Hawaii Employer-Union Health Benefits Trust Fund

REFERENCE GUIDE (EUTF and HSTA VB)

FOR ACTIVE EMPLOYEE BENEFIT PLANS

Effective July 1, 2016 through June 30, 2017

Disclaimer: This Reference Guide offers general information on your health and other benefits plans. Your health benefits are exclusively governed by the Hawaii Revised 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 Revised 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

April 2016

Aloha State or County Employee,

We are pleased to present the 2016 Reference Guide for Active Employee Benefit Plans. Inside you will find detailed information about the health benefit plans available to you beginning July 1, 2016. The benefit plans and rates contained in this Reference Guide are for the period of July 1, 2016 through June 30, 2017.

We appreciate the dedication and hard work you provide as a State or County employee. The EUTF Board of Trustees and EUTF staff are working hard to provide you with the best health benefit plans to take care of your health care needs.

We're also pleased to share with you our new well-being logo, "Be Well. Be Strong." This reminds us that we can all take action to improve our well-being and be strong for our families, work teams, and communities.

This Reference Guide and the information contained herein will help you navigate and understand the benefits available to you and your eligible spouse and/or dependents. For your added convenience, you may also visit the EUTF website at eutf.hawaii.gov for information on carrier plans and the benefits being offered. You may also call the EUTF and speak with one of our helpful staff at 808-586-7390 or toll free at 1-800-295-0089.

Thank you for your service,

Celeste Nip, Chair
EUTF Board of Trustees

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Welcome to Open Enrollment for Active Employee Benefit Plans

The Open Enrollment period for Active Employee Health and Life insurance plans will be from April 1, 2016 through April 29, 2016.

Why is Open Enrollment special?
Now is the time when you should stop and think about health coverage for yourself and your family and determine which plan offered will best meet your needs for the new plan year (July 1, 2016 through June 30, 2017). 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 changes without a qualifying event during the plan year such as needing to enroll a new dependent due to marriage or a birth. Paperwork must be submitted during the open enrollment period for changes to become effective July 1, 2016. So, now is the time to think about health benefits.

Here are the important dates:

• **Open Enrollment Election Period:**	**April 1, 2016 through April 29, 2016**
• New coverage becomes effective:	July 1, 2016
• Rates change 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)
• Plan Period:	July 1, 2016 through June 30, 2017

Here's what you need to do now:

- **Know what you are enrolled in now:** What plans are you enrolled in? Who are the dependents enrolled on your plans? You may contact the EUTF at 586-7390 or toll-free at 1-800-295-0089, to inquire about which EUTF or HSTA VB plans you are enrolled in.
- **Learn what's being offered:** Read this Reference Guide to learn more about the plans and their cost. Attend an Open Enrollment informational session to get more details and talk to carrier representatives.
- **Make a decision about which plans best suit your needs**
- **Fill out the appropriate form:** Please refer to page 5 for complete enrollment instructions.

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

Plan Changes

Effective July 1, 2016 for Medical and Prescription Drug Plans:

I. For the EUTF HMSA 90/10, 80/20, and 75/25 PPO and HMO medical plans:
   1. Added autism benefits for individuals under 14 years of age up to $25,000 per year (office visit coinsurance or copayment apply).
   2. Added orthodontic services for children born with orofacial anomalies under age 26 up to $5,500 per treatment phase (no coinsurance or copayment apply).
   3. Added advanced care planning office visits (office visit coinsurance or copayment apply).
   4. Added Dr. Dean Ornish program ($20 copayment per session).

II. For the EUTF HMSA 80/20 and 75/25 PPO medical plan:
   1. Added an out-of-network deductible of $250 for single coverage and $750 for family coverage for the 80/20 plan.
   2. Changed the copayments for primary care, specialist, and second opinion (surgery), office visits, and inpatient physician services to 20% coinsurance for the 80/20 plan and 25% coinsurance for the 75/25 plan.
   3. Changed the outpatient diagnostic lab services to 20% coinsurance for the 80/20 plan and 25% for the 75/25 plan.
   4. Changed the in- and out-of-network emergency room charge to 20% coinsurance for the 80/20 plan and 25% for the 75/25 plan.
   5. Changed all out-of-network services to 40% coinsurance for both 80/20 and 75/25 plans, excluding out-of-network hospice care which will be Not Covered and emergency room facility charges which is required to remain at the in-network charge. Out-of-network charges for routine physical exams and immunizations will remain at No Charge.

III. For the EUTF Kaiser Comprehensive and Standard medical plans:
   1. Added autism benefits for individuals under 14 years of age up to $25,000 per year (office visit coinsurance or copayment apply).
   2. Added orthodontic services for children born with orofacial anomalies under age 26 up to $5,500 per treatment phase (no coinsurance or copayment apply).
   3. Changed the prescription drug copayment to $5 for generic tier 1, $10 for generic tier 2, $35 for brand, and $75 for specialty for the Comprehensive plan.
   4. Changed the prescription drug copayment to $5 for generic tier 1, $15 for generic tier 2, $50 for brand, and $75 for specialty for the Standard plan.

IV. For all EUTF and HSTA VB Caremark prescription drug plans:
   1. Increased the out-of-pocket limits by $250 for single coverage and $500 for family coverage.
   2. Changed the prescription drug copayments for a 30-day/60-day supply to $5/$10 for generics, $25/$50 for preferred brand, and $50/$100 for non-preferred brand, respectively, for the EUTF plans.
   3. Added the Retail 90 network with copayments of 2 times the 30-day supply copayment for a 90-day supply of medications filled at Retail 90 network pharmacies and mail order, and copayments of 3 times the 30-day supply copayment for medications filled at non-Retail 90 network pharmacies for the EUTF 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. See page 4 for plan changes.

Step 2: **Gather Information:** If you have questions about plan choices, please attend an Open Enrollment Informational Session. The schedule of sessions with location information is on page 7.

During Open Enrollment, all active employees are invited to explore health care and insurance options at the informational sessions. The following insurance carriers and administrator representatives will be on hand to answer your questions about their benefit plans.

Medical plans:	HMSA & Kaiser
Prescription Drug plans:	CVS/caremark & Kaiser
Supplemental Plan (Medical & Drug):	Royal State National
Dental plan:	HDS
Vision plan:	VSP
Life insurance:	USAble Life
Chiropractic plan:	Royal State National

If you are not sure which plan you're enrolled in now, please contact the EUTF at 808-586-7390 or toll-free at 1-800-295-0089, or you may call the carrier customer service numbers which are found on your ID cards. There are also links to the carrier websites on the EUTF website at eutf.hawaii.gov.

Step 3: **Which plans do you want to enroll in?** Review this Reference Guide and determine which health plans best meet your needs. The EUTF website includes links to insurance carriers' web pages along with the latest information regarding open enrollment. Questions regarding specific provisions for certain services should be directed to the carriers. Please refer to the back of this Guide for carrier contact information. The Summary of Benefits and Coverage for the medical and drug plans can be found at EUTF's website at eutf.hawaii.gov.

Step 4: **How much will it cost you**? Review the rates in the Premiums section of this Guide which show the employer/employee contributions for each employer and bargaining unit. (See pages 69-74)

Step 5: **Who do you need to cover?** You may add, or drop dependents from your plan, including a spouse, domestic partner (DP), civil union partner (CUP) or eligible children. Adding a spouse, domestic partner or civil union partner requires additional documentation. Refer to the Employee and Dependent Eligibility section beginning on page 12 of this Guide for details on who can be enrolled as an eligible dependent and visit the EUTF website at eutf.hawaii.gov to download forms.

Step 6: **Complete the Enrollment Form: Make your selections on the Form EC-1 for Active EUTF Employees, or EC-1H for those currently enrolled in HSTA VB plans. Please refer to the perforated pages at the end of this Guide or these forms can be downloaded from the EUTF website at eutf.hawaii.gov.**

A: To make changes to your personal information, such as your address, complete Section 1 and Section 6 on the Form EC-1 or Section 1 and Section 5 on the Form 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 Sections 1, 3, 4 and 5 on the Form EC-1H. **Please mark all the coverages you want to be enrolled in, not just the ones you want to change.**

NOTE: If you are adding a new dependent, you are required to submit your dependent's Social Security Number (SSN) at the initial enrollment (except newborns, whose SSN must be submitted within 180 days of their birth).

C: Employees enrolled in the HSTA VB plans who change to the EUTF plans may NOT change back to HSTA VB plans in the future. Additionally, employees enrolled in the HSTA VB plans may not enroll in some HSTA VB plans and some EUTF plans – they must be enrolled in all HSTA VB plans or all EUTF plans.

Step 7: **THE MOST IMPORTANT STEP: REVIEW YOUR COMPLETED FORM.** Make sure these are the plans you want and the dependents you want to cover are eligible for coverage. You will not be able to change your selections after Open Enrollment ends, except as noted below, unless you experience a qualifying event during the plan year.

Last Step: **Submit the completed and signed form to your identified open enrollment designee no later than April 29, 2016.**

The designee may be your office secretary, financial officer, human resources personnel, etc.—find out who has been designated by your agency/department. It is very important that you submit your completed form on time.

FORMS SUBMITTED AFTER APRIL 29, 2016 WILL BE REJECTED.

The EUTF will send you an enrollment **confirmation notice** after processing is completed. The confirmation notice allows you to review the changes that were made to your coverages. If you note an error **after April 29, 2016,** you will have a one-time opportunity to correct errors that you made in selecting your coverages (e.g. plan, tier level and dependents) on your enrollment form by notifying EUTF within 10 calendar days from the date of the confirmation notice.

Although your coverage begins on July 1, 2016, your enrollment may not be processed right away. Therefore, if you need to fill a prescription or go to the doctor prior to receiving your ID cards you should email EUTF at eutf@hawaii.gov. In the email subject line type "URGENT – Confirmation of coverage needed". EUTF checks this email daily and will contact the carrier to rush your enrollment after it receives the EC-1 or EC-1H from your employer.

IMPORTANT: If any of your dependents are no longer eligible due to a divorce, reaching the limiting age or losing full-time student status (for dental and vision), they cannot continue to be covered under the EUTF plans. You are required to notify the EUTF and make these terminations when these events occur. Do not wait for open enrollment to submit these terminations.

ATTENTION: COBRA PARTICIPANTS

The COBRA Open Enrollment is also taking place April 1 – 29, 2016. Please refer to the EUTF website at eutf.hawaii.gov for more information.

Revised April 5, 2016

Schedule of Open Enrollment Informational Sessions for Active Employees

Date	Island	Locations	Time
Apr 1	Kauai	Kauai Community College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 4	Maui	UH Maui College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 5	Oahu	Mission Memorial Auditorium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 6	Hawaii-Hilo	Aunty Sally Kaleohano's Luau Hale	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 7	Oahu	Aloha Stadium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 8	Oahu	Windward Community College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 11	Kauai	Kauai Community College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 12		Webinar	8:30-10:00am, 1:00-2:30pm, 3:30-5:00 pm
Apr 13	Molokai	Kualapuu Park & Community Center	10:30am-12pm
Apr 14	Lanai	Lanai Community Center	8:30-10:00am, 10:30am-12pm
Apr 15	Oahu	Leeward Community College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 18		Webinar	8:30-10:00am, 1:00-2:30pm, 3:30–5:00 pm
Apr 19	Oahu	UH Manoa	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 20	Hawaii-Kona	West Hawaii Civic Center	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 21	Oahu	UH West Oahu	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 22	Oahu	Aloha Stadium	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 25	Maui	UH Maui College	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 26	Oahu	Hawaii State Capital	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 27	Hawaii-Hilo	Aunty Sally Kaleohano's Luau Hale	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
Apr 28		Webinar	8:30-10:00am, 2:30-4:00pm

MAUI

UH Maui College
Pilina Multi-Purpose Room
310 Kaahumanu Avenue
Kahului, HI 96732

KAUAI

Kauai Community College
OCET Room 106 C & D
3-1901 Kaumualii Highway
Lihue, HI 96766

OAHU

Aloha Stadium
Hospitality Room
99-500 Salt Lake Boulevard
Honolulu, HI 96818

Mission Memorial Auditorium
550 South King Street
Honolulu , HI 96813

MOLOKAI

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

LANAI

Lanai Community Center
8th Street
Lanai City, HI 96763

UH West Oahu
Campus Center C208
91-1001 Farrington Highway
Kapolei, HI 96707

Leeward Community College
Education Building
96-045 Ala Ike Street
Pearl City, HI 96782

HAWAII

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

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

Windward Community College
Hale Akoakoa Room 101-105
45-720 Keaahala Road
Kaneohe, HI 96744

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

How to Access the Webinar

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

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

MONEY SAVING TIPS

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

Choose the Best Plan for Your Needs

Not all plans are created equal. Just because a plan has the highest monthly premium, does not mean it will be the most cost efficient.

Be sure to factor in the copayments/coinsurances, monthly premiums, calendar year maximum out-of-pocket and your expected usage for the year before making any plan decisions.

Every year open enrollment offers an opportunity to choose a plan that best suits your needs, which may change from year to year.

Pick the Right Facility

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

If you have a non-emergency illness or injury, go to your regular doctor or an urgent care clinic. For example, the total cost of a typical office visit would be less than $100 while an emergency room visit could cost upwards of $1,000. Other options include Kaiser or HMSA's online or telephonic care and clinics.

Participating Providers

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

Preventative Care

Getting regular preventative care is the best barometer of your health, and it may help you ward off potential big health issues. It is much easier, and far less costly, to prevent an illness than it is to cure one.

Thanks to the Affordable Care Act, most preventative services are completely free of charge for our active employees and dependents. Examples include: immunizations, routine physical exams, mammograms, and well baby care visits.

WHAT YOU CAN DO TO MAINTAIN GOOD HEATH

HMSA Members

Staying healthy is the best way to control your health care costs. Take care of yourself all year long. See your provider early. Don't let a minor health problem become a major one. Take advantage of your many preventive care benefits, such as your annual physical exam—an annual checkup your doctor uses to assess your overall health. Talk to your doctor to learn about recommended preventive services and screening tests appropriate for your age and gender.

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

Chronic Condition Management

HMSA members have access to telephonic health coaching at no cost, to support better management of chronic conditions and lifestyle changes. Coaches provide guidance for conditions such as asthma, chronic obstructive pulmonary disease, heart failure and coronary artery disease, diabetes, as well as for other areas such as stress, depression, substance abuse, smoking, weight management, fitness and nutrition or other health issues.

You may receive a call from a health coach if you completed the Well-Being Survey, based on the information you provided in the survey. You may also connect with a coach directly for guidance in managing your health condition or lifestyle change by calling **HMSA Well-Being Connection at 1-855-329-5461** - **option 3**. Mon. - Fri. 8 am – 7 pm & Sat. 8 am – 5 pm, HST.

Dr. Ornish's Program for Reversing Heart Disease™

A scientifically proven program to reverse heart disease using lifestyle as medicine. Learn how to transform your life in four areas: fitness, nutrition, stress management, and group support. The program consists of eighteen, 4-hour sessions over nine weeks at two program delivery sites: **'Ekahi Healthcare Center** 500 Ala Moana Blvd., Honolulu 808-948-9500 and **Hawaii Pacific Health,** 1100 Ward Ave., Honolulu 808-522-4114. To find out if you are eligible for this program, talk to your doctor or contact an Ornish care specialist at 1-877-888-3091 toll-free. The cost for members is $20.00 per session.

Tobacco Cessation Program

QuitNet® is a tobacco cessation program that is free of charge to our members. Members will have access to a multitude of tools such as personalized content, support groups, self-assessment questionnaires, coaching by highly trained and certified tobacco cessation specialists, quit medication selection and adherence program, and a lifetime membership to encourage long-term relapse prevention. This program provides unlimited tobacco cessation support. Call **HMSA Well-Being Connection at 1-855-329-5461** to talk to a health coach today.

DO YOU KNOW ABOUT THESE HEALTH PLAN BENEFITS?

Kaiser Permanente Members

Preventive Services. *Prevention makes good health possible!*

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

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

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

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

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

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

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

Tobacco Cessation. *Break the habit for good!*

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

DO YOU KNOW ABOUT THESE PHARMACY PLAN BENEFITS?

CVS/caremark Members

Diabetes Products

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

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

Tobacco Cessation Products

Tobacco cessation products are provided as a plan benefit to support our members to quit smoking. CVS/caremark provides education and plan recommendations for certain products at no cost to members such as nicotine patches and other prescription medications.

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

TIPS FOR USING YOUR PRESCRIPTION DRUG BENEFITS

All Plan Members

Ways to Save Money on Your Prescription Drug Costs

Ask your prescribing doctor if a generic medication is available and if you are able to make a switch to a generic drug. Taking a brand named drug over a generic drug can cost you 80% or more in copayments per prescription. Making a switch to a generic drug could save you hundreds of dollars annually. If we all make these changes, collectively we could potentially save the EUTF plan hundreds of thousands of dollars annually which would result in lower plan premiums.

