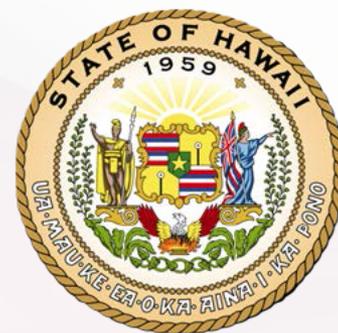




2016 Active Employee Open Enrollment Informational Session

Hawaii Employer-Union Health Benefits Trust Fund



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

AGENDA

- Important Dates
- Changes for 2016
- Completing the EC-1/EC-1H Form
- Understanding Your Benefits
- Contact Information



Important Dates

- Election Period
April 1, 2016 through April 29, 2016
- New Coverage and Rate Changes
Effective July 1, 2016
- New premiums deducted from paycheck:
July 15, 2016 through June 30, 2017 (County Employees)
July 20, 2016 through July 5, 2017 (State Employees)
- Deadline for employees to submit EC-1/EC-1H
is **April 29, 2016**

Open Enrollment

- Enroll, cancel or change plans
- Add or remove dependents
- If you do not want to make changes, no action is needed

Disclaimer: This Reference Guide offers general information on your health and other benefits plans. 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

You will be eligible for Medicare Part B when you become eligible for a prescription drug plan

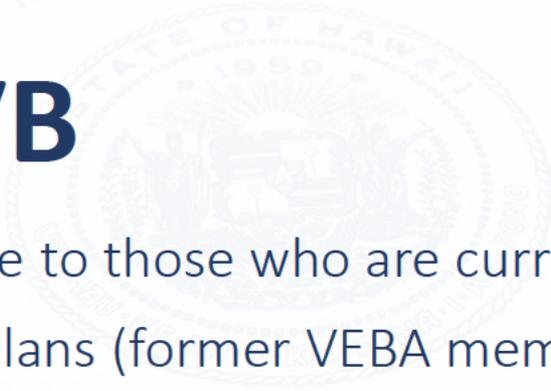
Information on your health and other benefits plans, the EUTF Administrative Rules, and all of your options is provided to amend or contract any legal

HSTA VB

- Only available to those who are currently enrolled in HSTA VB plans (former VEBA members)
- HSTA VB members should complete the EC-1H Enrollment Form if making changes
- HSTA VB members can switch to EUTF plans, but cannot switch back to HSTA VB plans (Complete EC-1 Form)
- HSTA VB members cannot enroll in both EUTF and HSTA VB plans simultaneously

Hawaii Employer-Union Health Benefits Trust Fund

REFERENCE GUIDE
(EUTF and HSTA VB)



RETIREE BENEFIT PLANS
REFERENCE GUIDE
(EUTF and HSTA VB)



You will be eligible for Medicare Part B when you become eligible for a prescription drug plan

Information on your benefits, the EUTF Act, and amendments all of which are provided to amend or contract any legal



Changes for 2016

Medical Coverage

EUTF HMSA and Kaiser Plans

- *Autism benefit*
- *Orthodontic services for orofacial anomalies*

EUTF HMSA Plans

- *Advanced care planning*
- *Dr. Dean Ornish Program for heart disease*
(Facility located on Oahu only)

EUTF HMSA 80/20 & 75/25 plans

- *Outpatient physician services – copayment to coinsurance*
- *Outpatient diagnostic lab coinsurance*
- *Out-of-Network –*
 - *\$250/\$750 deductible (80/20)*
 - *Coinsurance increase*
- *Emergency Room – copayment to coinsurance*



Changes for 2016

Prescription Drug Coverage

CVS Caremark (HMSA members)

