Active Employee Open Enrollment Informational Session

Hawaii Employer-Union Health Benefits Trust Fund

This presentation is a brief summary and does not constitute a legal document or contract and is subject to change.

AGENDA

- OPEN ENROLLMENT
- PREMIUM & CONTRIBUTIONS
- HEALTH PLAN CHANGES
- ENROLLMENT FORM
- HEALTH PLAN SELECTION

OPEN ENROLLMENT

OPEN ENROLLMENT

IMPORTANT DATES

- Election Period is from April 1, 2015 through April 30, 2015.
- New coverage and rate changes effective July 1, 2015.
- If you do not want to make changes, do nothing.
- Deadline for employees to submit their EC-1/EC-1H form to their identified open enrollment personnel designee is April 30, 2015.

OPEN ENROLLMENT

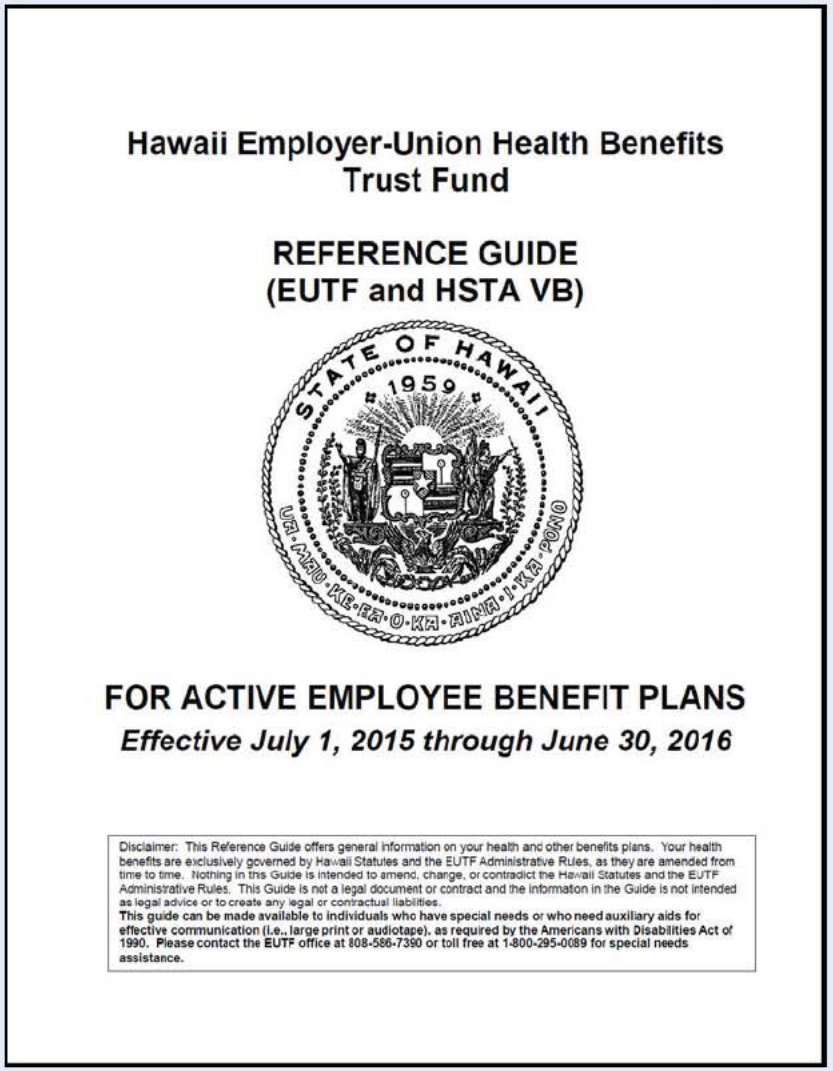
Changes You Can Make During Open Enrollment

- Add a plan, change to another plan, or drop a plan
- Add dependents or drop dependents
- Change coverage tiers (single, two-party or family)

OPEN ENROLLMENT

The Reference Guide

- Available at eutf.hawaii.gov
- Rates and contribution amounts
- Dependent eligibility criteria
- Health plan options



Hawaii Employer-Union Health Benefits Trust Fund

REFERENCE GUIDE
(EUTF and HSTA VB)