Another way to save money is by using the mail-order program for 90-day supplies of prescription drugs. Mail order provides you with the lowest copayment and the convenience of free shipping to a location of your choice. The EUTF plan has the potential to save a significant amount of money since it cost less to fill prescriptions at a mail pharmacy versus a retail pharmacy. Those savings can help to lower future prescription drug premiums. Additionally, filling your prescriptions in a 90-day supply help to improve adherence. Members who fill prescriptions in a 90-day supply have a 10% improvement in optimal adherence to manage their health conditions. This also supports long-term savings to the EUTF plan. To start mail order, contact CVS/caremark at 1-855-801-8263.

For more information visit caremark.com or call CVS Customer Care at 1-855-801-8263. For Kaiser members, if you have not done so already, you'll need to register for a secure kp.org account in order to refill prescriptions online. You also can set up mail-order services when you visit your Kaiser Permanente or call the number on the prescription label.

Employee and Dependent Eligibility

Eligibility for coverage is determined by the Hawaii Revised Statutes and by the EUTF Administrative Rules adopted by the EUTF Board of Trustees. Requests for enrollments, terminations, and other changes must be submitted to the EUTF through your designated personnel officer. DOE employees please submit your changes to the DOE-HBAU office. If you have any questions concerning eligibility provisions, please refer to the EUTF Administrative Rules posted on the EUTF website at eutf.hawaii.gov. You may also call the EUTF Member Services Branch at 808-586-7390 or toll free at 1-800-295-0089 or email your inquiry to eutf@hawaii.gov.

Health Plans

Employee Eligibility: The following persons are eligible to enroll as employee-beneficiaries in the benefit plans offered or sponsored by the EUTF for Active employees:

- An eligible employee, including an elective officer of the State, county or legislature
- The surviving spouse, Domestic Partner or Civil Union Partner (DP/CUP) of an employee killed in the performance of duty, provided the spouse or DP/CUP does not remarry or enter into another domestic or civil union partnership, shall be enrolled in Retiree plans
- The unmarried child of an employee killed in the performance of duty, provided the child is under the limiting age, as defined in the EUTF Administrative Rule 1.02 or is an adult disabled child in accordance with the EUTF Administrative Rule 3.01(b)(3) and does not have a surviving parent who is eligible to be an employee-beneficiary, shall be enrolled in Retiree plans

Dependent Eligibility: The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the EUTF for Active employees:

- The Employee's legal spouse, Domestic Partner or Civil Union Partner (DP/CUP)
- You or your spouse's/DP's/CUP's children under the age of 26 (for medical and prescription drug coverage). This includes children by birth, marriage (stepchild), or adoption or placement for adoption. For dental and vision coverage, dependent children under the age 19, and from age 19 through age 23 if they are full time students. For children covered under legal guardianship, their coverage will terminate at age 18.
- Coverage can be continued for an unmarried child, regardless of age, who is incapable of self-support due to mental/physical incapacity that existed prior to the child reaching age 19.

Group Life Insurance

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

Special Eligibility Requirements for Domestic and Civil Union Partners

Domestic Partner (DP): A person in a spouse-like relationship with an employee-beneficiary who meets the following requirements (you may also enroll a Domestic Partner's children as dependents so long as the children meet the EUTF eligibility requirements applicable to the enrollment of dependent children):

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

Civil Union Partner (CUP): A person who has entered into a civil union under the rules established by the State of Hawaii Department of Health. You may also enroll a civil union partner's children as dependents so long as the children meet the EUTF eligibility requirements applicable to the enrollment of dependent children.

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

Enrollment

To enroll, you must complete a EUTF Enrollment Form for Active Employees (EC-1 or EC-1H [if you are already enrolled in the HSTA VB plans]) (see the perforated pages at the end of this Guide). If you do not enroll eligible members of your family within 30 days (180 days for newborns) of when you or they first become eligible, you must wait until the next Open Enrollment period to do so. The plan year for active employees begins July 1 and ends June 30 of the following year.

ID Cards

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

- HMSA and HDS will issue two identical ID cards showing the name of the subscriber
- Kaiser and CVS/caremark issue an ID card for each enrolled member of a family upon initial enrollment
- ChiroPlan Hawaii under Royal State National, USAble and VSP – ID cards are not required to obtain services.

Dual Enrollment Is Not Allowed

No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse/DP/CUP are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans.

Medicare Part B Premium Reimbursement

If you and your dependent are enrolled in a EUTF active employee medical plan, you and your dependent are not eligible for Medicare Part B reimbursement. However, if you are an active employee, enrolled in Medicare Part B and covered by the EUTF retiree medical plan as a dependent through your spouse/DP/CUP, your spouse/DP/CUP is entitled to Medicare Part B reimbursement on your behalf.

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

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

1. You marry and want to enroll your spouse and/or newly eligible dependent children. A copy of your marriage certificate is required.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide appropriate documents verifying the adoption in order to have the application accepted. To enroll a newborn you do not need to attach a copy of the birth certificate or submit the social security number. A copy of the birth certificate is required only if

the child has a different last name from the employee. A social security number is required within 180 days of the date of birth.

3. You have a change in family status involving the loss of eligibility of a family member (e.g., legal separation, divorce, death, child turns age 26 for medical and prescription drug, child age 19-23 is no longer a full-time student for dental & vision). See pages 19-22 for a list of the required documents.
4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage. A copy of the Loss of Coverage letter from your previous employer or insurance plan is required.
5. You move out of your plan's service area.

To change your coverage, you must complete Form EC-1 or EC-1H (if currently enrolled in the HSTA VB plans) and submit it through your employer representative within 30 days of the date of the event (180 days for newborns). Generally, removal of dependents is effective on a prospective basis, depending upon receipt of the enrollment form by the EUTF. Dependent children are automatically terminated from the medical and prescription drug plans at the end of the month that they attain age 26 and do not require the completion of an enrollment form to terminate coverage. 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 terminate 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, Birth (filed within 180 days of the date of birth), Guardianship, Newly Eligible Student, Marriage, New Domestic Partner, New Civil Union Partner, Reinstatement in Employment, and Return from Authorized Leave of Absence (if not currently enrolled). See Common Qualifying Events That Allow Enrollment Changes for Active Employees on pages 19-22.

End of Coverage

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

1. You do not make required premium payments.
2. You die, subject to exceptions.
3. You fail to comply with the EUTF Administrative Rules.
4. You file fraudulent claims.
5. Your dependent reaches the limiting age.
6. A surviving spouse, DP or CUP remarries or enters into another partnership.

Effective Dates of Coverage for New Hires and Employees Newly Eligible for EUTF Benefits

You have 3 choices of when you would like your coverage to begin:

1) Your date of hire or date you become newly eligible for EUTF benefits
2) First day of the first pay period from your date of hire or date you become newly eligible for EUTF benefits
3) First day of second pay period from your date of hire or date you become newly eligible for EUTF benefits

For example:

Date of hire or date you became newly eligible is January 3, 2016:

Option 1 effective date of coverage:	January 3, 2016
Option 2 effective date of coverage:	January 16, 2016
Option 3 effective date of coverage:	February 1, 2016

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

If you were enrolled in the EUTF with your previous public employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage is continuous and you will experience no break in coverage. (See Transfer of Employment below.)

Transfer of Employment
If you terminate employment and are rehired by the same public employer within the same pay period or the next consecutive pay period, you are considered as having transferred employment and you shall be treated as if continuously enrolled in the EUTF benefit plans. If you terminate employment and are rehired by a different public employer (e.g., state to county or county to county) within the same pay period or the next consecutive pay period, you are allowed to change between plans, including adding or deleting dependents and changing coverage tiers. For purposes of this section only, the different public employers are: 1) State, including executive, legislative and judicial branches, Department of Education, University of Hawaii, Hawaii Health Systems Corporation, Office of Hawaiian Affairs, and all Charter Schools; 2) City and County of Honolulu; 3) County of Hawaii; 4) County of Kauai, and 5) County of Maui.

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

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

An enrollment application shall be rejected if:
1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
2. The application is not filed within the time limitations prescribed by the EUTF Administrative Rules (see Common Qualifying Events That Allow Enrollment Changes During the Plan Year for Active Employees on pages 19-22);
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The employee-beneficiary owes past due contributions or other amounts to the EUTF; or
5. Acceptance of the application would violate applicable federal or state law or any other provision of the rules.

Employee-beneficiaries will be notified by mail of the rejection of any enrollment application.

Premium Conversion Plan – State of Hawaii Employees Only

Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to pay their health benefit plan premiums on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://dhrd.hawaii.gov.

By electing to participate in the PCP, please note that:

1. Your authorization will automatically continue year-to-year for the duration of the plan until you change or cancel your participation in the PCP during the Open Enrollment period or as provided under number 2 below.
2. If you have an allowable change in status event (e.g., marriage, birth or adoption of children, divorce, etc.), you must complete/file all the required PCP forms within 90 days of the event, to change or cancel your reduction in pay (otherwise, changes can be made only during the Open Enrollment period). Please note that you must notify the EUTF within 30 days of the event in order to make the change in coverage.
3. Allowable changes/cancellations shall become effective as soon as administratively possible, on a **prospective** basis, after you file your forms (e.g. the beginning of the pay period following receipt of your form). To avoid the risk of losing money, you need to file the forms as soon as possible. Changes in pre-tax payroll deductions are always done after receipt of the PCP-2 forms; never retroactively.
4. Your PCP payroll deduction, in the absence of a PCP allowable change in status, cannot be changed for the current plan year.
5. If you change/cancel your health insurance plan coverage, but your PCP change/cancellation is not allowable, your PCP payroll deduction will remain in effect through the end of the plan year and your payments will be forfeited until PCP change/cancellation forms are filed and approved during the next Open Enrollment period.

PCP Example #1:

- Employee's divorce is effective August 2, 2016, and moves from a 2-party to self only plan.
- Employee has 30 days to submit an EC-1/EC-1H (if enrolled in HSTA VB plans) requesting to remove his/her ex-spouse.
- Employee submits an EC-1/EC-1H and DPO completes "Date EC-1/EC-1H Received in Employing Office" section on August 18, 2016.
- EUTF changes coverage effective August 15, 2016 (end of pay period in which event occurred)
- PCP allows payroll deduction change to occur on September 1, 2016 – prospective (next pay period) from the date the DPO receives the EC-1/EC-1H.
- Employee suffers one pay-period forfeiture (08/16/2016 – 08/31/2016).
- If employee had turned in EC-1 and the DPO completed the "Date EC-1 Received in Employing Office" section on or before August 15, 2016, there would be no forfeiture.

PCP Example #2:

- Employee acquires health coverage through spouse's plan, effective July 1, 2016.
- Employee has 30 days to submit EC-1/EC-1H (if enrolled in HSTA VB plans) form to terminate coverage.
- Employee submits an EC-1/EC-1H form and the DPO completes "Date EC-1/EC-1H Received in Employing Office" section on July 7, 2016.
- EUTF terminates coverage effective June 30, 2016.
- PCP allows payroll deduction change to become effective July 16, 2016, prospective (next pay period) from the date the DPO receives the EC-1/EC-1H.
- Employee suffers one pay period forfeiture (07/1/2016 – 07/15/2016).
- If employee had submitted their EC-1/EC-1H form and the DPO completed the "Date EC-1 Received in Employing Office" section on or before June 30, 2016, there would be no forfeiture.

Note: The PCP Election Change Form (PCP-2) must be submitted with the EC-1/EC-1H form. The date the DPO completes the "Date EC-1 Received in Employing Office" section is the key date used to determine the PCP effective date.

Premium Conversion Plan – County Employees Only

Please contact your department personnel office for more information on available options.

Administrative Appeals Related to Eligibility (not related to claims filing)

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

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

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

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

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

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

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

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

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

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

For Emergency Appeals of Eligibility, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

For Claim Filing and Appeals Information for Self-Insured Plan Administered Benefits, please refer to the EUTF Administrative Rule 2.06 for information on this appeal process.

The EUTF Administrative Rules can be found on the EUTF website at eutf.hawaii.gov.

Common Qualifying Events That Allow Enrollment Changes During the Plan Year for Active Employees

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Designated Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H*	EFFECTIVE DATE	CHANGES ALLOWED TO PLANS OR TO ENROLL IN PLANS OR ADD DEPENDENTS?
Acquisition of Coverage (employee gets coverage from another plan and wishes to cancel EUTF plans)	Within 30 days from effective date of gaining coverage elsewhere.	Letter from carrier or employer detailing type of coverages enrolled in (i.e., medical, drug, dental, vision) effective date and names of covered insured/dependents.	If coverage is gained 1st of month, EUTF coverage ends day before 1st. If coverage is gained 16th of month, EUTF coverage ends 15th.	N/A
Birth (employee wishes to add newborn to EUTF plans)	Within 180 days from date of birth.	Birth certificate only if child has a different last name from employee. Social Security Number within 180 days of date of birth.	Employee can choose: birth date, beginning of next pay period after birth date, or beginning of 2nd pay period after birth date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Court Order (to cover child)	EUTF receives the order directly from the Child Support Enforcement Agency (CSEA). No EC-1/ EC-1H is required if employee is already enrolled in EUTF plans.	CSEA notice	Effective date on CSEA notice.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Death	As soon as reasonably practical.	Death certificate or copy of obituary as soon as available.	Date of death or last day of pay period in which date of death occurs for dependents.	N/A
Divorce (employee must terminate spouse's or civil union partner's coverage)	Within 30 days of date of divorce If EC-1/EC-1H filed more than 30 days after date of divorce, employee shall be responsible for paying any claims incurred after the date of divorce.	Pages 1 and 2 of divorce decree, along with signature page. If children are involved, those pages that outline health benefits for children.	Coverage ends last day of pay period in which divorce date occurs.	No
Guardianship (employee wishes to add child to EUTF plans)	Within 30 days from date of guardianship.	Guardianship decree within 60 days.	Employee can choose: Date of guardianship, beginning of next pay period after date of guardianship, or beginning of 2nd pay period after date of guardianship.	No plan changes allowed if already in plan. May enroll in plans if not already enrolled or may add dependents if already enrolled.

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Designated Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H*	EFFECTIVE DATE	CHANGES ALLOWED TO PLANS OR TO ENROLL IN PLANS OR ADD DEPENDENTS?
Legal Separation (employee must terminate spouse's EUTF coverage)	Within 30 days from date of legal separation If EC-1/EC-1H filed more than 30 days after date of legal separation, employee shall be responsible for paying any claims incurred after the date of legal separation.	Court document establishing legal separation, including any pages regarding health benefits for children.	Coverage ends last day of pay period of date of legal separation.	No
Leave of Absence Without Pay Lasting More than 30 Days (employee may 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, and wishes to enroll in EUTF plans)	Within 30 days from loss of other coverage.	Loss of coverage letter from previous employer/carrier detailing type of coverages lost (i.e., medical, dental, drug, vision), date of loss of coverage, and names of any covered dependents within 60 days.	Day following loss of coverage from other plan.	No plan changes allowed if already in plan. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Marriage (employee wishes to enroll new spouse in EUTF plans)	Within 30 days from date of marriage.	Marriage Certificate within 60 days of date of marriage.	Employee can choose: Date of marriage, beginning of next pay period after date of marriage or beginning of 2nd pay period after date of marriage.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Newly Eligible Student (employee wishes to add child in dental or vision plan because child became a full time student and is between the ages of 19 through 23)	Within 30 days from school start date.	Student certification from an accredited college on school letterhead with registrar's signature confirming full time status within 60 days after becoming a full time student. Transcripts not acceptable.	Employee can choose: Date child becomes full time student, beginning of next pay period after becoming full time student, or beginning of 2nd pay period after becoming full time student.	No

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Designated Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H*	EFFECTIVE DATE	CHANGES ALLOWED TO PLANS OR TO ENROLL IN PLANS OR ADD DEPENDENTS?
New Hire (new employee wishes to enroll in EUTF plans) Adult children through age 25 may be included in medical and prescription drug	Within 30 days of date of new hire.	1) Student Certificate if enrolling a dependent 19 through 23 in dental and/or vision (on school letterhead, signed by registrar) 2) Birth certificate if enrolling a dependent with a different last name and Social Security Number 3) Marriage certificate if married or civil union certificate Employees have 60 days from date of hire to turn in documents.	Employee can choose: New hire date, beginning of next pay period after new hire date, or beginning of 2nd pay period after new hire date.	N/A
New Domestic Partner (employee wishes to enroll new domestic partner in EUTF plans)	Within 30 days from date of notarized signature (event date is considered date of notarization).	Notarized Declaration of Domestic Partnership, and Affidavit of Dependency (notarized if IRS qualified) with EC-1 or EC-1H (forms available on the EUTF website).	Employee can choose: Date of notarization of Declaration of Domestic Partnership, beginning of next pay period after notary date, or beginning of 2nd pay period after notary date.	No plan changes allowed if already enrolled in plan. May enroll in plans if not already enrolled or may add dependents if already enrolled.
New Civil Union Partner (employee wishes to enroll new civil union partner in EUTF plans)	Within 30 days from date of civil union.	Civil union certification (on-line proof accepted), Affidavit of Dependency within 60 days of civil union date.	Employee can choose: Date of civil union, beginning of next pay period after date of civil union, or beginning of 2nd pay period after date of civil union.	No plan changes allowed if already in plan. May enroll in plans if not already enrolled or may add dependents if already enrolled.