- *Copayments*
- *Retail 90-Network*
- *Maximum Out-of-Pocket*

Kaiser Prescription Drug

- *Kaiser Comprehensive and Standard Plan Copayments*



CVS Prescription Drug

30-day supply copayments

Current	July 1, 2016
Generic Drugs \$5	Generic Drugs \$5
Preferred Brand \$15	Preferred Brand \$25
Non-Preferred Brand \$30	Non-Preferred Brand \$50
Specialty 20%	
\$250 max per fill & \$2,000 annual max	



Kaiser Prescription Drug

Comprehensive Plan 30-day supply copayments

Current	July 1, 2016
Generic Tier 1 \$15	Generic Tier 1 \$5
Generic Tier 2 \$15	Generic Tier 2 \$10
Brand \$15	Brand \$35
	Specialty \$75



Kaiser Prescription Drug

Standard Plan 30-day supply copayments

Current	July 1, 2016
Generic Tier 1 \$5	Generic Tier 1 \$5
Generic Tier 2 \$10	Generic Tier 2 \$15
Brand \$35	Brand \$50
	Specialty \$75



Changes for 2016

EUTF Qualifying Life Event Changes

Birth Event

- Submission deadline changed from 60 days to 180 days

Acquisition of Coverage

- Submit letter from insurance carrier or employer detailing:
 - Type of coverage gained (i.e., medical, drug, dental, vision)
 - Effective date of insurance
 - Names of those enrolled under the plan

EC-1

Rev. April 2016

Hawaii Employer-Union Health Benefits Trust Fund

EC-1: Enrollment Form for Active Employees**DUE DATE: This form must be submitted to your Personnel Officer or Departmental Personnel Office within 30 days (180 days for newborns) of the event date.**PLEASE SUBMIT THIS
EC-1 FORM TO YOUR
PERSONNEL OFFICE
DOE EMPLOYEES:
PO BOX 2360
HONOLULU HI 96804**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)

Kealoha, John K.Home Phone (808) 555-9999Mobile Phone (808) 555-1234Work Phone (808) 555-5678Email John.K.Kealoha@hawaii.govMailing Address (Check this box if your address has changed)Street 1234 Aloha Lane

Line 2 _____

City Honolulu State HI Zip Code 96813

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

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

____ / ____ / ____

 Open Enrollment (effective 07/01/2016) Termination
Date of Termination (MM/DD/YYYY)

____ / ____ / ____

Employee's Social Security Number (SSN)
or EUTF ID Number555-44-3333Gender Male Female
Birth Date: (MM/DD/YYYY)12 / 04 / 1983 During the Plan Year Qualifying Event (describe)

Event Date: ____ / ____ / ____

Marital Status Married Single
Marriage Date: (MM/DD/YYYY)02 / 14 / 2014 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, Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her Name, Date of Birth and SSN:

Name: Mary L. Kealoha DOB: 11 / 12 / 1983 SSN: 555-99-8888

- Full name
- Contact Information
- Current address

- Mark "Open Enrollment"
- SSN, Gender & DOB

- Marital status
- Civil Union
- Domestic Partner

SECTION 2: COVERAGE AND DEDUCTION START SELECTION

Leave Section 2 blank

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PPO-80/20 HMSA Medical, CVS Prescription Drug, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	PPO-75/25 HMSA Medical, CVS Prescription Drug, Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HMO-HMSA CVS Prescription Drug, Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO-Kaiser Standard Prescription Drug, Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO-Kaiser Comprehensive Prescription Drug, Chiro	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete section 3

Indicate plan selection & coverage tier

Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service <small>if enrolling new dependent ages 19-23 attach student verification</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Vision	Vision Service Plan <small>if enrolling new dependent ages 19-23 attach student verification</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Life	USable Life	<input type="checkbox"/>	<input checked="" type="checkbox"/>		

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

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONSPlease 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
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Kealoha, Mary L.	11 /12 /1983	555-99-8888	SP	F	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" 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 <http://eutf.hawaii.gov> in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.

Dependent Certification and Student Certification– See Section 4 item 8 on "Instructions for Completing Form EC-1" for more information.