FOR ACTIVE EMPLOYEE BENEFIT PLANS

Effective July 1, 2015 through June 30, 2016

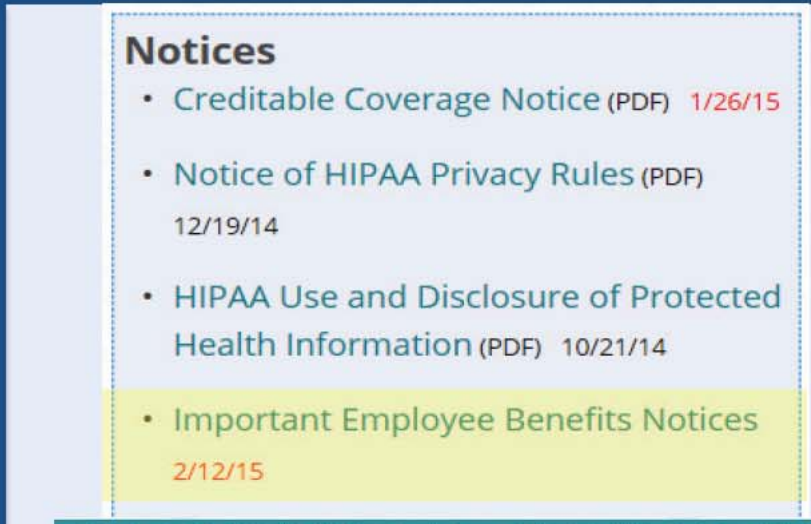
Disclaimer: This Reference Guide offers general information on your health and other benefits plans. Your health benefits are exclusively governed by Hawaii Statutes and the EUTF Administrative Rules, as they are amended from time to time. Nothing in this Guide is intended to amend, change, or contradict 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.
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.

OPEN ENROLLMENT

Required Notices

- Available at eutf.hawaii.gov under "Important Employee Benefits Notices" in the Notices section.

- Includes
  - Summary of Benefits Coverage
  - COBRA Notices
  - HIPAA Privacy Notice
  - New Health Insurance Marketplace Coverage Option and Your Health Coverage Notice
  - And more!



PREMIUM & CONTRIBUTIONS

PREMIUM & CONTRIBUTIONS

WHAT IS COLLECTIVE BARGAINING?

- The portion of health coverage costs paid by the employer are negotiated within the collective bargaining process.
- Premiums are available in the Reference Guide following page 64.

PREMIUM & CONTRIBUTIONS

The following bargaining units are still in or may be in negotiations. Employers will continue their July 1, 2014 to June 30, 2015 monthly employer contributions until an agreement is reached.

PENDING COLLECTIVE BARGAINING AGREEMENT
BU 02, 03, 04, 08, 09

PENDING AGREEMENT ON EMPLOYER CONTRIBUTION
BU 10, 11, 12

PENDING LEGISLATIVE APPROVAL
BU 07

HEALTH PLAN CHANGES

Plan Changes Effective July 1, 2015

Maximum out-of-pocket (MOOP)

- Financial protection
- Insurance carriers keep track of your out-of-pocket cost
- Once MOOP is reached, benefits increase to 100%
- Resets every calendar year

MEDICAL/DRUG PLAN OPTIONS	MEDICAL MAXIMUM OUT-OF-POCKET	PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET
HMSA 90/10 / CVS Caremark	$2,000 for Single $4,000 for Family	$4,100 for Single $8,200 for Family
HMSA 80/20 / CVS Caremark	$2,500 for Single $5,000 for Family	$4,100 for Single $8,200 for Family
HMSA 75/25 / CVS Caremark	$5,000 for Single $10,000 for Family	$1,600 for Single $3,200 for Family
HMSA HMO / CVS Caremark	$1,500 for Single $3,000 for Family	$4,100 for Single $8,200 for Family
HSTA VB HMSA 90/10 / CVS Caremark	$2,000 for Single $4,000 for Family	$4,100 for Single $8,200 for Family
HSTA VB HMSA 80/20 / CVS Caremark	$2,500 for Single $5,000 for Family	$4,100 for Single $8,200 for Family

Plan Changes Effective July 1, 2015

Life Insurance Plan

New carrier: **USAble Life**

- RSN will automatically transfer beneficiary information to USAble Life
- Beneficiary forms available on USAble Life website thru "Links to Carrier Websites"
- **Life insurance benefit: $41,116 for Active Employees (previously $38,361) up through age 64**