EVENT	WHEN EC-1/EC-1H MUST BE SUBMITTED TO EMPLOYER (Designated Personnel Office)	DOCUMENTATION REQUIRED TO BE ATTACHED TO EC-1/EC-1H*	EFFECTIVE DATE	CHANGES ALLOWED TO PLANS OR TO ENROLL IN PLANS OR ADD DEPENDENTS?
Termination of Domestic Partnership (employee must terminate domestic partner and domestic partner's dependents)	Within 30 days of termination of partnership If EC-1/EC-1H is filed more than 30 days after date of termination of domestic partnership, employee shall be responsible for paying any claims incurred after the date of termination of domestic partnership.	Declaration of Termination of Domestic Partnership With EC-1 or EC-1H (forms are available on the EUTF website).	Coverage ends last day of pay period in which termination of domestic partnership occurred.	No
Child is No Longer a Full-time Student (employee must terminate dental and vision coverage for a child between ages 19 through 23)	Within 30 days of school end date.	None	Coverage ends the last pay period of school end date.	No
Note: For termination and transfer of employment, bargaining unit changes or death, the employer is required to notify EUTF immediately.				

*If the required proof documents are not available within 30 days of the event to attach to your EC-1/EC-1H form, submit the EC-1/EC-1H form to your designated personnel office within 30 days of the event without the proof documents. You have 60 days from the event to submit the proof documents unless otherwise noted.

The amended EUTF Administrative Rules were filed effective January 12, 2016. For a copy of the complete Administrative Rules please visit the EUTF website at eutf.hawaii.gov.

Rev. 02.01.16

Active Employee Benefit Plan Summaries

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

Medical and Prescription Drug Plan Options

Medical coverage is important to everyone. The Plans offered by the EUTF provide preventive care benefits to keep you healthy and many other benefits to help during those times when you are not. The EUTF offers the following Plan options, including prescription drug:

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

The HSTA VB medical plan options, including prescription drug:

- Preferred Provider Organization (PPO) 90/10 Plan
- Preferred Provider Organization (PPO) 80/20 Plan
- Health Maintenance Organization (HMO) Plan

Understanding the Plan Designs
Preferred Provider Organization Plans (PPO) - EUTF 90/10, 80/20, and 75/25 and HSTA VB 90/10 and 80/20

A PPO plan is a medical plan that is based on a network of preferred medical providers who have contracts with the carrier. Coverage is also available if you go to a provider who is not in the network. A PPO gives you the flexibility to visit the providers you choose – inside or outside of the Plan's network. However, your out of pocket medical costs will be lower if you receive care from an in-network provider or facility. The numbers in the plan titles – 90/10, 80/20, or 75/25 – refer to the percent of eligible charges that the carrier pays for most network services – 90%, 80%, or 75% - and the amount the employee is responsible for, 10%, 20%, or 25%. It's important to note that when you participate in a PPO, you are responsible for asking if your medical provider is in the network or not. If you use an out-of-network provider, your out of pocket costs will be higher since most out-of-network expenses are paid at 60%, 70%, or 80% and you would be responsible for 40%, 30%, or 20% of the covered expense. Also, you'll often be responsible for submitting your own claims. Services provided by an out-of-network provider will impact your total cost. In addition to the higher copayments, you are responsible for the difference between the provider's billed charge and the Plan's eligible charge.

Health Maintenance Organization (HMO) - EUTF HMSA HMO and Kaiser Comprehensive and Standard HMO and HSTA VB Kaiser Comprehensive HMO

Under an HMO, you agree to use the health care professionals and facilities associated with that HMO. Except in emergencies, HMO's do not cover the cost of services you receive from doctors or other providers outside of the HMO's network. With an HMO, there are no deductibles or claim forms. After a copayment for each office visit, most medical expenses are covered at 100%. You must select a Primary Care Provider to coordinate your care.

Supplemental Plan (Co-Payment Plan) - EUTF Royal State National Supplemental

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

EUTF ACTIVES

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

Plan Design	EUTF 90/10 PPO Plan		EUTF 80/20 PPO Plan	
Carrier	**HMSA**		**HMSA**	
General	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Calendar Year Deductible Single/Family	None	$100 per person; $300 per family	None	$250 per person; $750 per family
Calendar Year Maximum Out-of-Pocket Single/Family	$2,000/$4,000		$2,500/$5,000	
Lifetime Benefit Maximum	None		None	
Plan Year Benefit Maximum	None		None	
Physician Services	**YOU PAY*:**		**YOU PAY*:**	
Primary Care Office Visit	10%	30%	20%	40%
Specialist Office Visit	10%	30%	20%	40%
Routine Physical Exams	No Charge	No Charge**	No Charge	No Charge**
Screening Mammography	No Charge	30%**	No Charge	40%**
Immunizations	No Charge	No Charge**	No Charge	No Charge**
Well Baby Care Visits	No Charge	30%**	No Charge	40%**
Maternity	Same as any other condition	Same as any other condition	10%	40%
Second opinion – surgery	10%	30%	20%	40%
Emergency Services				
Emergency Room (ER care)	10%	10%**	20%	20%**
Ambulance	10%	30%	20%	40%
Inpatient Hospital Services				
Room & Board	10%	30%	20%	40%
Ancillary Services	10%	30%	20%	40%
Physician Services	10%	30%	20%	40%
Surgery	10%	30%	20%	40%
Anesthesia	10%	30%	20%	40%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%	30%	20%	40%
Surgery	10%	30%	20%	40%
Diagnostic Lab	10%	30%	20%	40%
Diagnostic X-ray	10%	30%	20%	40%
Anesthesia	10%	30%	20%	40%
Mental Health Services				
Inpatient Care	10%	30%	20%, Facility Services	40%, Facility Services
Outpatient Care	10%	30%	20%, Facility Services	40%, Facility Services
Other Services				
Durable Medical Equipment	10%	30%	20%	40%
Home Health Care	No Charge	30%	20%	40%
Hospice Care	No Charge	Not Covered	No Charge	Not Covered
Nursing Facility - Skilled Care	10%, 120 days/CY	30%, 120 days/CY	20%, 120 days/CY	40%, 120 days/CY
Physical & Occupational Therapy	10%	30%	20%	40%
Notes:	* If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge. **Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 28.		* If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge. **Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 28.	

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

Plan Design	EUTF 75/25 PPO Plan		Supplemental
Carrier	**HMSA**		**Royal State**
General	In-Network	Out-of-Network*	
Calendar Year Deductible Single/Family	$300/$900		None/None
Calendar Year Maximum Out-of-Pocket Single/Family	$5,000/$10,000		None
Lifetime Benefit Maximum	None		None
Plan Year Benefit Maximum	None		Medical Services:$3,500; Rx: $350/$700/$1,000
Physician Services	**YOU PAY*:**		**YOU PAY:**
Primary Care Office Visit	25%**	40%	Co-pay covered
Specialist Office Visit	25%**	40%	Co-pay covered
Routine Physical Exams	No Charge**	No Charge**	Co-pay covered
Screening Mammography	No Charge**	40%**	Co-pay covered
Immunizations	No Charge**	No Charge**	Co-pay covered
Well Baby Care Visits	No Charge**	40%**	Co-pay covered
Maternity	25%	40%	Co-pay covered
Second Opinion – Surgery	25%**	40%	Co-pay covered
Emergency Services			
Emergency Room (ER care)	25%	25%	Co-pay covered
Ambulance	25%	40%	Co-pay covered
Inpatient Hospital Services			
Room & Board	25%	40%	Co-pay covered
Ancillary Services	25%	40%	Co-pay covered
Physician Services	25%	40%	Co-pay covered
Surgery	25%	40%	Co-pay covered
Anesthesia	25%	40%	Co-pay covered
Outpatient Services			
Chemotherapy/ Radiation Therapy	25%	40%	Co-pay covered
Surgery	25%	40%	Co-pay covered
Diagnostic Lab	25%	40%	Co-pay covered
Diagnostic X-ray	25%	40%	Co-pay covered
Anesthesia	25%	40%	Co-pay covered
Mental Health Services			
Inpatient Care	25%, Facility Services	40%, Facility Services	Co-pay covered
Outpatient Care	25%, Facility Services	40%, Facility Services	Co-pay covered
Other Services			
Durable Medical Equipment	25%	40%	Co-pay covered
Home Health Care	25%	40%	Co-pay covered
Hospice Care	No Charge	Not Covered	Co-pay covered
Nursing Facility - Skilled Care	25%, 120 days/CY	40%, 120 days/CY	Co-pay covered
Physical & Occupational Therapy	25%	40%	Co-pay covered
Notes:	* If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge. **Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 28		For the Royal State Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed $20 per prescription drug (RX) up to $350 if enrolled in single coverage or $700 if enrolled in 2-party coverage and $1,000 if enrolled in family coverage per plan year. Reimbursement for prescription drugs co-payment count towards the Plan Year Maximum Benefit Payable.

EUTF ACTIVES

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

Plan Design	HMO Comprehensive	HMO Standard	EUTF HMO
Carrier	**Kaiser***	**Kaiser***	**HMSA**
General			
Calendar Year Deductible Single/Family	None/None	None/None	None/None
Calendar Year Out-of-pocket limit Single/Family	$2,000/$6,000	$2,500/$7,500	$1,500/$3,000
Lifetime Benefit Maximum	None	None	None
Plan Year Benefit Maximum	None	None	None
Physician Services	**YOU PAY:**	**YOU PAY:**	**YOU PAY:**
Primary Care Office Visit	$15	$20	$15
Specialist Office Visit	$15	$20	$15
Routine Physical Exams	No Charge	No Charge	$15
Screening Mammography	No Charge	No Charge	No Charge
Immunizations	No Charge	No Charge	No Charge
Well Baby Care Visits	No Charge	No Charge	No Charge
Maternity	No charge for routine prenatal visits and one postpartum visit	No charge for routine prenatal visits and one postpartum visit	No Charge, Routine Pre/Post Natal Care & Delivery
Second Opinion – Surgery	$15	$20	$15
Emergency Services			
Emergency Room (ER care)	$50	$100	$25
Ambulance	20%	20%	20%
Inpatient Hospital Services			
Room & Board	No Charge	15%	No Charge
Ancillary Services	No Charge	15%	No Charge
Physician Services	No Charge	15%	No Charge
Surgery	No Charge	15%	No Charge
Anesthesia	No Charge	15%	No Charge
Outpatient Services			
Chemotherapy/ Radiation Therapy	$15	$20 for chemotherapy; 20% for radiation therapy	$15
Surgery	$15	15%	$15
Diagnostic Lab	$15/department/ day	$10/ department/ day for basic; 20% for specialty	No Charge
Diagnostic X-ray	$15/department/ day	$10/ department/ day for basic; 20% for specialty	$15 per X-ray
Anesthesia	$15	15%	$15
Mental Health Services			
Inpatient Care	No Charge	15%	No Charge, Facility Services
Outpatient Care	$15	$20	No Charge, Facility Services
Other Services			
Durable Medical Equipment	20%	50%	20%
Home Health Care	No Charge	No Charge	No Charge
Hospice Care	No Charge	No Charge	No Charge
Nursing Facility - Skilled Care	No Charge, 100 days/benefit period	15%, 60 days/benefit period	No Charge, 100 days/CY
Physical & Occupational Therapy	$15	$20	$15 (Outpatient)
Notes:	For prescription drug coverage, refer to the Kaiser HMO plan on page 29.		For prescription drug coverage, refer to the HMO plan on page 29.

*For Kaiser Members only:

1. Except for certain situations described in your *Group Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to your *Group Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement*.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

EUTF ACTIVES

PPO and HMO Prescription Drug Plans Coverage Chart (CVS/caremark & Kaiser) – EUTF

COVERAGE	PPO Prescription Drug Plan CVS/caremark*	
	Participating Pharmacy	**Nonparticipating Pharmacy****
Calendar Year Maximum Out-of-Pocket Single/Family	90/10 and 80/20 PPO Plan: $4,350/$8,700*** 75/25 PPO Plan:$1,850/$3,700***	None
RETAIL PRESCRIPTION PROGRAM (30/60/90 day supply)		
Generic	$5/$10/$15 copayment	$5/$10/$15 + 20% of eligible charges
Preferred Brand Name	$25/$50/$75 copayment	$25/$50/$75 + 20% of eligible charges
Other Brand Name	$50/$100/$150 copayment	$50/$100/$150 + 20% of eligible charges
Injectables and Specialty Drug	20% of eligible charges; Up to $250 maximum; $2,000 out-of-pocket maximum per calendar year; $30 copay oral oncology specialty medications	Not a benefit
Insulin		
Preferred Insulin	$5/$10/$15 copayment	$5/$10/$15 + 20% of eligible charges
Other Insulin	$25/$50/$75 copayment	$25/$50/$75 + 20% of eligible charges
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	20% of eligible charges
Other Diabetic Supplies	$25/$50/$75 copayment	$25/$50/$75 copayment + 20% of eligible charges
RETAIL 90 PHARMACY & MAIL ORDER PRESCRIPTION PROGRAM (30/60/90 day supply)		
	Retail 90 or Mail Pharmacy	**Non-Retail 90 Pharmacy**
Generic	$5/$10/$10 copayment	$5/$10/$15 copayment
Preferred Brand Name	$25/$50/$50 copayment	$25/$50/$75 copayment
Other Brand Name	$50/$100/$100 copayment	$50/$100/$150 copayment
Insulin		
Preferred Insulin	$5/$10/$10 copayment	$5/$10/$15 copayment
Other Insulin	$25/$50/$50 copayment	$25/$50/$75 copayment
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	No copayment
Other Diabetic Supplies	$25/$50/$50 copayment	$25/$50/$75 copayment

For the Royal State Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed $20 per prescription drug (RX) up to $350 if enrolled in single coverage, $700 if enrolled in 2-party coverage or $1,000 if enrolled in family coverage per policy year. Reimbursement for prescription drugs co-payment count towards the Plan Year Maximum Benefit Payable.

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

**If you receive services from a nonparticipating (out-of-network) pharmacy you are responsible for the copayment + coinsurance and any cost difference between the actual charge and the eligible charge.

***There is a prescription drug Maximum Out-of-Pocket (MOOP) limit of $4,350 per individual and $8,700 per family for the 90/10 PPO and 80/20 PPO plans and $1,850 per individual and $3,700 per family for the 75/25 PPO plan for the calendar year (1/1/16 – 12/31/16). Applicable copayments and caps for specialty medications apply and are counted towards the total annual out-of-pocket maximum for the 90/10 plan, the 80/20 plan, and the 75/25 plan.

The CVS/caremark prescription drug plan is bundled with the HMSA medical plan that you select. If you change from one HMSA medical plan to another during open enrollment your drug Maximum Out-of-Pocket (MOOP) may change on the effective date of your new plan selection. The new plan may have changes to the specialty drug cap, or a change to the prescription drug MOOP which may be of a higher or lower amount. All applicable drug copayments and co-insurance are accumulated on a calendar year basis towards an annual MOOP amount, and once the MOOP amount is met, you will no longer pay applicable copayments and coinsurance for the remainder of the calendar year while enrolled on that plan. If you change to a plan with a higher MOOP amount, you are responsible to meet the new MOOP level, but all prior applicable copayments and co-insurance paid towards one CVS/caremark plan can be credited towards the new MOOP amount for the new plan. If you change to a plan with a lower MOOP amount, there are no refunds for copayments or co-insurance that was paid towards the higher MOOP of the prior plan, that are over the amounts of the new MOOP for the new plan.

All copayments and co-insurance paid are applied prospectively to the applicable MOOP amount based upon the plan the member is enrolled at the time.

Please note: Maintenance medications must be filled in a 90-day supply. Medications prescribed for treatment that are not approved by the Federal Drug Administration are excluded from the plan.