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

JKK (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)

Proof Documents

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

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
			/ /	<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 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 K. Kealoha Date Signed: 4/3/2016

**DEADLINE FOR EMPLOYEES TO SUBMIT
EC-1/EC-1H IS APRIL 29, 2016**

Confirmation Notice

- Check for any errors
- Must respond in writing within 10 calendar days of the date of the notice
- County employees are responsible for notifying their personnel office and payroll of any plan changes



HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

P.O. Box 2121
Honolulu, HI 96805-2121
Oahu (808) 588-7390
Toll Free 1(800) 295-0089
www.eutf.hawaii.gov

Confirmation Notice

Date: May 04, 2015

SARAH ALOHA
123 MAHALO STREET
HONOLULU, HI 96805

HB #: 9999999
Agency/Department: Budget and Finance
Bargaining Unit: 13

This Confirmation Notice details the enrollment changes that were made to your account. Please carefully review its contents to make sure it does not contain any errors. You have a one-time opportunity to correct errors that you made in selecting your coverages (e.g. plan, tier level and dependents) on your enrollment form by notifying EUTF within 10 calendar days from the date of this notice. Any approved changes will be made retroactively to the effective date of the changes as noted below. You will be responsible for any additional premiums.

Please submit your corrections in writing by completing the attached Corrective Action Request Form. Keep a copy of the Corrective Action Request Form for your records. If the EUTF does not hear from you in writing within 10 calendar days from the date of this notice, the change(s) will remain in effect as indicated. Any additional changes to your plans will not be allowed until the next Open Enrollment period, unless you experience a mid-year qualifying event that permits changes under the EUTF Administrative Rules.

Your Benefit Plan Enrollments: as of 01/31/2015

Plan Type	Benefit Plan	Coverage Type	Effective Date	Pay Period Deduction
PCP	Enroll	N/A	01/31/2015	\$0.00
Medical	PPO Medical (90/10) w/ Chiro	Self	01/31/2015	\$101.52
Dental	Dental	Self	01/31/2015	\$6.42
Vision	Vision	Self	01/31/2015	\$1.28
Prescription Drug	PPO Prescription Drug	Self	01/31/2015	\$17.68
Life	Life Insurance	Self	01/31/2015	\$0.00

NOTE: Kaiser and HMSA HMO includes prescription drug coverage.

Your Total Pay Period Deduction:

\$126.90

The EUTF Notice of Privacy Rules describes how your medical information may be used and disclosed and how you can get access to the information. It is available online at eutf.hawaii.gov. Please review it carefully.

EUTF's Mission: We care for the health and well being of our beneficiaries by striving to provide quality benefit plans that are affordable, reliable, and meet their changing needs. We provide services that are excellent, courteous, compassionate, and informative.



Understanding Your Benefits

- Selecting the right plan for you
- Prescription drug copayment increases
- How premiums are determined

Maximum Out-Of-Pocket

- Financial protection
- Insurance keeps track of out-of-pocket
- When MOOP is reached – 100% coverage
- Resets every calendar year

EUTF ACTIVES

Medical Plan Coverage Chart (HMSA, Kaiser, RSN) - EUTF

Plan Design	EUTF 90/10 PPO Plan		EUTF 80/20 PPO Plan	
Carrier	HMSA		HMSA	
General	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Calendar Year Deductible Single/Family	None	\$100 per person; \$300 per family	None	\$250 per person; \$750 per family
Calendar Year Maximum Out-of-Pocket Single/Family	\$2,000/\$4,000		\$2,500/\$5,000	
Lifetime Benefit Maximum	None		None	
Plan Year Benefit Maximum	None		None	
Physician Services	YOU PAY*:		YOU PAY*:	
Primary Care Office Visit	10%	30%	20%	40%
Specialist Office Visit	10%	30%	20%	40%
Routine Physical Exams	No Charge	No Charge**	No Charge	No Charge**
Screening Mammography	No Charge	30%**	No Charge	40%**
Immunizations	No Charge	No Charge**	No Charge	No Charge**
Well Baby Care Visits	No Charge	30%**	No Charge	40%**
Maternity	Same as any other condition	Same as any other condition	10%	40%
Second opinion – surgery	10%	30%	20%	40%