Participants age 65 through 69	**$26,725**
Participants age 70 through 74	**$18, 502**
Participants age 75 through 79	**$12,335**
Participants age 80 and over	**$8,223**

HEALTH PLAN OPTIONS

HEALTH PLAN OPTIONS

- **Medical**
  - HMSA
  - Kaiser Permanente
  - Royal State National
- **Prescription Drug**
  - CVS Caremark (HMSA subscribers)
  - Kaiser Prescription Drug
- **Dental & Vision**
  - Hawaii Dental Service
  - Vision Service Plan
- **Life Insurance**
  - USAble Life

HEALTH PLAN OPTIONS

HSTA VB

- Only available to those who are currently enrolled in the HSTA VB plans *(former VEBA members)*

- Employees enrolled in HSTA VB who change to the EUTF plans may **NOT** change back to HSTA VB plans in the future

Hawaii Medical Service Association

EUTF 90/10 Plan
EUTF 80/20 Plan
EUTF 75/25 Plan
EUTF HMO Plan

HSTA VB 90/10 Plan
HSTA VB 80/20 Plan

Health plans include prescription drug coverage through CVS Caremark and chiropractic coverage through Royal State National.

Kaiser Permanente

Standard Plan
Comprehensive Plan

HSTA VB Comprehensive Plan

Kaiser Health plans include prescription drug coverage through Kaiser Permanente and chiropractic coverage through Royal State National.

Other Plans

Hawaii Dental Service

Vision Service Plan

Royal State National (Supplemental Medical)