PPO and HMO Prescription Drug Plans Coverage Chart (CVS/caremark & Kaiser) – EUTF continued

COVERAGE	HMO Prescription Drug Plan		
	Kaiser Comprehensive	Kaiser Standard	CVS/caremark*
	Copayment up to	Copayment up to	In-Network
Calendar Year Maximum Out-of-Pocket Single/Family	Applies towards the medical out of pocket supplemental charge maximum	Applies towards the medical out of pocket supplemental charge maximum	$4,350/$8,700**
RETAIL PRESCRIPTION PROGRAM (30/60/90 day supply)			
Generic	$5/$10/$15 – tier 1 $10/$20/$30 – tier 2	$5/$10/$15 – tier 1 $15/$30/$45 – tier 2	$5/$10/$15 copayment
Preferred Brand Name	$35/$70/$105	$50/$100/$150	$25/$50/$75 copayment
Other Brand Name	$35/$70/$105	$50/$100/$150	$50/$100/$150 copayment
Injectables and Specialty Drug	$75/$150/$225	$75/$150/$225	20% of eligible charges; Up to $250 maximum; $2,000 out-of-pocket maximum per calendar year; $30 copay oral oncology specialty medications
Insulin			
Preferred Insulin	$35/$70/$105 – brand insulin	$50/$100/$150 – brand insulin	$5/$10/$15 copayment
Other Insulin	$10/$20/$30 – generic insulin	$15/$30/$45 – generic insulin	$25/$50/$75 copayment
Diabetic Supplies			
Preferred Diabetic Supplies	$35/$70/$105	50% of applicable charges	No copayment
Other Diabetic Supplies	$35/$70/$105	50% of applicable charges	$25/$50/$75 copayment
MAIL ORDER PRESCRIPTION PROGRAM (30/60/90 day supply)			
			Mail or Retail 90 Pharmacy
Generic	$5/$10/$10 – tier 1 $10/$20/$20 – tier 2	$5/$10/$10 tier 1; $15/$30/$30 – tier 2	$5/$10/$10 copayment
Preferred Brand Name	$35/$70/$70	$50/$100/$100	$25/$50/$50 copayment
Other Brand Name	$35/$70/$70	$50/$100/$100	$50/$100/$100 copayment
Insulin			
Preferred Insulin	Not Available through Mail Order	Not Available through Mail Order	$5/$10/$10 copayment
Other Insulin			$25/$50/$50 copayment
Diabetic Supplies			
Preferred Diabetic Supplies	$35/$70/$70	50% of applicable charges	No copayment
Other Diabetic Supplies	$35/$70/$70	50% of applicable charges	$25/$50/$50 copayment

For the Royal State Supplemental Plan, reimbursement for prescription drug co-payments charges shall not exceed $20 per prescription drug (RX) up to $350 if enrolled in single coverage, $700 if enrolled in 2-party coverage or $1,000 if enrolled in family coverage per policy year. Reimbursement for prescription drugs co-payment count towards the Plan Year Maximum Benefit Payable.

* This plan is the prescription drug coverage for the HMSA HMO medical options and is administered by CVS/caremark.

**There is a prescription drug Maximum Out-of-Pocket (MOOP) limit of $4,350 per individual and $8,700 per family for the EUTF HMSA HMO plan for the calendar year (1/1/16 – 12/31/16). Applicable copayments and caps for specialty medications apply and are counted towards the total annual drug out-of-pocket maximum for the EUTF HMSA HMO plan.

For a summary of out-of-network benefits for the CVS/caremark plan, please refer to table on page 28.

The CVS/caremark prescription drug plan is bundled with the HMSA medical plan that you select. If you change from one HMSA medical plan to another during open enrollment your drug Maximum Out-of-Pocket (MOOP) may change on the effective date of your new plan selection. The new plan may have changes to the specialty drug cap, or a change to the prescription drug MOOP which may be of a higher or lower amount. All applicable drug copayments and co-insurance are accumulated on a calendar year basis towards an annual MOOP amount, and once the MOOP amount is met, you will no longer pay applicable copayments and coinsurance for the remainder of the calendar year while enrolled on that plan. If you change to a plan with a higher MOOP amount, you are respons ble to meet the new MOOP level, but all prior applicable copayments and co-insurance paid towards one CVS/caremark plan can be credited towards the new MOOP amount for the new plan. If you change to a plan with a lower MOOP amount, there are no refunds for copayments or co-insurance that was paid towards the higher MOOP of the prior plan, that are over the amounts of the new MOOP for the new plan.

All copayments and co-insurance paid are applied prospectively to the applicable MOOP amount based upon the plan the member is enrolled at the time.

Please note: Maintenance medications must be filled as a 90-day supply. Medications prescribed for treatment that are not approved by the Federal Drug Administration are excluded from the plan.

Additional Information for EUTF PPO and HMO prescription drug plans

What's New

Effective 7/1/16, the CVS/caremark prescription drug plan will have a calendar year maximum out-of-pocket (MOOP) of $4,350 per individual, and $8,700 per family for the 90/10, 80/20 PPO plans, and the HMO plan, per calendar year. The calendar year MOOP for the 75/25 PPO plan will be $1,850 per individual, and $3,700 per family, per calendar year.

Effective 7/1/16, the CVS/caremark prescription plan will add a Retail 90 network for EUTF plans. Members that fill a 90-day supply of medication at a Retail 90 network pharmacy or through the mail pharmacy will pay 2x the 30-day supply copayment. Members that fill a 90-day supply of medication at a non-Retail 90 pharmacy will pay 3x the 30-day supply copayment.

Effective 7/1/16, the prescription drug copayments for EUTF plans will change from $15 to $25 for up to a 30-day supply for preferred brands, and from $30 to $50 for up to a 30-day supply for non-preferred brands. The prescription drug copayment for EUTF plans will remain at $5 for up to a 30-day supply for generics.

General Information

The prescription drug plan includes programs that offer a financial incentive for participants to use the generic equivalent or Preferred Brand medication without compromising care as these medications have the same level of effectiveness. Preferred medications are usually priced lower than Non-Preferred Brand name medications and have lower copayments.

To comply with the Affordable Care Act, generic forms of Tamoxifen and Raloxifene are covered with no copayment to the member when prescribed for primary prevention of breast cancer. If you are eligible for this benefit, please have your physician call 877-418-4130 to complete a copayment exception form on your behalf.

Web Service

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

Customer Care

For assistance with questions about your plan, finding a participating pharmacy, ordering a new ID card, refilling your mail order, etc. you may call CVS/caremark toll free 1-855-801-8263 to speak with a Hawaii representative, or you may visit our customer service office in downtown Honolulu at the Pauahi Tower, 1003 Bishop Street, Suite 704, Monday through Friday from 7:45 am – 4:30pm.

Coordination of Benefits

Some participants may be enrolled in additional prescription coverage outside of their EUTF benefits. If this applies to you, please contact CVS/caremark Customer Care at 1-855-801-8263 to advise if your EUTF plan is secondary. When you go to the pharmacy, let them know that your EUTF plan is secondary and they will be able to coordinate benefits for you at the Point of Sale. You also have the option to send in a paper claim form for reimbursement. Below is a list of the required documentation to submit a paper claim for reimbursement. Please note that Coordination of Benefits does not guarantee 100% coverage of your medication. All EUTF plan parameters and guidelines will still apply and may conflict with your other benefits in some cases.

Required Documentation for Paper Claims:
Paper claims must be submitted to CVS/caremark within 1 year from the date of purchase

- Pharmacy receipt including:
  - Patient's name
  - Date of fill
  - Prescription number
  - Name of medication

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

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

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

EUTF participates in CVS/caremark's Specialty Guideline Management (SGM) Program and the Specialty Preferred Drug Strategy (SPDS).

SGM uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. All specialty medications require prior authorization. Physicians may call SGM at 808-254-4414 to obtain prior authorization.

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

Most medications that fall within the Tier 4 (specialty drugs) will be subject to a 20% participant co-insurance up to a maximum $250 co-payment per fill. There is a $2,000 out-of-pocket maximum per person, per calendar year for specialty drug copayments. Exception: Oral oncology medications provided under the Specialty Drug Program will have a $30 copayment instead of a Tier 4 copayment.

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

Dispensed as Written (DAW 1&2) Program

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

Filling prescriptions at a Retail 90 Pharmacy or through the voluntary Mail Order Program for Maintenance Medications for EUTF Active Employee PPO or HMO Members

Maintenance medications are those prescriptions taken for an extended period of time to treat such chronic conditions as high blood pressure, diabetes, heart disease, or high cholesterol. Typically, your physician may write your prescription for these medications in a 90-day supply The Mail Order Program is voluntary, but the requirement to fill maintenance medications in a 90-day supply is still required when you fill your prescription for maintenance medications at the CVS/caremark Mail Order Facility, or through any retail pharmacy in the CVS/caremark network. Participants are allowed (3) 30-day initial fills at the retail pharmacy for each new medication or new dosage amount in order to determine if the medication or dosage is correct. When you fill a prescription for a 90-day supply of a medication through either the mail order facility or through a Retail 90 pharmacy, you will pay two copayments for a three-month supply. If you fill a prescription for a 90-day supply of medication at a non-Retail 90 pharmacy, you will pay three copayments for a three-month supply. Overall, the cost to the plan is the lowest when you use the mail-pharmacy to fill your prescriptions for maintenance medications. You are encouraged to use mail order services to keep plan costs lower. To start mail order contact CVS/caremark at 1-855-801-8263.

HSTA VB ACTIVES

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

Plan Design	HSTA VB 90/10 PPO Plan		HSTA VB 80/20 PPO Plan	
Carrier	**HMSA**		**HMSA**	
General	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Calendar Year Deductible Single/Family	None	$100 per person; $300 per family	None	
Calendar Year Maximum Out-of-Pocket Single/Family	$2,000/$4,000		$2,500/$5,000	
Lifetime Benefit Maximum	Unlimited		Unlimited	
Plan Year Benefit Maximum	None		None	
Physician Services	**YOU PAY*:**		**YOU PAY*:**	
Primary Care Office Visit	10%	30%	20%	20%
Specialist Office Visit	10%	30%	20%	20%
Routine Physical Exams	No Charge	No Charge**	No Charge	No Charge
Screening Mammography	No Charge	30%	No Charge	No Charge
Immunizations	No Charge	30%	No Charge	No Charge
Well Baby Care Visits	No Charge	30%**	No Charge	No Charge
Maternity	Same as any other condition	Same as any other condition	20%	20%
Second Opinion – Surgery	10%	30%	20%	20%
Emergency Services				
Emergency Room (ER care)	10%	10%**	20%	20%
Ambulance	10%	30%	20%	20%
Inpatient Hospital Services				
Room & Board	10%	30%	20%	20%
Ancillary Services	10%	30%	20%	20%
Physician Services	10%	30%	20%	20%
Surgery	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%	30%	20%	20%
Surgery	10%	30%	20%	20%
Diagnostic Lab	10%	30%	No Charge	No Charge
Diagnostic X-ray	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Mental Health Services				
Inpatient Care	10%	30%	20%	20%
Outpatient Care	10%	30%	20%	20%
Other Services				
Durable Medical Equipment	10%	30%	20%	20%
Home Health Care	No Charge	30%	No Charge	No Charge
Hospice Care	No Charge	Not Covered	No Charge	No Charge
Nursing Facility - Skilled Care	10%, 120 days/CY	30%, 120 days/CY	20%, 120 days/CY	20%, 120 days/CY
Physical & Occupational Therapy	10%	30%	20%	20%
Notes:	* If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge. **Deductible does not apply For prescription drug coverage, refer to the PPO plan on page 35		* If you receive services from a nonparticipating (out-of-network) provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge. For prescription drug coverage, refer to the PPO plan on page 35	

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

Plan Design	HSTA VB HMO Comprehensive
Carrier	**Kaiser***
General	
Calendar Year Deductible Single/Family	None/None
Calendar Year Out-of-pocket limit Single/Family	$2,000/ $6,000
Annual Benefit Maximum	None
Lifetime Benefit Maximum	None
Plan Year Benefit Maximum	None
Physician Services	**YOU PAY:**
Primary Care Office Visit	$15
Specialist Office Visit	$15
Routine Physical Exams	No Charge
Screening Mammography	No Charge
Immunizations	No Charge
Well Baby Care Visits	No Charge
Maternity	No charge for routine prenatal visits and one postpartum visit
Second Opinion – Surgery	$15
Emergency Services	
Emergency Room (ER care)	$50
Ambulance	20%
Inpatient Hospital Services	
Room & Board	No Charge
Ancillary Services	No Charge
Physician Services	No Charge
Surgery	No Charge
Anesthesia	No Charge
Outpatient Services	
Chemotherapy/ Radiation Therapy	$15
Surgery	$15
Diagnostic Lab	$15/ department/ day
Diagnostic X-ray	$15/ department/ day
Anesthesia	$15
Mental Health Services	
Inpatient Care	No Charge
Outpatient Care	$15
Other Services	
Durable Medical Equipment	20%
Home Health Care	No Charge
Hospice Care	No Charge
Nursing Facility - Skilled Care	No Charge, 100 days / benefit period
Physical & Occupational Therapy	$15
Notes:	For prescription drug coverage, refer to the Kaiser HMO plan on page 35

*For Kaiser Members only:

1. Except for certain situations descr bed in your *Group Medical and Hospital Service Agreement*, all claims, disputes, or causes of action arising out of or related to your *Group Medical and Hospital Service Agreement*, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement*.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

PPO and HMO Prescription Drug Plans Coverage Chart (CVS/caremark & Kaiser) – HSTA VB

COVERAGE	HSTA VB PPO Prescription Drug Plan CVS/caremark		HMO Prescription Drug Plan Kaiser
	Participating Pharmacy*	**Non-Participating Pharmacy***	**Copayment**
Calendar Year Maximum Out-of-Pocket Single/Family	$4,350/$8,700**	None	Applies towards the medical out of pocket supplemental charge maximum
RETAIL PRESCRIPTION PROGRAM (30/60/90 day supply)			
Generic and Insulin	$5/$9/$9 copayment	$5/$9/$9 + 30% of eligible charges	$10/$20/$30
Brand Name	$15/$27/$27 copayment	$15/$27/$27 + 30% of eligible charges	$10/$20/$30
MAIL ORDER PRESCRIPTION PROGRAM (30/60/90 day supply)	**CVS/caremark**	**Vendor other than CVS/caremark**	**Kaiser**
Generic and Insulin	$5/$9/$9 copayment	Not a Benefit	Generic: $10/$20/$20 Insulin: Not Available through Mail Order
Preferred Brand Name	$15/$27/$27 copayment	Not a Benefit	$10/$20/$20

*If you receive services from a nonparticipating (out-of-network) pharmacy you are responsible for the copayment + coinsurance, and any difference between the actual charge and the eligible charge. Please note: Specialty medications and Injectables are covered under this plan and are subject to the applicable Generic or Brand Name copayment.

**There is a prescription drug Maximum Out-of-Pocket (MOOP) limit of $4,350 per individual and $8,700 per family, for the 2016 calendar year (1/1/16 – 12/31/16).

Medications prescribed for treatment that are not approved by the Federal Drug Administration are excluded from the plan.

Additional Information for the HSTA VB Prescription Drug Plan

What's New

Effective 7/1/16, the CVS/caremark prescription drug plan will have a calendar maximum out-of-pocket (MOOP) of $4,350 per individual, and $8,700 per family, per calendar year.

General Information

The prescription drug plan includes programs that offer a financial incentive for participants to use the generic equivalent or Preferred Brand medication without compromising care as these medications have the same level of effectiveness. Preferred medications are usually priced lower than Non-Preferred Brand name medications and have lower copayments.

To comply with the Affordable Care Act, generic forms of Tamoxifen and Raloxifene are covered with no copayment to the member when prescribed for primary prevention of breast cancer. If you are eligible for this benefit, please have your physician call 877-418-4130 to complete a copayment exception form on your behalf.

Web Service
Members can register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your Prescription Card ready. If you are not currently a member, please visit the CVS/caremark website at 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 a Hawaii representative, or you may visit our customer service office in downtown Honolulu at the Pauahi Tower, 1003 Bishop Street, Suite 704, Monday through Friday from 7:45 am – 4:30pm.

Coordination of Benefits
Some participants may be enrolled in additional prescription coverage outside of their EUTF benefits. If this applies to you, please contact CVS/caremark Customer Care at 1-855-801-8263 to advise if your EUTF plan is secondary. When you go to the pharmacy, let them know that your EUTF plan is secondary and they will be able to coordinate benefits for you at the Point of Sale. You also have the option to send in a paper claim form for reimbursement. Below is a list of the required documentation to submit a paper claim for reimbursement. Please note that Coordination of Benefits does not guarantee 100% coverage of your medication. All EUTF plan parameters and guidelines will still apply and may conflict with your other benefits in some cases.