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	\$11,610	\$7,997
Kimo's family estimates \$30,000 in medical expenses through in-network HMSA providers from April through June 2017.	Coinsurance 10% \$3,000	Coinsurance 20% \$5,000
Maximum Out-Of-Pocket (MOOP)	\$4,000 Not met	\$5,000 Met
Total Estimated Annual Cost:	\$14,610	\$12,997

Total estimated annual savings under the HMSA 80/20 plan: \$1,613

Malia is considering enrolling in the Kaiser Comprehensive or Standard plan.

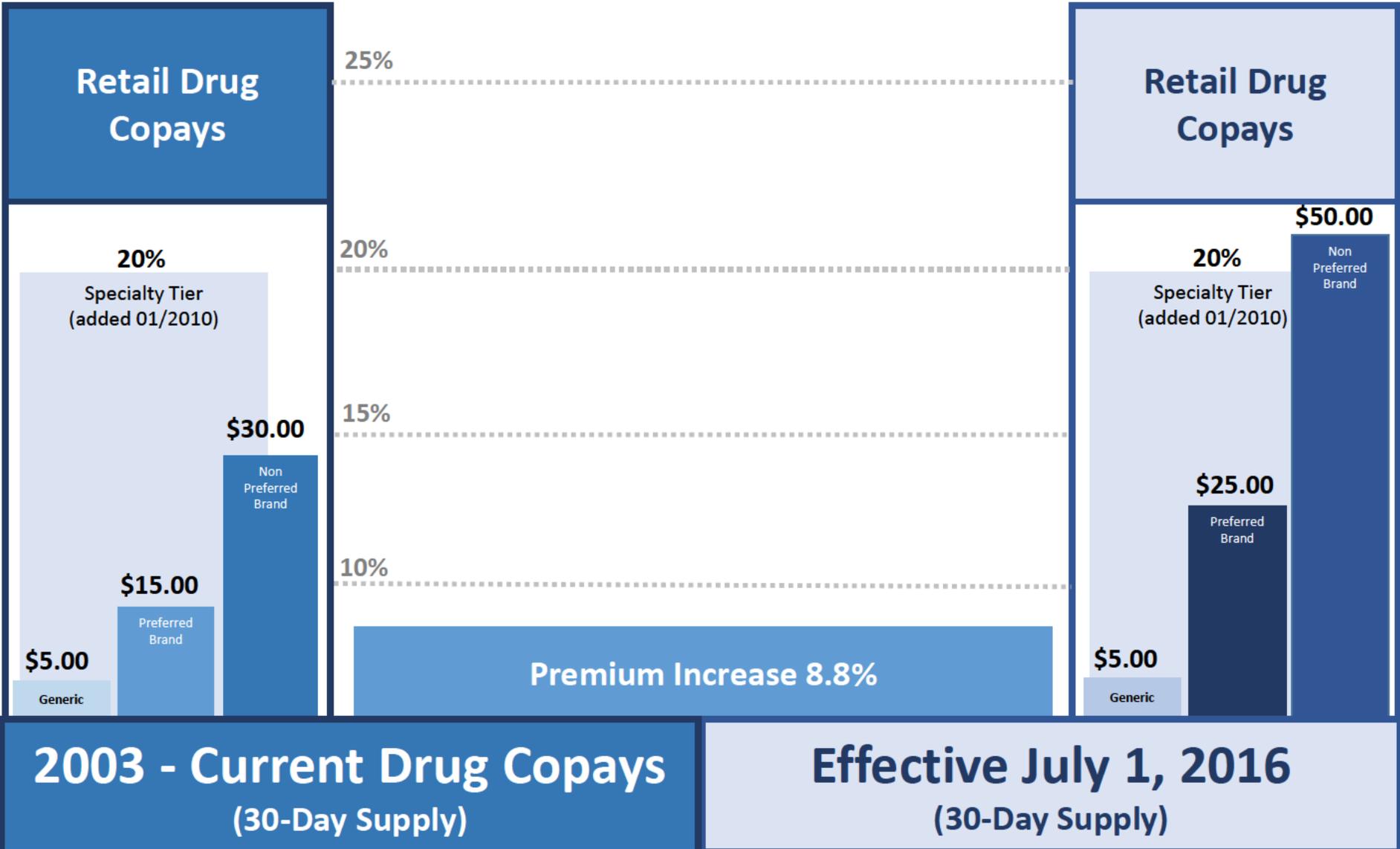


Kaiser HMO Plans	Comprehensive Plan	Standard Plan
Annual Employee Premium Contribution	\$7,963	\$2,573
Malia and her two dependents are anticipating \$100,000 in in-patient hospital costs at an in-network Kaiser facility this year.	No Charge	Coinsurance 15% \$7,500
Maximum Out-Of-Pocket (MOOP)	\$6,000 Not met	\$7,500 Met
Total Estimated Annual Cost:	\$7,963	\$10,073

Total estimated annual savings under the Kaiser Comprehensive plan: \$2,110

A 3D maze with white walls and a white path leading to the text. The maze is composed of various rectangular and square paths, creating a complex network of corridors. The path starts from the bottom left and leads towards the center-right of the image.

Prescription Drug Copayment Increases



2003 - Current Drug Copays
(30-Day Supply)

Effective July 1, 2016
(30-Day Supply)

Retail Drug Copays



20%

15%

10%

5%

Premium Increase
17%

Premium Increase 8.8%

Retail Drug Copays



\$50.00

20%

Specialty Tier
(added 01/2010)

\$25.00

Preferred
Brand

Non
Preferred
Brand

\$5.00

Generic

2003 - Current Drug Copays
(30-Day Supply)

Effective July 1, 2016
(30-Day Supply)

A 3D maze with white walls and a white path leading from the bottom left towards the center. The maze is composed of various rectangular and square openings. The text is overlaid on the white path.