USAble Life

ENROLLMENT FORM

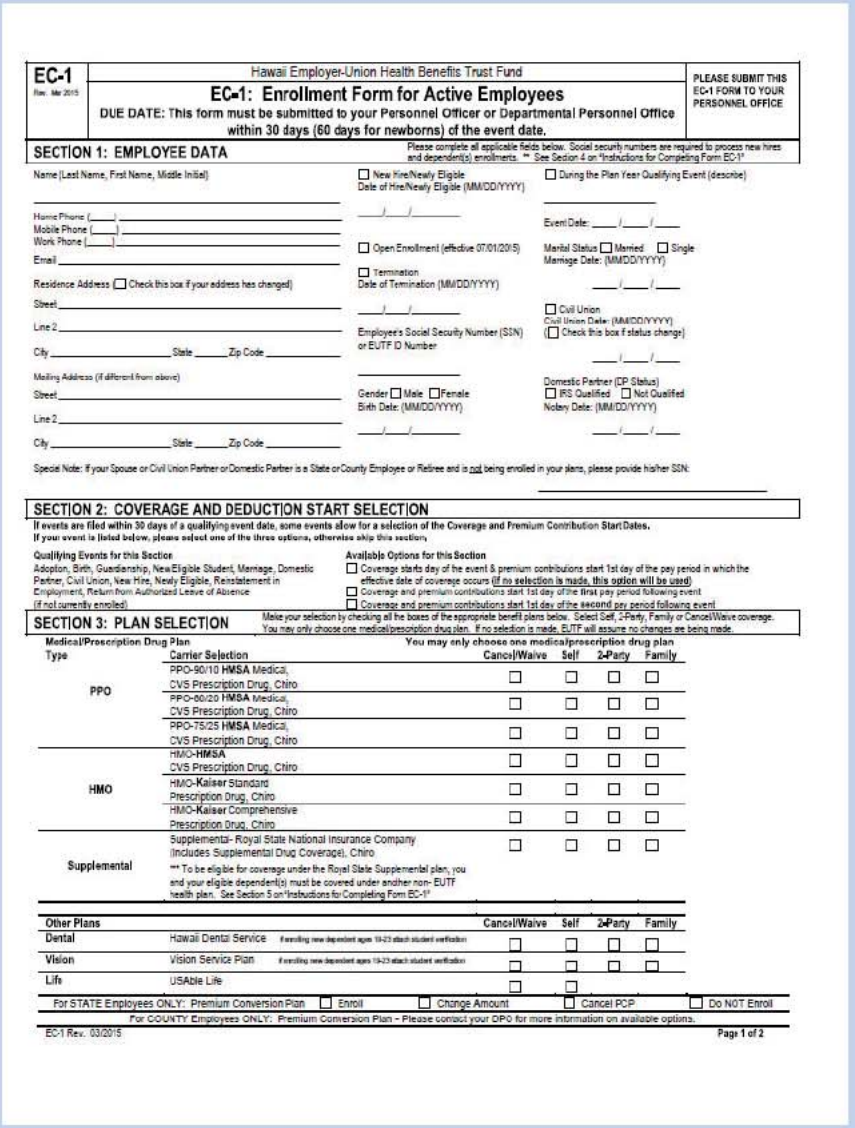
ENROLLMENT FORM

EC-1/EC-1H Enrollment Form:

- Available at eutf.hawaii.gov

Form Revisions:

- Section 1: Complete personal information
- Section 2: Leave blank
- Section 3: Plan Selection – If no selection is made, EUTF will assume no changes are being made.
- Submit to identified open enrollment designee on or before April 30, 2015



EC-1 Rev. Mar 2015

Hawaii Employer-Union Health Benefits Trust Fund

EC-1: Enrollment Form for Active Employees

DUE DATE: This form must be submitted to your Personnel Officer or Departmental Personnel Office within 30 days (60 days for newborns) of the event date.

PLEASE SUBMIT THIS EC-1 FORM TO YOUR PERSONNEL OFFICE

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social security numbers are required to process new hires and dependent(s) enrollments. ** See Section 4 on "Instructions for Completing Form EC-1"

Name (Last Name, First Name, Middle Initial)

Home Phone (___) ___
Mobile Phone (___) ___
Work Phone (___) ___
Email ___

Residence Address ☐ Check this box if your address has changed)
Street ___
Line 2 ___
City ___ State ___ Zip Code ___

Mailing Address (if different from above)
Street ___
Line 2 ___
City ___ State ___ Zip Code ___

☐ New Hire/Newly Eligible
Date of Hire/Newly Eligible (MM/DD/YYYY)
___/___/___

☐ Open Enrollment (effective 07/01/2015)

☐ 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)
___/___/___

☐ During the Plan Year Qualifying Event (describe)

Event Date: ___/___/___

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
___/___/___

☐ Civil Union
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)
___/___/___

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
Notary Date: (MM/DD/YYYY)
___/___/___

Special Note: If 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 a 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, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section
☐ Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used)
☐ Coverage and premium contributions start 1st day of the first pay period following event
☐ Coverage and premium contributions start 1st day of the second pay period following event

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If no selection is made, EUTF will assume no changes are being made.

Medical/Prescription Drug Plan Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 HMSA Medical, CVS Prescription Drug, Chiro	☐	☐	☐	☐
	PPO-80/20 HMSA Medical, CVS Prescription Drug, Chiro	☐	☐	☐	☐
	PPO-75/25 HMSA Medical, CVS Prescription Drug, Chiro	☐	☐	☐	☐
HMO	HMO-HMSA CVS Prescription Drug, Chiro	☐	☐	☐	☐
	HMO-Kaiser Standard Prescription Drug, Chiro	☐	☐	☐	☐
	HMO-Kaiser Comprehensive Prescription Drug, Chiro	☐	☐	☐	☐
Supplemental	Supplemental- Royal State National Insurance Company (Includes Supplemental Drug Coverage), Chiro	☐	☐	☐	☐
	** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under another non- EUTF health plan. See Section 5 on "Instructions for Completing Form EC-1"				

Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service If enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Vision	Vision Service Plan If enrolling new dependent ages 19-23 attach student verification	☐	☐	☐	☐
Life	USAble Life	☐	☐		

For STATE Employees ONLY: 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.

EC-1 Rev. 03/2015

Page 1 of 2

EC-1
Rev. Mar 2015

Hawaii Employer-Union Health Benefits Trust Fund

EC-1: Enrollment Form for Active Employees

DUE DATE: This form must be submitted to your Personnel Officer or Departmental Personnel Office within 30 days (60 days for newborns) of the event date.

