shall be deposited into the state
4 parks special fund established in section
5 184-3.4; and

6 (B) Ten per cent shall be deposited into the special
7 land and development fund established in section
8 171-19 for the Hawaii statewide trail and access
9 program;

10 provided that of the 34.2 per cent, 0.5 per cent shall
11 be transferred to a sub-account in the tourism special
12 fund to provide funding for a safety and security
13 budget, in accordance with the Hawaii tourism
14 strategic plan 2005-2015; provided further that of the
15 revenues remaining in the tourism special fund after
16 revenues have been deposited as provided in this
17 paragraph and except for any sum authorized by the
18 legislature for expenditure from revenues subject to
19 this paragraph, beginning July 1, 2007, funds shall be
20 deposited into the tourism emergency trust fund,
21 established in section 201B-10, in a manner sufficient



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1 to maintain a fund balance of \$5,000,000 in the
2 tourism emergency trust fund; and
3 (3) 44.8 per cent of the revenues collected under this
4 chapter shall be transferred as follows: Kauai county
5 shall receive 14.5 per cent, Hawaii county shall
6 receive 18.6 per cent, city and county of Honolulu
7 shall receive 44.1 per cent, and Maui county shall
8 receive 22.8 per cent; provided that for any period
9 beginning on July 1, 2011, and ending on June 30,
10 2015, the total amount transferred to the counties
11 shall not exceed \$93,000,000 per fiscal year[-];
12 provided that commencing with fiscal year 2018-2019, a
13 sum that represents the difference between a county
14 public employer's annual required contribution for the
15 separate trust fund established under section 87A-42
16 and the amount of the county public employer's
17 contributions into that trust fund shall be retained
18 by the state director of finance and deposited to the
19 credit of the county public employer's annual required
20 contribution into that trust fund in each fiscal year,
21 as provided in section 87A-42, if the respective
22 county fails to remit the total amount of the county's



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1 required annual contributions, as required under
2 section 87A-B.

3 Revenues collected under section 237D-2(b) shall be
4 deposited into the general fund. All transient accommodations
5 taxes shall be paid into the state treasury each month within
6 ten days after collection and shall be kept by the state
7 director of finance in special accounts for distribution as
8 provided in this subsection.

9 As used in this subsection, "fiscal year" means the twelve-
10 month period beginning on July 1 of a calendar year and ending
11 on June 30 of the following calendar year."

12 SECTION 11. Notwithstanding the amount of a public
13 employer annual required contribution determined in any fiscal
14 year by an actuary retained by the board for this purpose, for
15 the five-year fiscal period from 2014-2015 to 2018-2019, public
16 employer contributions into the separate trust fund established
17 under section 87A-42, Hawaii Revised Statutes, shall be at the
18 specified percentages of the respective annual required
19 contributions, as follows:

	<u>Fiscal Year</u>	<u>Annual Required Contribution</u>
20		
21	(1) 2014-2015	Twenty per cent;
22	(2) 2015-2016	Forty per cent;



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- 1 (3) 2016-2017 Sixty per cent;
2 (4) 2017-2018 Eighty per cent; and
3 (5) 2018-2019 One hundred per cent.

4 SECTION 12. Not less than twenty days prior to the
5 convening of the regular session of 2015, the director of
6 finance, in order to maximize the efficient use of resources and
7 public funds, shall submit an implementation plan and any
8 proposed legislation to the legislature to execute the
9 following:

- 10 (1) Joint use of any investment information, advice, and
11 services provided by fund managers retained by the
12 board of trustees of the employees' retirement system
13 with the board of trustees of the employer-union
14 health benefits trust fund for the purpose of
15 investing moneys contained in the separate trust fund
16 established under section 87A-42, Hawaii Revised
17 Statutes; and
18 (2) Procedures to accept and deposit employer
19 contributions from county public employers into the
20 separate trust fund established under section 87A-42,
21 Hawaii Revised Statutes.



1 SECTION 13. There is appropriated out of the general
2 revenues of the State of Hawaii the sum of \$500,000 or so much
3 thereof as may be necessary for fiscal year 2013-2014 and the
4 same sum or so much thereof as may be necessary for fiscal year
5 2014-2015 for the department of budget and finance to conduct a
6 study and develop an implementation plan to have both the
7 employer-union health benefits trust fund and the employees'
8 retirement system jointly share investment information and
9 services.

10 The sums appropriated shall be expended by the department
11 of budget and finance for the purposes of this Act.

12 SECTION 14. In codifying the new sections added by section
13 6 of this Act, the revisor of statutes shall substitute
14 appropriate section numbers for the letters used in designating
15 the new sections in this Act.

16 SECTION 15. Statutory material to be repealed is bracketed
17 and stricken. New statutory material is underscored.

18 SECTION 16. This Act shall take effect on July 1, 2013;
19 provided that the amendments made to section 237D-6.5, Hawaii
20 Revised Statutes, in section 10 of this Act shall not be
21 repealed when section 237D-6.5, Hawaii Revised Statutes, is
22 repealed and reenacted on June 30, 2015, pursuant to Act 61,



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1 Session Laws of Hawaii 2009, and Act 103, Session Laws of Hawaii
2 2011.

APPROVED this 3 day of JUL, 2013



GOVERNOR OF THE STATE OF HAWAII