How Premiums are Determined



Premiums Factors

Benefit Plan Design

Medical Inflation

Utilization

Premiums Factors



Utilization

Generic vs Brand Names



Choosing generic drugs when possible can represent significant savings in out-of-pocket costs and health plan cost share. For example, the cholesterol medication, Lipitor costs approximately seven times the generic equivalent. Generic drugs are FDA approved and contain the same active ingredients found in their brand equivalent. Check with your doctor if generic alternatives are available to you.

Mail Order vs Retail



Using mail order for prescriptions can save you time and money if you are on maintenance medication or medication you take on a long-term basis. Our prescription drug plans provide significant cost savings for most maintenance medication dispensed in a 90-day supply.

Mail order can save up to 25% compared to retail.

Emergency Room use for non-emergent care



Emergency Room services come with substantially higher costs compared to a regular doctor's visit. We encourage you to use the emergency room only for emergencies in order to keep healthcare cost down. Members have alternatives such as urgent care facilities or telephonic doctor visits.

**Health and Wellness
Benefits**



Contact Information

- **Phone**

Oahu: 586-7390

Toll-Free: 1-800-295-0089

- **Office Hours**

Monday – Friday

7:45 am - 4:30 pm

(except State holidays)

- **E-mail**

eutf@hawaii.gov

- **Mailing Address**

P.O. Box 2121

Honolulu, HI 96805-2121

- **Walk-In**

Oahu: City Financial Tower

201 Merchant Street, 17th Floor

Honolulu, HI 96813

(No Validated Parking)

- **Website**

eutf.hawaii.gov