PLEASE SUBMIT THIS EC-1 FORM TO YOUR PERSONNEL OFFICE

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social security numbers are required to process new hires and dependent(s) enrollments. ** See Section 4 on "Instructions for Completing Form EC-1"

Name (Last Name, First Name, Middle Initial)
John K Kealoha

Home Phone (808) 555-5555
Mobile Phone (808) 666-6666
Work Phone (808) 777-7777
Email jkealoha@hawaii.gov

Residence Address (☐ Check this box if your address has changed)
Street 555 Kealoha Street
Line 2 Apt 1000
City Honolulu State HI Zip Code 96800

Mailing Address (if different from above)
Street
Line 2
City State Zip Code

☐ New Hire/Newly Eligible
Date of Hire/Newly Eligible (MM/DD/YYYY)
__/__/____

☒ Open Enrollment (effective 07/01/2015)

☐ Termination of Employment
Date of Termination (MM/DD/YYYY)
__/__/____

Employee's Social Security Number (SSN) or EUTF ID Number
555-55-5555

Gender ☒ Male ☐ Female
Birth Date: (MM/DD/YYYY)
06/19/1960

☐ During the Plan Year Qualifying Event (describe)

Event Date: __/__/__

Marital Status ☒ Married ☐ Single
Marriage Date: (MM/DD/YYYY)
02/14/1980

☐ Civil Union
Civil Union Date: (MM/DD/YYYY)
(☐ Check this box if status change)
__/__/__

Domestic Partner (DP Status)
☐ IRS Qualified ☐ Not Qualified
Notary Date: (MM/DD/YYYY)
__/__/__

Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide the following:

NAME: SSN: DOB:

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of a 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, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section
☐ Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used)
☐ Coverage and premium contributions start 1st day of the first pay period following event
☐ Coverage and premium contributions start 1st day of the second pay period following event

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If no selection is made, EUTF will assume no changes are being made.

Medical/Prescription Drug Plan Type	Carrier Selection	You may only choose one medical/prescription drug plan: Cancel/Waive	Self	2-Party	Family

City _____ State _____ Zip Code _____

Mailing Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Employee's Social Security Number (SSN) or EUTF ID Number

_____

Gender ☐ Male ☐ Female

Birth Date: (MM/DD/YYYY)

____/____/_____

(☐ Check this box if status change)

____/____/____

Domestic Partner (DP Status)

☐ IRS Qualified ☐ Not Qualified

Notary Date: (MM/DD/YYYY)

____/____/____

Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide the following:

NAME: _____ SSN: _____ DOB: _____

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of a 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, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Leave Blank

☐ Coverage and premium contributions start 1st day of the first pay period following event

☐ Coverage and premium contributions start 1st day of the second pay period following event

SECTION 3: PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. You may only choose one medical/prescription drug plan. If no selection is made, EUTF will assume no changes are being made.

Medical/Prescription Drug Plan

You may only choose one medical/prescription drug plan

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 HMSA Medical, CVS Prescription Drug, Chiro	☐	☐	☐	☐
	PPO-80/20 HMSA Medical, CVS Prescription Drug, Chiro	☐	☐	☐	☐
	PPO-75/25 HMSA Medical, CVS Prescription Drug, Chiro	☐	☐	☐	☐
HMO	HMO-HMSA CVS Prescription Drug, Chiro	☐	☐	☐	☐
	HMO-Kaiser Standard Prescription Drug, Chiro	☐	☒	☐	☐
	HMO-Kaiser Comprehensive Prescription Drug, Chiro	☐	☐	☐	☐
Supplemental	Supplemental- Royal State National Insurance Company (Includes Supplemental Drug Coverage), Chiro *** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under another non- EUTF health plan. See Section 5 on "Instructions for Completing Form EC-1"	☐	☐	☐	☐

Other Plans			Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	If enrolling new dependent ages 19-23 attach student verification	☐	☒	☐	☐
Vision	Vision Service Plan	If enrolling new dependent ages 19-23 attach student verification	☐	☒	☐	☐
Life	USAble Life					

Employee's Name John Kealoha

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CU=Civil Union Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, CUCH=Civil Union Partner's Child, SC=Step Child, GC=Guardianship/Foster child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information received/issued by the SSA.