Required Documentation for Paper Claims:
Paper claims must be submitted to CVS/Caremark within 1 year from the date of purchase

- Pharmacy receipt including:
  - Patient's name
  - Date of fill
  - Prescription number
  - Name of medication
  - Metric quantity
  - Day supply
  - Pharmacy name & address or pharmacy NABP number
- Completely filled out paper claim form with patient signature

All paper claim reimbursement requests should be mailed to:
CVS/caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Utilization Management Programs
In an ongoing effort to effectively manage the prescription drug benefit, certain medications are subject to clinical guidelines as part of the prescription benefit plan design. The drug benefit includes the addition of the following three (3) clinical guidelines:

1. ***Quantity Limitations*** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies and input, review, and approval from the CVS/caremark National Pharmacy and Therapeutics (P&T) Committee.
2. ***Performance Generic Step Therapy Program (PGST)*** – Performance Generic Step Therapy Program (PGST) - The EUTF encourages the use of generic medications as an alternative to certain brand medications as an affordable and effective form of treatment of many health conditions. In an effort to promote use of generic medications, CVS/caremark has a generic step therapy program in place for HSTA VB active employees. For certain non-preferred brand drugs, PGST may require that you try a generic drug treatment prior to the use of a non-preferred brand drug for nasal steroids or for ulcer medications (proton pump inhibitors). In some situations you may pay a higher copayment, please contact CVS/caremark Customer Care at 1-855-801-8263 for more information. Also see section labeled – Dispensed as Written (DAW 2) Program on page 37.

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

Specialty Drug Program

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

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

The copayments for specialty medications for HSTA VB members are based upon the applicable copayment which is usually a brand copayment.

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

Voluntary Mail Order Program for Maintenance Medications for HSTA VB Active Employee PPO or HMO Members

Maintenance medications are those prescriptions taken for an extended period of time to treat such chronic conditions as high blood pressure, diabetes, heart disease, or high cholesterol. When you fill a prescription for a 90-day supply of a maintenance medication through either the mail order facility or through a retail pharmacy, you will pay a lower copayment for a three-month supply. The cost to the plan is the lowest if you use the mail-order facility to fill your prescriptions for maintenance medications. You are encouraged to use mail order services to keep plan costs lower. To start mail order, contact CVS/caremark at 1-855-801-8263.

Dispensed as Written (DAW 2) Program

The Dispensed as Written Program requires participants use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic co-payment will apply. However, if a participant chooses to use a brand medication instead of the generic equivalent, the member is responsible for the standard generic co-payment plus the difference in the cost of the generic and brand medication.

Dental Plan Benefits Coverage Chart (Hawaii Dental Service [HDS]) – HSTA VB Supplemental Plan

Your Plan provides:

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	$750
DIAGNOSTIC	
Examinations - twice per calendar year	50%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	50%
Other X-rays (full mouth X-rays limited to once every 5 years)	50%
PREVENTIVE	
Cleanings – twice per calendar year	50%
• Diabetic Patients – four cleanings or *periodontal maintenance	50%
• Expectant Mothers – three cleanings or *periodontal maintenance	
*Periodontal maintenance benefit level	*45%
Fluoride (once per calendar year through age 19)	50%
• Fluoride - high risk - once per calendar year	
Space maintainers (through age 17)	50%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molars with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	50%
RESTORATIVE	
Amalgam (silver-colored) fillings	45%
Composite (white-colored) fillings – limited to the anterior (front) teeth	45%
Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	45%
Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
ENDODONTICS	45%
Pulpal therapy	
Root canal treatment, retreatment, apexification, apicoectomy	
PERIODONTICS	45%
Periodontal scaling and root planing – once every two years	
Gingivectomy, flap curettage and osseous surgery – once every three years	
Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	
PROSTHODONTICS	
Fixed bridges (once every 5 years; ages 16 and older)	45%
Dentures (complete and partial – once every 5 years; ages 16 and older)	45%
Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth (ages 16 and older)	50%
ORAL SURGERY	50%
ADJUNCTIVE GENERAL SERVICES	45%
Palliative treatment (for relief of pain but not to cure)	50%
ORTHODONTICS	100%
Maximum amount payable by HDS for an eligible patient shall be $750 lifetime per case paid in eight quarterly payments of $93.75.	
Orthodontic services are not covered:	
*If services were started prior to the date the patient became eligible under this employer's plan.	
*If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue.	
*If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	

The HDS public website at www.hawaiidentalservice.com includes a section exclusively for EUTF members. In this section, you will find valuable information on your HDS dental plan including your dental benefits and plan brochure.
Sign up for an online account today to check on your eligibility for services, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, rate your dentist, and receive paperless benefit statements from the convenience of your home computer or smartphone.

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

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

ALL ACTIVES

Dental Plan Benefits Coverage Chart (Hawaii Dental Service [HDS]) – EUTF and HSTA VB

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	$2,000
DEDUCTIBLE per plan year (July 1 – June 30) (does not apply to benefits covered at 100%)	$50/person
DIAGNOSTIC	
Examinations - twice per calendar year	100%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	100%
Other X-rays (full mouth X-rays limited to once every 5 years)	100%
PREVENTIVE	
Cleanings – twice per calendar year • Diabetic Patients – four Cleanings or *Periodontal Maintenance • Expectant Mothers – three Cleanings or *Periodontal Maintenance *Periodontal Maintenance benefit level	100% *80%
Fluoride (twice per calendar year through age 19) For HSTA VB Members: Fluoride (once per calendar year through age 19) Fluoride – high risk patients of any age - once per calendar year	100%
Space maintainers (through age 17)	100%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molars with no 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 Root canal treatment, retreatment, apexification, apicoectomy	80%
PERIODONTICS Periodontal scaling and root planing – once every two years Gingivectomy, flap curettage and osseous surgery – once every three years Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment	80%
PROSTHODONTICS Fixed bridges (once every 5 years; ages 16 and older) Dentures (complete and partial – once every 5 years; ages 16 and older) Implants: Surgical placement of endosteal implant and abutment, once per tooth, every five years (ages 19 and older) For HSTA VB Members: Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth. Once per tooth every 5 years (ages 16 and older).	60%
ORAL SURGERY	80%
ADJUNCTIVE GENERAL SERVICES	80%
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. 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.	50%

Shaded areas indicate coverage after a Wait Period of 12 months of continuous enrollment in the plan.

Visiting a Non-Participating Dentist

If you choose to have services performed by a dentist who is not an HDS or Delta Dental participating dentist, you are responsible for the difference between the amount that the non-participating dentist actually charges and the amount paid by HDS in accordance with your plan. In most cases you will need to pay in full at the time of service. The non-participating dentist will render services and may provide you with the completed claim form (universal ADA claim form) to submit to HDS. Mail the completed claim form for processing to: HDS – Dental Claims, 700 Bishop Street, Suite 700, Honolulu, HI 96813-4196. HDS payment will be based on the HDS non-participating dentist fee schedule and a reimbursement check will be sent to you along with your Explanation of Benefit (EOB) report.

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

Your coverage from a VSP Doctor:

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

Prescription Glasses

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

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

Frame..... every other plan year*

- $120 allowance, plus 20% off any out-of-pocket costs
- OR $65 allowance at COSTCO (no additional discounts)

~Instead of Glasses~

Contact Lenses ..... every plan year*

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

****plan year is July 1st – June 30th***

Extra Discounts and Savings

Glasses & Sunglasses

- Average 35-40% savings on all non-covered lens options (such as tints, progressive lenses, anti-scratch coatings, etc.)
- 30% off additional glasses & sunglasses, including lens options, from the same VSP doctor on the same day as your Exam. OR get 20% off from any VSP doctor within 12 months of your last Exam.

Contact Lenses

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

Laser Vision Correction

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

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

Out-of-Network Reimbursement Amounts

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

Before seeing an out-of-network provider, call VSP at 1-800-877-7195, or go on-line at www.vsp.com to search for a VSP doctor near you!

Chiropractic Plan Benefits (Royal State National [RSN]) – EUTF and HSTA VB

Royal State National Insurance Company, Ltd., through ChiroPlan Hawaii, Inc., is the provider of the chiropractic benefits. The chiropractic benefit is packaged with all active employee medical plans, including the Royal State National Supplemental Plan.

The plan benefits include the initial exam, any necessary x-rays (when taken in a ChiroPlan provider's office), therapeutically necessary chiropractic treatment and therapeutic modalities. For EUTF, the co-payment is $15 per visit up to 20 visits per calendar year. For HSTA VB, the co-payment is $12 per visit up to 20 visits per calendar year. Chiropractic services must be received by a credentialed ChiroPlan Provider. A complete list of ChiroPlan doctors and plan information may be obtained from the EUTF website at eutf.hawaii.gov. Please refer to the plan certificate for complete information on benefits, limitations and exclusions.

Life Insurance (USAble Life) – EUTF and HSTA VB

Your life insurance benefit will be $41,116, for active employees.

- Your benefit will be reduced once you reach age 65 and continue to be reduced as follows:
  - $26,725 for participants age 65 through 69
  - $18,502 for participants age 70 through 74
  - $12,335 for participants age 75 through 79
  - $8,223 for participants age 80 and over

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

- Conversion – If your life insurance ceases because of termination of employment or is reduced due to age or retirement, you may convert to an individual whole life insurance policy within the first 30 days after termination. You do not need to provide evidence of good health.
- Portability - this provision allows a terminated participant to continue their life insurance at a group discounted rate instead of an individual rate, provided they meet the eligibility requirements.
- Accelerated Benefit – allows you to receive an early payment of a portion of your life insurance if you have a Qualified Medical Condition and meet certain requirements.
- Repatriation of Remains Benefit – this benefit reimburses an individual who incurs expenses related to transporting your remains back to a mortuary near your primary place of residence if you pass away 200 miles or more away from home.

Contact USAble Life at (808) 538-8920 or toll free at 1-855-207-2021 if you would like to change your beneficiary. You may download the beneficiary designation form from the USAble Life website at https://www.usablelife.com/portal/eutf.

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

- Providing current and accurate personal information as prescribed in this booklet
- Paying the employee's premium contributions in the amount or amounts provided by statute, or an applicable bargaining unit agreement;
- Paying the employee's premium contributions at the times and in the manner designated by the board; and
- Complying with the EUTF's Administrative Rules.

Employer Responsibilities

Any public employer whose current or former employees participate in EUTF benefit plans is responsible for:

- Providing information as requested by the EUTF under section 87A-24(9) of the HRS;
- Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;
- Assisting the EUTF in distributing information to and collecting information from the employee-beneficiaries;
- Complying with the EUTF's rules;
- Notifying EUTF immediately following termination, transfer, and bargaining unit changes or death.

Authorized Leave of Absence Without Pay (LWOP) and Other Contribution Shortages

If you are going on an Authorized Leave Without Pay (LWOP) lasting more than 30 days, please ask your personnel office for a completed Form L-1 – Authorized Leave of Absence Without Pay.

- You may voluntarily cancel your EUTF plans by submitting an EC-1/EC-1H form within 30 days of the beginning of the LWOP, and you may re-enroll in the same benefit plans upon return from LWOP by submitting an EC-1/EC-1H form within 30 days of your return from LWOP.
- Or, you may continue coverage while on a LWOP by timely paying the amounts listed on the Form L-1 directly to the EUTF.
- If any employee on LWOP does not cancel his or her plans by submitting an EC-1/EC-1H form and does not make payments to the EUTF, he or she will be cancelled for non-payment from all plans (except for the EUTF Life Insurance plan) and will not be able to re-enroll until the next open enrollment period.

If at any time the EUTF fails to receive an employee-beneficiary's premium deduction or receives only a partial deduction from his/her payroll, he/she will receive a Contribution Shortage Reminder Notice from the EUTF. ***If the employee-beneficiary fails to pay the premium shortage by the date specified in the contribution shortage notice, his/her plans will be cancelled retroactive to the date of the last paid premium. Reinstatement of the terminated employee-beneficiary and their dependent's health benefit coverage which was cancelled for non-payment, will be allowed if within 30 days from the date of the notice of cancellation, payment is made in full of past and currently due premiums. To be eligible for reinstatement, the terminated member must not have been terminated for non-payment of premiums within 12 months from the date of the notice of cancellation. Otherwise, he/she will NOT be able to re-enroll in any EUTF plans (medical, prescription drug, dental, and/or vision) until the next open enrollment.***

Future Retirees

Enrollment or Changes in Enrollment Upon Retirement

An employee-beneficiary may enroll or change coverages in the health benefit plans offered or sponsored by the EUTF and obtain coverage for eligible dependent-beneficiaries when they become a retired member of the Employees' Retirement System of the State of Hawaii (ERS) as defined in 87A-1.HRS. The effective date of the coverage shall be the first of the month on or after the employee-beneficiary's date of retirement provided a completed EC-2 enrollment application is received by the EUTF within sixty (60) days of retirement or within sixty (60) days of certification from the ERS if a disability retirement. Retired employee-beneficiaries shall be eligible to enroll in the EUTF benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the date of retirement.

Medicare Part B Enrollment for Medicare Eligible Employees (65+) Considering Retirement

The Hawaii Revised Statutes 87A-23(4) requires that State and County retirees and their dependents who are enrolled in EUTF retiree medical and/or prescription drug benefit plans, enroll in Medicare Part B. Active employees considering retirement who are eligible for Medicare should enroll in Medicare Part B prior to retirement in order to participate in any EUTF retiree medical and prescription drug benefit plans. At the time you complete your retiree (EC-2) enrollment form, provide EUTF with a copy of your Medicare Part B card as proof of enrollment. If no proof of enrollment is submitted to the EUTF within 60 days, your enrollment into the EUTF retiree medical and prescription drug benefit plans will be cancelled back to your date of retirement.

In addition, as a retiree you and your dependent qualify for reimbursement of your Medicare Part B premiums. You must provide the EUTF with proof of your Medicare Part B enrollment and a copy of the letter from the Social Security Administration (SSA) or Centers for Medicare and Medicaid Services (CMS) showing the Medicare Part B Premium that you pay in order to receive the reimbursement. Reimbursement will be made beginning the effective date of your Medicare Part B or the first of the month in which EUTF receives proof of your Medicare Part B enrollment and a copy of the letter from SSA or CMS, whichever is later. Reimbursement is made via direct deposit into the checking or savings account of the retiree, and the EUTF must receive a completed Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement (DDA) form from the retiree in order to reimburse the Medicare Part B premium.

Employees should begin the Medicare Part B enrollment process at least 45 days prior to retirement, by contacting the Social Security Administration at 1-800-772-1213. For more information regarding Medicare, employees should contact Medicare directly at 1-800-633-4227.

If you or your dependent are currently Medicare eligible and you are not retired, EUTF does not require you or your dependent to enroll in Medicare.

In addition, if you are thinking about retirement during the upcoming plan year, you should consider the policies implemented by the providers regarding annual maximums and annual limits for medical, dental, vision and prescription drug benefits. Benefits that are paid under the Active employee plans are counted against the maximums and limitations of the Retiree Plans if they occur within the same calendar year.

Dental example:

For HSTA VB: On January 1, 2016, John was an active employee and incurred $500 in dental services. He retires on July 1, 2016 and proceeds to have additional dental services totaling $1,000. In total, John has incurred $1,500 in dental services for 2016. 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 $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 charges exceed the Retiree dental benefit.

Medical Out-of-Pocket maximum example:

On January 1, 2016, Jane was an active employee enrolled in the EUTF HMSA 90/10 PPO Plan. By July 1, 2016 she had met her $2,000 calendar year out of pocket limit under that plan. She incurs additional medical expenses of $100 in August 2016, which are paid at 100% since her out of pocket limit was satisfied. She retires on September 1, 2016 and enrolls in the EUTF HMSA non-Medicare Retiree PPO plan. She proceeds to have additional medical services totaling $1,000 before the end of 2016. 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, 2016, 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 2016. She retires on June 1, 2016 and enrolls in the EUTF HMSA Retiree PPO plan. The $100 deductible she met under the Active employee plan will apply to the Retiree plan since it is within the same calendar year. She will not be subject to an additional deductible under the Retiree plan.

Attention: Medicare Eligible Members and/or Dependents Enrolling in EUTF

Attention: Medicare Eligible Members
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage through Medicare Part D. However, the EUTF active employee prescription drug plans offer benefits that are as good, or better, than the standard Medicare Part D plan coverage; therefore, you do not have to enroll in a Medicare Part D plan until you retire. For more information, a summary of your Notice of Creditable Coverage appears below.