Continue Coverage	Add	Delete	Dependent: Last Name, First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☒	☐	Jane Kealoha	12 /01 /1965	777-77-7777	SP	F	☒	☒	☒

Proof Documents

- Marriage/ Civil Union/ Domestic Partnership Documentation
- Birth Certificate
- Student Certification

I certify that my spouse, civil union or domestic partner and/or dependent children meet eligibility requirements for enrollment in the EUTF plans, JK (initials)

I certify that my dependent child is a full-time student and have attached all documentation as required in Section 4 regarding dependent and student certification in the "Instructions for Completing Form EC-1", _____(initials)

SECTION 5: OTHER INSURANCE INFORMATION

*** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under another non- EUTF health plan

If you or any of your dependents are covered under another non-EUTF 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, 2-party, Family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Self	2-Party
			/ /	☐	☐
			/ /	☐	☐

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 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

I certify that my dependent child is a full-time student and have attached all documentation as required in Section 4 regarding dependent and student certification in the "Instructions for Completing Form EC-1". _____(initials)

SECTION 5: OTHER INSURANCE INFORMATION

*** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under another non- EUTF health plan

If you or any of your dependents are covered under another non-EUTF 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, 2-party, Family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Self	2-Party
			/ /	☐	☐
			/ /	☐	☐

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 that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Employee Signature: John Kealoha Date Signed: 04/15/2015

DEADLINE FOR EMPLOYEES TO SUBMIT EC-1/EC-1H IS APRIL 30, 2015

HEALTH PLAN SELECTION

HEALTH PLAN SELECTION

Things to Consider

- EMPLOYEE CONTRIBUTION
- DEDUCTIBLES

- IN-NETWORK/OUT-OF-NETWORK
- CO-INSURANCE/COPAYMENT % vs. $
- MAXIMUM OUT-OF-POCKET MOOP

Kalani is a state employee under BU 13 and covers a family of three and all of his doctors are in-network with the HMSA PPO Plans.
So Kalani is considering enrolling in the HMSA 90/10 or 80/20 plan.

HMSA PPO Plans	HMSA 90/10	HMSA 80/20
Annual Employee Premium Contribution	$10,356	$7,308
Kalani's family estimates 12 doctor visits during the calendar. Their doctors charge $100 per visit. Total $1,200	Co-Insurance 10% $120	Copayment $14 $168
Maximum Out-Of-Pocket (MOOP)	$4,000 Not met	$5,000 Not met
Total Estimated Annual Cost:	$10,476	$7,476

Total estimated annual savings under the HMSA 80/20 plan: $3,000

Kimo is a state employee under BU 13 and covers a family of four and all of his doctors are in-network with the HMSA PPO Plans. Kimo's family anticipates $30,000 in medical expenses from January 2016 – April 2016.
So Kimo is considering enrolling in the HMSA 90/10 or 80/20 plan.

HMSA PPO Plans	HMSA 90/10	HMSA 80/20
Annual Employee Premium Contribution	$10,356	$7,308
Kimo's family anticipates $30,000 in medical expenses from January 2016 - April 2016	Co-Insurance 10% $3,000	Co-Insurance 20% *$5,000
Maximum Out-Of-Pocket (MOOP)	MOOP $4,000 Not met	MOOP $5,000 Met
Total Estimated Annual Cost:	$13,356	$12,308

Total annual estimated savings under the HMSA 80/20 plan: $1048
100% family coverage for remainder of the calendar year

* The Out-Of-Pocket Expense has been adjusted because it exceeded the MOOP

HEALTH PLAN SELECTION

Questions to ask yourself

Are all my doctors In-Network?

How much are my employee contributions?

What will my out-of-pocket be this year?

What are the plans' maximum out-of-pocket? **MOOP**

REMINDERS

- If you do not want to make any changes, do nothing.
- Ensure all necessary proof documents are submitted.
- Deadline to submit EC-1/EC-1H to your identified open enrollment personnel designee is APRIL 30, 2015

EUTF Contact Information

- **Location:**
  Oahu: City Financial Tower
  201 Merchant Street, Suite 1520
  Honolulu, HI 96813
  (No Validated Parking)

- **Hours:**
  Monday – Friday (except holidays)
  7:45am - 4:30pm

- **Phone:**
  Oahu: 808-586-7390
  Toll-Free: 1-800-295-0089

- **E-mail:**
  eutf@hawaii.gov

- **Mailing Address:**
  P.O. Box 2121
  Honolulu, HI 96805-2121

- **Website:**
  http://eutf.hawaii.gov

MAHALO