Prescription Drug Benefits

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

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

Since you are or may become eligible for Medicare during the next year, the EUTF is required by law to notify you regarding your rights to the Medicare Part D prescription drug coverage. If you are enrolled in an EUTF plan, your prescription drug benefits are as good as or better than the standard Medicare Part D drug benefits. Although you have the right to join a Medicare Part D prescription drug plan, doing so may disrupt your regular medical coverage, and you do not have to do so at this time. Medicare will not penalize you if you decide to enroll in a Medicare Part D plan in the future, because the prescription drug coverage you now have through the EUTF is creditable coverage.

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

LATE ENROLLMENT PENALTY (LEP)

When you become eligible for Medicare, you must enroll in a Medicare Part D prescription drug plan if you are NOT enrolled in a creditable prescription drug plan. If you do not enroll in a Medicare Part D

prescription drug plan, and you do not have creditable prescription drug coverage, Medicare may assess you a Late Enrollment Penalty (LEP). The LEP is a lifetime penalty and is not reimbursable by the EUTF. The LEP is assessed when you fail to enroll into a Medicare Part D prescription drug plan when you initially become eligible for enrollment, or you do not have creditable coverage and you have a gap of 63 continuous days without Medicare Part D coverage.

For your information, EUTF's prescription drug plans for active employees through CVS/caremark and Kaiser are considered creditable coverage and EUTF's prescription drug plans for retirees are considered a Medicare Part D prescription drug plan.

The cost of the LEP depends on how long you did not have creditable prescription drug coverage. Currently, the LEP is calculated by multiplying 1% of the “national base beneficiary premium” ($34.10 in 2016) times the number of full, uncovered months that you were eligible but didn’t join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest $.10 and added to your monthly premium. Since the “national base beneficiary premium” may increase each year, the penalty amount may also increase each year. You may have to pay this penalty for as long as you have a Medicare drug plan. This amount is billed separately by SilverScript and paid to Medicare and is not a part of any EUTF premium.

EUTF Important Notices

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

CHANGES DURING THE PLAN YEAR TO YOUR HEALTH CARE BENEFIT ELECTIONS

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

- *Special Enrollment Event:*

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

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

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

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

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

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

  EUTF follows the Internal Revenue Service (IRS) regulations on if and when benefits can be changed during the plan year (the plan year being the period July 1 through June 30). The following events **may** allow certain changes in benefits mid-year, **if** permitted by the IRS:

  - Change in legal marital status (e.g., marriage, divorce/legal separation, death).
  - Change in number or status of dependents (e.g., birth, adoption, death).
  - Change in employee/spouse/dependent's employment status, work schedule, or residence that affects their eligibility for benefits.
  - Coverage of a child due to a QMCSO.
  - Entitlement or loss of entitlement to Medicare or Medicaid.
  - Certain changes in the cost of coverage, composition of coverage or curtailment of coverage of the employee or spouse's plan.
  - Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify your Designated Personnel Office by submitting an EC-1/EC-1H Enrollment Change form within 30 days of the mid-year change.

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

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

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

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

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0964
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

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

To find out whether the prescription drug coverage under the HMSA, HSTA VB and Kaiser medical plans is or is not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage available at the end of this Important Notice section and also available from the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

PRIVACY NOTICE REMINDER FROM EUTF

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

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

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

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

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

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

AVAILABILITY OF SUMMARY HEALTH INFORMATION: THE SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical plan benefits.

Choosing a health coverage option is an important decision. To help you make an informed choice, the Summary of Benefits and Coverage (SBC), summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages long the SBC should be, the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our various medical plan options, go to the EUTF website at http://eutf.hawaii.gov/ or for a paper copy, contact the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

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

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

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

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

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

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

COBRA COVERAGE REMINDER

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

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

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

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

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

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

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

When you elect EUTF-sponsored health coverage, EUTF will provide you with a COBRA Initial Notice. HMSA-CVS/caremark COBRA members: The COBRA medical and drug must be bundled to enroll in COBRA. You will need to set-up COBRA with HMSA and CVS/caremark separately and make separate COBRA payments to each carrier. If you have questions about COBRA or would like another copy of a COBRA Initial Notice please contact the EUTF Office at 808-586-7390 or toll-free at 800-295-0089.

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

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

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

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

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

Direct Access to OB/GYN Providers:

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the **Hawaii Employer-Union Health Benefits Trust Fund (EUTF) office at 808-586-7390 or toll-free at 800-295-0089**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Hawaii Employer-Union Health Benefits Trust Fund		4. Employer Identification Number (EIN) 14-2014628
5. Employer address P.O. Box 2121		6. Employer phone number 808-586-7390 or toll-free at 800-295-0089
7. City Honolulu	8. State Hawaii	9. ZIP code 96805-2121
10. Who can we contact about employee health coverage at this job? EUTF Member Services Branch Manager		
11. Phone number (if different from above)	12. Email address eutf@hawaii.gov	

Here is some basic information about health coverage offered by this employer:

- **As your employer, we offer a health plan to:**

☐ All employees.

☒ Some employees. Eligible employees are:
Effective 2015, eligible employees are those defined in the Chapter 87A-1 of the Hawaii Revised Statutes.

- **With respect to dependents:**

☒ We do offer coverage. Eligible dependents are:
Effective 2015, eligible dependents include a legally married Spouse, or Civil Union Partner or Domestic Partner, and the following categories of children of the employee, Spouse, Civil Union Partner or Domestic Partner (with eligibility permitted to the last day of the month in which the married or unmarried child reaches age 26): natural child, stepchild, adopted child or child placed for adoption, or child under a Qualified Medical Child Support Order (QMCSO). Unmarried children age 26 and older may continue eligibility if disabled and that disability existed prior to age 19. A child under a legal guardianship order may continue eligibility to the last day of the month in which the child reaches age 18. Proof of dependent status is required by the Plan.

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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

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

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

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

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

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

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

- **the HMSA 75/25 PPO Plan (as administered by Caremark),**
- **HMSA 80/20 PPO Plan (as administered by Caremark),**
- **HMSA 90/10 PPO Plan (as administered by Caremark),**
- **HMSA HMO Plan (as administered by Caremark),**
- **HSTA VB HMSA 90/10 PPO Plan (as administered by Caremark),**
- **HSTA VB HMSA 80/20 PPO Plan (as administered by Caremark),**
- **Kaiser HMO plans (as administered by Kaiser).**

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

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser) you will not pay extra if you later decide to enroll in Medicare prescription drug**

coverage. You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

YOUR RIGHT TO RECEIVE A NOTICE

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

WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

> If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.
>
> For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

Your Choices:	What you can do:	What this option means to you:
Option 1	You can select or keep your current medical and prescription drug coverage under the Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser) and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through the Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser). • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during October 15th through December 7th of each year). • As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.

Your Choices:	What you can do:	What this option means to you:
Option 2	You can select or keep your current medical and prescription drug coverage with the Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser) **and also enroll in a Medicare prescription drug plan**. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.	Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows: • for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and the group health plan pays secondary. • for Medicare eligible Active Employees and their Medicare eligible Dependents, the group health plan pays primary and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under the Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser HMO plans (as administered by Kaiser). That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts; • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number), for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Para más información sobre sus opciones bajo la cobertura de Medicare para recetas médicas.

Revise el manual "Medicare Y Usted" para información más detallada sobre los planes de Medicare que ofrecen cobertura para recetas médicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben llamar al 1-877-486-2048. Para más información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
P. O. Box 2121
Honolulu, Hawaii 96805-2121
Phone Number: 808-586-7390 or toll-free at 800-295-0089

As in all cases, EUTF and, when applicable, the medical plan insurance companies, reserve the right to modify benefits at any time, in accordance with applicable law. This document (dated December 17, 2015) is intended to serve as your Medicare Part D Notice of Creditable Coverage, as required by law.

HIPAA Notice: Notice of Privacy Rules

Effective date of this notice is December 16, 2014.

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

A federal law, commonly known as HIPAA (the Health Insurance Portability and Accountability Act of 1996), governs all group health plans' use and disclosure of medical information. You may find HIPAA's privacy rules at 45 Code of Federal Regulations Parts 160 and 164.

This notice describes the EUTF's privacy practices and your rights regarding the uses and disclosures of your medical information as it relates to the EUTF group health plan. The EUTF self-funded group health plan includes the Outpatient Prescription Drug Program Benefits (hereafter referred to as the "Plan") and is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**) and to inform you about the Plan's legal duties and privacy practices with respect to protected health information.

You may receive a Privacy Notice from various insured group health benefit programs. Each of these notices will describe your rights as it pertains to that plan and in compliance with the Federal regulation, HIPAA. This Privacy Notice however, pertains to your protected health information related to the EUTF benefit plan (the "Plan") and outside companies contracted to help administer Plan benefits, also called "business associates."

The EUTF acknowledges that your medical and health information is personal – and is committed to protecting your privacy.

For administration purposes, the EUTF has access to a record of your claims reimbursed under your health insurance benefits plan. This notice applies to all of the medical records that the EUTF maintains or can access. Your personal doctor, health care provider, or health insurance carrier might have different policies or notices regarding their use and disclosure of medical information that they maintain or create. However, HIPAA applies to all organizations or persons that maintain personal health information, if they fall under HIPAA's definition of "Covered Entities."

By law, the EUTF MUST:

- Make sure that medical information that identifies you is kept private,
- Give you this notice of the EUTF's legal duties and privacy practices with respect to your medical information,
- Retain copies of the notices the EUTF issues to you,
- Retain any written acknowledgments that you received the notices, or document the EUTF's good faith efforts to obtain such written acknowledgments from you,
- Follow the terms of the notice that is currently in effect, and
- Notify affected individuals following a breach of unsecured protected health information.

HIPAA also requires the EUTF to tell you about:

- The EUTF's uses and disclosures of your medical information,
- Your privacy rights with respect to your medical information,
- Your right to file a complaint with the EUTF and with the Secretary of the Department of Health and Human Services, and
- The person or office at the EUTF whom you may contact for additional information about the EUTF's privacy practices.

How the EUTF May Use and Disclose Your Medical Information

The following categories describe the different ways the EUTF may use and disclose your medical information. Some uses and disclosures of your medical information require your authorization or the opportunity to agree or object to the use or disclosure. Other uses and disclosures do not. This notice clearly identifies whether or not the use or disclosure of your medical information requires your authorization or the opportunity to agree or object. Each category contains an explanation of what is meant

by the "use and disclosure" of your medical information, and some examples. Not every use or disclosure in a category will be listed. However, the ways the EUTF is allowed to use and disclose your medical information will generally fall into one of the categories listed.

The following categories DO NOT REQUIRE the EUTF to obtain your consent, authorization, or to provide you the opportunity to agree or object to the use or disclosure.

- **For Treatment**: the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under the your insurance plan. For example, the EUTF might disclose the name of your child's dentist to your child's orthodontist so that the orthodontist may ask the dentist for your child's dental X-rays.

- **For Payment**: the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health plan to coordinate benefit payments.

- **For EUTF Operations**: the EUTF may use and disclose your medical information for health care operations and other EUTF operations. These uses and disclosures are necessary to administer the EUTF benefit plans. For example, the EUTF may use and disclose your medical information to conduct or facilitate quality assessments and improvement activities, patient safety activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, enrollment, premium rating and other activities related to creating, renewing or replacing insurance contracts or benefit plans, claims review and appeals, legal functions and services, business planning and development, and other activities related to business management and administration. In connection with the foregoing, the EUTF may disclose your medical information to third parties who perform various health care operations or EUTF operations on its behalf.

- **As Required By Law**: the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF's compliance with federal privacy regulations (this notice).

- **To Avert a Serious Threat to Health or Safety**: the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

Disclosure to Business Associates: the EUTF may disclose your medical information to business associates in carrying out treatment, payment, health care operations and EUTF operations. For example, the EUTF may disclose your medical information to a utilization management organization to review the appropriateness of a proposed treatment under your insurance plan.

Disclosure to Health Insurance Companies or Health Maintenance Organizations: In carrying out treatment, payment or health care operations, the EUTF may disclose your medical information to health insurance companies or health maintenance organizations (HMOs) that it contracts with to provide services or benefits under its health benefits plans. For example, the EUTF may disclose your medical information to the Hawaii Medical Service Association, Kaiser Permanente and Kaiser Health Plan, UnitedHealthcare, Hawaii Dental Service, Vision Service Plan, Royal State National and ChiroPlan Hawaii in order to verify your eligibility for benefits or services.

Disclosure to the Plan Sponsor and Its Representatives: the EUTF is sponsored by State, county and other public employers who are represented on the EUTF's Board of Trustees. The EUTF may disclose information to the EUTF's Board of Trustees, the sponsoring public employers, and the Employees

Retirement System (ERS) for payment, health care operations, and EUTF operations. For example, the EUTF may disclose information to the sponsoring employers about whether you are participating in a group health plan that is offered by the EUTF, or whether you are enrolled or disenrolled in any such group health plan. Disclosure to the sponsoring employers may include disclosures to your departmental personnel officer (DPO) or any other person who functions as your employer's personnel officer. In the event you appeal a denied eligibility issue or other matter to the EUTF's Board of Trustees, the EUTF may disclose your medical information to the EUTF's Board of Trustees and its staff, consultant, and legal counsel as may be necessary to allow the EUTF's Board of Trustees to make a decision on your appeal. The EUTF may also disclose your medical information to the EUTF's Board of Trustees for plan administration functions, including such functions as quality assurance and auditing or monitoring the operations of group health plans that are part of the EUTF.

Public Health Activities: the EUTF may disclose your medical information to a public health authority for the purpose of preventing or controlling disease, injury or disability or to report child abuse or neglect.

Immunizations: To a school about an individual who is a student or prospective student of the school if the protected health information this is disclosed is limited to proof of immunization, the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; or the individual, if the individual is an adult or emancipated.

Organ and Tissue Donation: If you are an organ donor, the EUTF may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, the EUTF may release your medical information as required by military command authorities. The EUTF may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: the EUTF may release your medical information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Health Oversight Activities: the EUTF may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the EUTF may disclose your medical information in response to a court order or administrative ruling. The EUTF may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the medical information requested.

Law Enforcement: the EUTF may release your medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About the victim of a crime if, under certain limited circumstances, the EUTF is able to obtain the person's agreement,
- About a death the EUTF believes might be the result of criminal conduct, and
- In emergency circumstances to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: the EUTF may release your medical information to a coroner or medical examiner. This might be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities: the EUTF may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

The following category REQUIRES the EUTF to obtain your written authorization for the use or disclosure.

Generally, the Plan will require that you sign a valid authorization form in order to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operation. You have the right to revoke an authorization.

The Plan generally will require an authorization form for uses and disclosure of your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed. The Plan generally will require an authorization form for the sale of protected health information if the Plan receives direct or indirect financial remuneration (payment) from the entity to whom the PHI is sold. The Plan does not intend to engage in fundraising activities.

Psychotherapy Notes: Generally the EUTF must obtain your written authorization to use and disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the EUTF may use and disclose your psychotherapy notes when needed by the EUTF to defend against a lawsuit filed by you.

The following category REQUIRES that the EUTF gives you an opportunity to agree or disagree prior to the use or disclosure.

- **Family or Friends Involvement**: the EUTF may disclose your medical information to family members, other relatives, or your friends without your written consent or authorization if:
  - ☐ The medical information is directly relevant to the family or friend's involvement with your care or payment for that care, and
  - ☐ You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information maintained by the EUTF:

Right to Inspect and Copy Your Medical Information: You have the right to inspect and obtain a copy (in hard copy or electronic form) of your PHI (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hard copy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

You have the right to inspect and obtain a copy of your medical information contained in a "designated record set," for as long as the EUTF maintains your medical information. The designated record set includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the EUTF to make decisions about people covered under the EUTF's health benefits plans. Information used for quality control or peer review analyses and not used to make decisions about people covered by the EUTF health benefits plans is not contained in the designated record set.

If you request a copy of your medical information, it will be provided to you in accordance with the time limits required under Part II of Chapter 92F, Hawaii Revised Statutes, and the rules enacted thereunder. Under those laws, the EUTF will generally provide a copy of your medical information to you within ten (10) business or working days. However, in certain circumstances, the EUTF may be entitled to additional time to respond to your request.

You or your personal representative must complete a form to request access to your medical information contained in the designated record set. You must submit the completed request form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice.

If you request a copy of the information, the EUTF may charge a fee for the costs of copying and mailing

the information to you, for creating the PHI or preparing a summary of your PHI, or for other supplies associated with complying with your request.

The EUTF may deny your request to inspect and copy medical information in certain, very limited circumstances. If you are denied access to medical information, you may appeal.

If the EUTF denies your request to inspect or copy your medical information, the EUTF will provide you or your personal representative with a written denial identifying the reason(s) for the denial. The denial will also include a description of how you may exercise your appeal rights, and a description of how you may file a complaint with the Secretary of the Department of Health and Human Services.

Right to Amend Your Medical Information: If you think that your medical information is incorrect or incomplete, you may ask the EUTF to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the EUTF.

To request an amendment, you must submit your request, in writing, to the EUTF Privacy Officer. Your written request must include a reason that supports your request.

After you request that the EUTF amend your medical information, the EUTF must comply with your request within twenty (20) business or working days, or notify you that your request has been denied.

The EUTF may deny your request for an amendment to your medical information if your request is not in writing or does not include a reason to support the request. In addition, the EUTF may deny your request if you ask the EUTF to amend information that:

- Is not part of the medical information kept by or for the EUTF,
- Was not created by the EUTF, unless the person or entity that created the information is no longer available to make the amendment,
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete.

If the EUTF denies your request in the whole or in part, the EUTF must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial, and have that statement included with any future disclosure of your medical information.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures” if a disclosure was made without your authorization for any purpose other than treatment, payment, or health care operations, or where the disclosure was to you about your own medical information.

To request this list of disclosures, you must submit a written request to the EUTF Privacy Officer. Your request must state a time period for which you are requesting the list of disclosures. This period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within any 12-month period will be provided free of charge. For additional lists, the EUTF may charge you for the costs of providing the list. The EUTF will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any costs.

The EUTF has 60 days from the date it receives your request to provide you the list of disclosures, and is allowed an additional 30 days to comply, if it provides you with a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to Request Restrictions: You have the right to request a restriction or limitation on your medical information uses or disclosures for treatment, payment or health care operations. You also have the right to request a limit on your medical information that the EUTF discloses to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that the EUTF not use or disclose information about a surgical procedure you had.

The EUTF is not required by law to agree to your request.

You or your personal representative must complete a form to request restrictions on the use or disclosure of your medical information. You must submit the completed form to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice. In your request, you must indicate:

- What information you want to limit,

- Whether you want to limit the EUTF's use, disclosure, or both, and
- To whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that the EUTF communicate with you about your medical information or other medical matters in a certain way, or at a certain location. For example, you may ask that the EUTF contact you only at work or by mail.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask the EUTF to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to request a paper copy of this notice. To obtain a paper copy of this notice, submit a written request to the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

Breach Notification Right: If a breach of your unsecured protected health information occurs, the Plan will notify you.

A Note about Personal Representatives

You may exercise your privacy rights through a personal representative. Your personal representative will be required to provide evidence of his or her authority to act on your behalf before that person will be given access to your medical information or allowed to take any action on your behalf with respect to your medical information. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A court order appointing the person as the your conservator or guardian, or
- An individual who is the parent of a minor child.

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

However, state or other applicable law will govern whether the EUTF is permitted to disclose an unemancipated minor dependent child's medical information to the child's parent(s). State or other applicable law will also govern whether the EUTF is permitted to provide a parent's access to his or her child's medical information.

Changes to This Notice

The EUTF reserves the right to change this notice. The EUTF also reserves the right to make the revised or changed notice effective for medical information it already maintains, or has access to about you as well as any information the EUTF receives in the future. The EUTF will post a copy of the current notice on the EUTF's web site. This notice will contain the effective date of the current notice on the first page, in the top right-hand corner.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your rights, the duties of the EUTF or other privacy practices stated in this notice. Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice. Because our health plan posts its Notice on its web site, we will prominently post the revised Notice on that web site by the effective date of the material change to the Notice. We will also provide the revised notice, or information about the material change and how to obtain the revised Notice, in our next annual Notice distribution to individuals covered by the Plan.

Minimum Necessary Standard

When the EUTF uses or discloses your medical information, or requests your medical information from another entity, the EUTF will make reasonable efforts not to use, disclose or request more than the minimum amount of your medical information needed to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply to:

- Disclosures to or requests by a health care provider for treatment,
- Uses by you or disclosures to you of your own medical information,
- Disclosures made to the Secretary of the Department of Health and Human Services,

- Uses or disclosures that may be required by law,
- Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- Uses and disclosures for which the EUTF has obtained your authorization.

The Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

This notice does not apply to medical information that has been "de-identified." De-identified information is medical information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

In addition, the EUTF may use or disclose "summary health information" to obtain premium bids or to modify, amend or terminate the EUTF's health benefits plans. Summary health information is information that summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom the EUTF has provided benefits, and from which identifying information has been deleted in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice. You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website (http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html) or this website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html or contact the Privacy Officer for more information about how to file a complaint. You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the EUTF will be made only with your written authorization. If you provide the EUTF with authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the EUTF will no longer use or disclose your medical information for the reasons covered by your written authorization.

You should understand that the EUTF is unable to take back any disclosures that have already been made with your authorization, and that the EUTF is required to retain any records regarding any care or services provided to you.

EUTF may not (and does not) use your genetic information that is PHI for underwriting purposes.

Questions?

If you have any questions about this notice, contact the EUTF Privacy Officer, at the address below.

Governing Law

If there is any discrepancy between the information in this notice and the actual HIPAA regulations, the regulations will prevail, and the EUTF will use and disclose your medical information in a manner consistent with the regulations.

You may contact the **EUTF Privacy Officer** at the following address:

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

Physical Address: 201 Merchant Street, Suite 1520, Honolulu, HI 96813

Telephone number: 808-586-7390, Toll Free number: 1-800-295-0089

Premiums

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
BU's 00, 01, 02, 03, 04, 05, 06, 08, 09, 10, 11, 13, 14

EFFECTIVE JULY 1, 2016

BU'S 00, 01, 02, 03, 04, 06, 08, 09, 10, 11, 13, 14: FOR ALL EMPLOYERS EXCEPT COUNTY OF MAUI

BU 05: FOR HAWAII PUBLIC CHARTER SCHOOLS, STATE OF HAWAII HSTA VEBA EMPLOYEES WHO OPTED TO TRANSFER TO EUTF PLANS or BU 05 EMPLOYEES HIRED ON OR AFTER JANUARY 1, 2011

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
MEDICAL PLANS						
PPO - 90/10 Plan - HMSA Medical	Self	$155.92	$311.84	$307.06	49.6%	$618.90
Prescription Drug - CVS Caremark	Two-Party	$384.98	$769.96	$731.96	48.7%	$1,501.92
RSN Chiropractic	Family	$483.77	$967.54	$946.90	49.5%	$1,914.44
PPO - 80/20 Plan - HMSA Medical	Self	$107.27	$214.54	$307.06	58.9%	$521.60
Prescription Drug - CVS Caremark	Two-Party	$266.90	$533.80	$731.96	57.8%	$1,265.76
RSN Chiropractic	Family	$333.22	$666.44	$946.90	58.7%	$1,613.34
PPO - 75/25 Plan - HMSA Medical	Self	$71.08	$142.16	$307.06	68.4%	$449.22
Prescription Drug - CVS Caremark	Two-Party	$179.05	$358.10	$731.96	67.1%	$1,090.06
RSN Chiropractic	Family	$221.19	$442.38	$946.90	68.2%	$1,389.28
HMSA HMO	Self	$193.57	$387.14	$307.06	44.2%	$694.20
Prescription Drug - CVS Caremark	Two-Party	$476.44	$952.88	$731.96	43.4%	$1,684.84
RSN Chiropractic	Family	$600.43	$1,200.86	$946.90	44.1%	$2,147.76
HMO - Kaiser Comprehensive Medical	Self	$105.62	$211.24	$307.06	59.2%	$518.30
Kaiser Prescription Drug	Two-Party	$265.20	$530.40	$731.96	58.0%	$1,262.36
RSN Chiropractic	Family	$331.78	$663.56	$946.90	58.8%	$1,610.46
HMO - Kaiser Standard Medical	Self	$33.24	$66.48	$307.06	82.2%	$373.54
Kaiser Prescription Drug	Two-Party	$89.17	$178.34	$731.96	80.4%	$910.30
RSN Chiropractic	Family	$107.21	$214.42	$946.90	81.5%	$1,161.32
Supplemental - Royal State National	Self	$8.51	$17.02	$25.52	60.0%	$42.54
Supplemental Prescription Drug	Two-Party	$21.13	$42.26	$63.40	60.0%	$105.66
RSN Chiropractic	Family	$23.49	$46.98	$70.48	60.0%	$117.46
DENTAL PLAN						
	Self	$6.27	$12.54	$18.82	60.0%	$31.36
HDS Dental	Two-Party	$12.55	$25.10	$37.62	60.0%	$62.72
	Family	$20.63	$41.26	$61.88	60.0%	$103.14
VISION PLAN						
	Self	$1.30	$2.60	$3.90	60.0%	$6.50
VSP Vision	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

Premiums

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
BU's 07

EFFECTIVE JULY 1, 2016

BU 07: FOR STATE OF HAWAII

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
MEDICAL PLANS						
PPO - 90/10 Plan - HMSA Medical	Self	$145.61	$291.22	$327.68	52.9%	$618.90
Prescription Drug - CVS Caremark	Two-Party	$356.03	$712.06	$789.86	52.6%	$1,501.92
RSN Chiropractic	Family	$450.91	$901.82	$1,012.62	52.9%	$1,914.44
PPO - 80/20 Plan - HMSA Medical	Self	$96.96	$193.92	$327.68	62.8%	$521.60
Prescription Drug - CVS Caremark	Two-Party	$237.95	$475.90	$789.86	62.4%	$1,265.76
RSN Chiropractic	Family	$300.36	$600.72	$1,012.62	62.8%	$1,613.34
PPO - 75/25 Plan - HMSA Medical	Self	$60.77	$121.54	$327.68	72.9%	$449.22
Prescription Drug - CVS Caremark	Two-Party	$150.10	$300.20	$789.86	72.5%	$1,090.06
RSN Chiropractic	Family	$188.33	$376.66	$1,012.62	72.9%	$1,389.28
HMSA HMO	Self	$183.26	$366.52	$327.68	47.2%	$694.20
Prescription Drug - CVS Caremark	Two-Party	$447.49	$894.98	$789.86	46.9%	$1,684.84
RSN Chiropractic	Family	$567.57	$1,135.14	$1,012.62	47.1%	$2,147.76
HMO - Kaiser Comprehensive Medical	Self	$95.31	$190.62	$327.68	63.2%	$518.30
Kaiser Prescription Drug	Two-Party	$236.25	$472.50	$789.86	62.6%	$1,262.36
RSN Chiropractic	Family	$298.92	$597.84	$1,012.62	62.9%	$1,610.46
HMO - Kaiser Standard Medical	Self	$22.93	$45.86	$327.68	87.7%	$373.54
Kaiser Prescription Drug	Two-Party	$60.22	$120.44	$789.86	86.8%	$910.30
RSN Chiropractic	Family	$74.35	$148.70	$1,012.62	87.2%	$1,161.32
Supplemental - Royal State National	Self	$8.51	$17.02	$25.52	60.0%	$42.54
Supplemental Prescription Drug	Two-Party	$21.13	$42.26	$63.40	60.0%	$105.66
RSN Chiropractic	Family	$23.49	$46.98	$70.48	60.0%	$117.46
DENTAL PLAN						
	Self	$6.27	$12.54	$18.82	60.0%	$31.36
HDS Dental	Two-Party	$12.55	$25.10	$37.62	60.0%	$62.72
	Family	$20.63	$41.26	$61.88	60.0%	$103.14
VISION PLAN						
	Self	$1.30	$2.60	$3.90	60.0%	$6.50
VSP Vision	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

Premiums

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
BU 12

EFFECTIVE JULY 1, 2016

BU12: FOR CITY AND COUNTY OF HONOLULU, COUNTY OF KAUAI, COUNTY OF HAWAII

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
MEDICAL PLANS						
PPO - 90/10 Plan - HMSA Medical	Self	$124.52	$249.04	$252.84	50.4%	$501.88
Prescription Drug - CVS Caremark	Two-Party	$318.98	$637.96	$616.42	49.1%	$1,254.38
RSN Chiropractic	Family	$407.00	$814.00	$811.20	49.9%	$1,625.20
PPO - 80/20 Plan - HMSA Medical	Self	$84.28	$168.56	$252.84	60.0%	$421.40
Prescription Drug - CVS Caremark	Two-Party	$218.34	$436.68	$616.42	58.5%	$1,053.10
RSN Chiropractic	Family	$276.52	$553.04	$811.20	59.5%	$1,364.24
PPO - 75/25 Plan - HMSA Medical	Self	$54.10	$108.20	$252.84	70.0%	$361.04
Prescription Drug - CVS Caremark	Two-Party	$142.91	$285.82	$616.42	68.3%	$902.24
RSN Chiropractic	Family	$178.75	$357.50	$811.20	69.4%	$1,168.70
HMSA HMO	Self	$160.96	$321.92	$252.84	44.0%	$574.76
Prescription Drug - CVS Caremark	Two-Party	$410.30	$820.60	$616.42	42.9%	$1,437.02
RSN Chiropractic	Family	$525.46	$1,050.92	$811.20	43.6%	$1,862.12
HMO - Kaiser Comprehensive Medical	Self	$94.80	$189.60	$252.84	57.1%	$442.44
Kaiser Prescription Drug	Two-Party	$247.22	$494.44	$616.42	55.5%	$1,110.86
RSN Chiropractic	Family	$314.43	$628.86	$811.20	56.3%	$1,440.06
HMO - Kaiser Standard Medical	Self	$28.50	$57.00	$252.84	81.6%	$309.84
Kaiser Prescription Drug	Two-Party	$80.65	$161.30	$616.42	79.3%	$777.72
RSN Chiropractic	Family	$98.38	$196.76	$811.20	80.5%	$1,007.96
Supplemental - Royal State National	Self	$8.51	$17.02	$25.52	60.0%	$42.54
Supplemental Prescription Drug	Two-Party	$21.13	$42.26	$63.40	60.0%	$105.66
RSN Chiropractic	Family	$23.49	$46.98	$70.48	60.0%	$117.46
DENTAL PLAN						
	Self	$6.27	$12.54	$18.82	60.0%	$31.36
HDS Dental	Two-Party	$12.55	$25.10	$37.62	60.0%	$62.72
	Family	$20.63	$41.26	$61.88	62.8%	$103.14
VISION PLAN						
	Self	$1.30	$2.60	$3.90	60.0%	$6.50
VSP Vision	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

Premiums

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
FOR ACTIVE EMPLOYEES FORMERLY UNDER THE HSTA VEBA
BU 05

EFFECTIVE JULY 1, 2016

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
MEDICAL PLANS						
HSTA VB HMSA 90/10 PPO Prescription Drug, RSN Chiropractic, VSP Vision	Self	$154.44	$308.88	$273.44	47.0%	$582.32
	Two-Party	$373.96	$747.92	$661.24	46.9%	$1,409.16
	Family	$476.83	$953.66	$842.98	46.9%	$1,796.64
HSTA VB HMSA 80/20 PPO Prescription Drug, RSN Chiropractic, VSP Vision	Self	$94.99	$189.98	$273.44	59.0%	$463.42
	Two-Party	$229.71	$459.42	$661.24	59.0%	$1,120.66
	Family	$292.82	$585.64	$842.98	59.0%	$1,428.62
HSTA VB Kaiser Comprehensive Prescription Drug, RSN Chiropractic, VSP Vision	Self	$95.91	$191.82	$273.44	58.8%	$465.26
	Two-Party	$234.53	$469.06	$661.24	58.5%	$1,130.30
	Family	$299.74	$599.48	$842.98	58.4%	$1,442.46
DENTAL PLAN						
HSTA VB HDS Dental	Self	$6.69	$13.38	$20.04	60.0%	$33.42
	Two-Party	$13.37	$26.74	$40.10	60.0%	$66.84
	Family	$21.99	$43.98	$65.98	60.0%	$109.96
HSTA VB HDS Supplemental Dental	Self	$3.66	$7.32	$10.98	60.0%	$18.30
	Two-Party	$7.32	$14.64	$21.96	60.0%	$36.60
	Family	$10.98	$21.96	$32.94	60.0%	$54.90
VISION PLAN						
HSTA VB VSP Vision	Self	$1.30	$2.60	$3.90	60.0%	$6.50
	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
HSTA VB USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

Premiums

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
MAUI COUNTY
ALL BU's EXCEPT BU 12

EFFECTIVE JULY 1, 2016

ALL BU's EXCEPT BU 12: FOR COUNTY OF MAUI

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
MEDICAL PLANS						
PPO - 90/10 Plan - HMSA Medical	Self	$152.97	$305.94	$312.96	50.6%	$618.90
Prescription Drug - CVS Caremark	Two-Party	$371.23	$742.46	$759.46	50.6%	$1,501.92
RSN Chiropractic	Family	$473.22	$946.44	$968.00	50.6%	$1,914.44
PPO - 80/20 Plan - HMSA Medical	Self	$104.32	$208.64	$312.96	60.0%	$521.60
Prescription Drug - CVS Caremark	Two-Party	$253.15	$506.30	$759.46	60.0%	$1,265.76
RSN Chiropractic	Family	$322.67	$645.34	$968.00	60.0%	$1,613.34
PPO - 75/25 Plan - HMSA Medical	Self	$68.13	$136.26	$312.96	69.7%	$449.22
Prescription Drug - CVS Caremark	Two-Party	$165.30	$330.60	$759.46	69.7%	$1,090.06
RSN Chiropractic	Family	$210.64	$421.28	$968.00	69.7%	$1,389.28
HMSA HMO	Self	$190.62	$381.24	$312.96	45.1%	$694.20
Prescription Drug - CVS Caremark	Two-Party	$462.69	$925.38	$759.46	45.1%	$1,684.84
RSN Chiropractic	Family	$589.88	$1,179.76	$968.00	45.1%	$2,147.76
HMO - Kaiser Comprehensive Medical	Self	$102.67	$205.34	$312.96	60.4%	$518.30
Kaiser Prescription Drug	Two-Party	$251.45	$502.90	$759.46	60.2%	$1,262.36
RSN Chiropractic	Family	$321.23	$642.46	$968.00	60.1%	$1,610.46
HMO - Kaiser Standard Medical	Self	$30.29	$60.58	$312.96	83.8%	$373.54
Kaiser Prescription Drug	Two-Party	$75.42	$150.84	$759.46	83.4%	$910.30
RSN Chiropractic	Family	$96.66	$193.32	$968.00	83.4%	$1,161.32
Supplemental - Royal State National	Self	$8.51	$17.02	$25.52	60.0%	$42.54
Supplemental Prescription Drug	Two-Party	$21.13	$42.26	$63.40	60.0%	$105.66
RSN Chiropractic	Family	$23.49	$46.98	$70.48	60.0%	$117.46
DENTAL PLAN						
	Self	$6.27	$12.54	$18.82	60.0%	$31.36
HDS Dental	Two-Party	$12.55	$25.10	$37.62	60.0%	$62.72
	Family	$12.55	$25.10	$78.04	75.7%	$103.14
VISION PLAN						
	Self	$1.30	$2.60	$3.90	60.0%	$6.50
VSP Vision	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

Premiums

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACTIVE EMPLOYEES
MAUI COUNTY
BU 12

EFFECTIVE JULY 1, 2016

BU12: FOR COUNTY OF MAUI

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
MEDICAL PLANS						
PPO - 90/10 Plan - HMSA Medical	Self	$124.52	$249.04	$252.84	50.4%	$501.88
Prescription Drug - CVS Caremark	Two-Party	$311.26	$622.52	$631.86	50.4%	$1,254.38
RSN Chiropractic	Family	$403.33	$806.66	$818.54	50.4%	$1,625.20
PPO - 80/20 Plan - HMSA Medical	Self	$84.28	$168.56	$252.84	60.0%	$421.40
Prescription Drug - CVS Caremark	Two-Party	$210.62	$421.24	$631.86	60.0%	$1,053.10
RSN Chiropractic	Family	$272.85	$545.70	$818.54	60.0%	$1,364.24
PPO - 75/25 Plan - HMSA Medical	Self	$54.10	$108.20	$252.84	70.0%	$361.04
Prescription Drug - CVS Caremark	Two-Party	$135.19	$270.38	$631.86	70.0%	$902.24
RSN Chiropractic	Family	$175.08	$350.16	$818.54	70.0%	$1,168.70
HMSA HMO	Self	$160.96	$321.92	$252.84	44.0%	$574.76
Prescription Drug - CVS Caremark	Two-Party	$402.58	$805.16	$631.86	44.0%	$1,437.02
RSN Chiropractic	Family	$521.79	$1,043.58	$818.54	44.0%	$1,862.12
HMO - Kaiser Comprehensive Medical	Self	$94.80	$189.60	$252.84	57.1%	$442.44
Kaiser Prescription Drug	Two-Party	$239.50	$479.00	$631.86	56.9%	$1,110.86
RSN Chiropractic	Family	$310.76	$621.52	$818.54	56.8%	$1,440.06
HMO - Kaiser Standard Medical	Self	$28.50	$57.00	$252.84	81.6%	$309.84
Kaiser Prescription Drug	Two-Party	$72.93	$145.86	$631.86	81.2%	$777.72
RSN Chiropractic	Family	$94.71	$189.42	$818.54	81.2%	$1,007.96
Supplemental - Royal State National	Self	$8.51	$17.02	$25.52	60.0%	$42.54
Supplemental Prescription Drug	Two-Party	$21.13	$42.26	$63.40	60.0%	$105.66
RSN Chiropractic	Family	$23.49	$46.98	$70.48	60.0%	$117.46
DENTAL PLAN						
	Self	$6.27	$12.54	$18.82	60.0%	$31.36
HDS Dental	Two-Party	$12.55	$25.10	$37.62	60.0%	$62.72
	Family	$12.55	$25.10	$78.04	75.7%	$103.14
VISION PLAN						
	Self	$1.30	$2.60	$3.90	60.0%	$6.50
VSP Vision	Two-Party	$2.41	$4.82	$7.20	59.9%	$12.02
	Family	$3.14	$6.28	$9.42	60.0%	$15.70
LIFE INSURANCE						
USAble Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

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Definitions

Premiums – The semi-monthly or monthly amount paid for your health insurance. Premiums are primarily influenced by utilization of services by the members, benefit plan design, and the cost of healthcare. For active employees under a collective bargaining agreement, the employer contribution to your premium is negotiated by your employee organization/union.

Eligible charge – The lower of the participating provider's actual charge or the amount the plan establishes as the maximum allowable fee (the maximum amount that the plan will pay for the covered services or supplies). This is the amount on which your coinsurance is based.

Copayment – A fixed amount (for example, $15) you pay for a covered service, usually when you receive the service. The amount can vary by plan and the type of covered service.

Coinsurance – Your share of the costs of a covered service, calculated as a percent (e.g. for most services under the HMSA 90/10 PPO medical plan, coinsurance is 10%) of the eligible charge. For example, if the plan's eligible charge for a primary care office visit is $100, your coinsurance payment of 10% would be $10. The plan pays the remainder of the eligible charge or $90 in this example.

Deductible – The amount you must pay for covered services before your plan begins to pay. For example, if you select the self EUTF HMSA 75/25 PPO medical plan your deductible is $300. For services that the deductible applies to (e.g. inpatient hospital services), you must pay the first $300 in eligible charges. Once the $300 deductible is met, the plan benefits begin (e.g. for eligible charges, you will pay your copayment or coinsurance and the plan will pay the remainder). The deductible does not apply to all services.

Out-of-Pocket Costs – Costs paid by the member related to deductibles, copayments and coinsurance for services. Out-of-pocket costs exclude premiums.

Maximum Out-of-Pocket Limits (MOOP) – The most you pay during a calendar year before your health insurance or plan starts to pay 100% for covered essential health benefits. This limit includes deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This limit does not include premiums, additional amounts for nonparticipating providers and other out-of-network charges, or spending for non-essential health benefits. The MOOP protects the members from catastrophic losses.

In-Network or Participating Provider – A physician, hospital, pharmacy, laboratory, or other healthcare provider your insurance carrier has contracted with to provide services at a negotiated fee or eligible charge rate. In most cases, participating providers are preferable to non-participating providers because of the lower out-of-pocket costs to the member.

Out-of-Network or Nonparticipating Provider – A physician, hospital, pharmacy, laboratory or other healthcare provider who has <u>not</u> contracted with your insurance carrier to provide services. When you receive services from a nonparticipating provider, you owe the plan's standard copayment or co-insurance plus the difference between the nonparticipating provider's charge for the services and your insurance carriers' eligible charge.

For example, if the nonparticipating provider's charge for a primary care office visit is $120, the plan's eligible charge is $100 and coinsurance is 10%, the plan will pay $90 ($100 * 90%) and you would pay $30 ($10 coinsurance plus $20 for the excess of the actual charge over the eligible charge). If the primary care provider was a participating provider, your total cost would be $10.

MEDICAL PLANS

Preferred Provider Organization (PPO) – A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network (participating providers). You can use doctors, hospitals, and providers outside of the network for an additional cost. Most of HMSA's EUTF and HSTA VB medical plans are PPO plans.

Health Maintenance Organization (HMO) – A type of health insurance plan that usually limits coverage to care from medical providers who work for or contract with the HMO. A HMO generally won't cover out-of-network care except in emergency situations. HMOs often provide integrated care and focus on prevention and wellness. Kaiser Permanente and one EUTF active employee medical plans are HMO plans.

Primary Care Provider (PCP) – A provider (usually an internist, family/general practitioner or pediatrician) who provides a range of services such as prevention, wellness, and treatment for common illnesses. PCPs often maintain long-term relationships with you, and advise and treat you on a range of health related issues. PCPs may also coordinate your care with specialists.

Specialist – A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

PRESCRIPTION DRUG PLAN

Generics – A prescription drug that has the same active-ingredient formula as a brand-name drug. The color or shape may be different, but the active ingredients must be the same. Generic drugs usually cost significantly less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

For prescription drug coverage under Kaiser Comprehensive and Standard plans:

1) Tier 1 Generic - Generic drugs for chronic conditions - Not all generic drugs used for the treatment of chronic conditions are considered generic maintenance drugs.

2) Tier 2 Generic - Generic drugs not covered in Tier 1

Brand Name – A prescription drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand prescription drugs are either preferred or other brand/non-preferred. You will pay more if you use other brand/non-preferred drugs than preferred or generic prescription drugs.

Formulary – A list of prescription drugs covered by a prescription drug plan. A formulary is also called a drug list. The formulary is normally updated quarterly for the active employee and the non-Medicare retiree plans and annually for the Medicare retiree plans.

INSTRUCTIONS FOR COMPLETING FORM EC-1

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

Submit the Form EC-1 to your Personnel Office or Department Personnel Officer (DPO) for verification, signature, and routing to EUTF within 30 days (180 days for newborns) of the event date. For DOE Employees: You must submit your EC-1 form to the DOE-HBAU Office at PO Box 2360, Honolulu, HI 96804.

SECTION 1 - EMPLOYEE DATA

1. Enter your Last Name, First Name, and Middle Initial.
2. Enter your contact information.
3. Enter your address information. If your **residence** address differs from your **mailing** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the New Hire/Newly Eligible box if:
   A) You are a new employee; and enter the effective date you were hired, or
   B) Your employment status is changing from part time (25% FTE) to full time (50% -100% FTE) employment; and enter the effective date you will become full time.
5. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
6. Mark the Termination box if you are terminating your employment, and enter your last day of employment.
7. If you are enrolling with the EUTF for the first time, you are required to provide your Social Security Number and your dependent(s) Social Security Number.
8. Enter your gender and birth date. If enrolling for the first time, EUTF is unable to process your paperwork without a gender and a birth date.
9. Mark the Qualifying Event During the Plan Year box if you have made any changes during the year, and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Change in Public Employer, Transfer In/Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
10. If you are Married, in a Civil Union, or Domestic Partnership, please be sure to check the appropriate boxes and include the date you were Married, entered into a Civil Union, or entered into a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health or your marriage certificate. If you do not receive the certificate within 60 days of the date of the event, contact the EUTF. A notarized Declaration of Domestic Partnership form is required (form is available on the EUTF website).
11. Special Note: If your Spouse, Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her Name, Date of Birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND DEDUCTION START SELECTION

1. If the "Qualifying Event" that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, New Hire, Newly Eligible, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contributions start 1st day of the pay period in which the effective date of coverage occurs) will be the default option selected.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the "Cancel/Waive" box for each plan that you choose not to select. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.
3. To be eligible for the Royal State Supplemental plan coverage, you must have other medical coverage from another source, not including this employer.
4. The RSN ChiroPlan is included with all medical plans, including the Royal State Supplemental plan.
5. Life insurance is provided for the employee only.
6. FOR STATE EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://dhrd.hawaii.gov. Please inquire with your DPO or DHRD on completing a PCP-2 form.
   -Mark one of the following boxes: ☐ Enroll, ☐ 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 on available options.

INSTRUCTIONS FOR COMPLETING FORM EC-1 (continued)

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number (SSN). Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the SSN blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1.
2. Use the following Relationship codes:

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

3. For Relationship codes with a √ or √√ or √√√ or √√√√, please see below for other required forms.
4. Other EUTF and/or DRHD forms to include with EC-1 (if applicable):

√ Marriage or Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable) and Affidavit of "Dependency" for Tax Purposes for Civil Unions

√√ Legal documents for guardianship or foster child

√√√ EUTF Declaration of Domestic Partnership and Affidavit of "Dependency" for Tax Purposes

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

√√√√√ Student certification if enrolling dependent age 19-23 in dental and/or vision plans

5. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF through your employer within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. Additions of a Civil Union Partner or a Domestic Partner are permitted outside of Open Enrollment. For a New Civil Union submitted within 30 days from the date of the civil union, the effective date of coverage is based on the event date. For a New Domestic Partner submitted within 30 days from the date of notarized signature, the effective date of coverage is based on the date of the notary. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
6. Gender – Write/type either M or F.
7. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
8. Dependent and Student certification. 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 on school letterhead, signed by the registrar, as required by the EUTF.

SECTION 5 – OTHER INSURANCE INFORMATION

1. If you selected the Royal State Supplemental plan, you are required to complete this section.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).

Note: To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must have health coverage through another source, not including this employer.

SECTION 6 - EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from your salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

You must submit the EC-1 through your personnel office. Your personnel office confirms that you are a current employee and are eligible for health benefits through the EUTF. Your personnel office will forward your EC-1 to EUTF.

For DOE Employees: You must submit your EC-1 form to the DOE-HBAU Office at PO Box 2360, Honolulu, HI 96804.

EMPLOYER VALIDATION **[for EMPLOYER USE ONLY]**

1. Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education, 010022 for University of Hawaii, 010053 for Budget and Finance, etc.
2. Department and Division/School - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. Enter the date the EC-1 was received from the employee. The date recorded should be the date that the **employer** received the Form EC-1, not the date the DPO / employer designee received it.
5. Please provide contact phone and fax numbers.
6. DPO / employer designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1 was signed by the DPO / employer designee.

INSTRUCTIONS FOR COMPLETING FORM EC-1H

Use of this form is for members currently enrolled in the HSTA VB plans. If you are not currently enrolled in the HSTA VB plans, please use the EC-1 form.

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

Submit the completed Form EC-1H to your Personnel Office (DOE-HBAU) at PO Box 2360, Honolulu HI 96804) or your Charter School Personnel Office for verification, signature, and routing to EUTF within 30 days (180 days for newborns) of the event date.

SECTION 1 - EMPLOYEE DATA

1. Enter your Last Name, First Name, and Middle Initial.
2. Enter your contact information.
3. Enter your address information. If your **residence** address differs from your **mailing** address, you must enter both addresses to ensure that correspondence reaches you.
4. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
5. Mark the Termination box if you are terminating your employment, and enter your last day of employment.
6. Enter your gender and birth date. EUTF is unable to process your paperwork without a gender and a birth date.
7. Mark the Qualifying Event During the Plan Year box if you have made any changes during the year, and enter the date of the event. The following are the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, Retirement, Death, Change in Public Employer, Transfer In/Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a birth and an address change, enter Birth in the event section.
8. If you are Married, in a Civil Union, or Domestic Partnership please be sure to check the appropriate boxes and include the date you were Married, entered into a Civil Union, or entered into a Domestic Partnership. You must attach a copy of your civil union certificate received from the Department of Health or your marriage certificate. If you do not receive the certificate within 60 days of the date of the event, contact the EUTF. A notarized Declaration of Domestic Partnership form is required (form is available on the EUTF website).
9. Special Note: If your Spouse or Civil Union Partner or Domestic Partner is a State or County Employee or Retiree, please provide his/her Name, Date of Birth and Social Security Number on the corresponding line. Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment). In addition, if you and your spouse, domestic partner or civil union partner are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), Hawaii Revised Statutes (HRS). However, both employee-beneficiaries are able to select EUTF Self-only plans. If your Spouse/Civil Union Partner/Domestic Partner has coverage outside of the EUTF that provides family coverage, this rule does not preclude you from also enrolling in a EUTF family coverage plan to cover your Spouse/Civil Union Partner/Domestic Partner. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

SECTION 2 – COVERAGE AND DEDUCTION START SELECTION

1. If the “Qualifying Event” that applies to you is listed in Section 2 [Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, Civil Union, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)], you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contributions start 1st day of the pay period in which the effective date of coverage occurs) will be the default option selected.

SECTION 3 – PLAN SELECTION

Mark all plans you are enrolled in/want to enroll in.

1. Carefully review each selection that you make. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan that you select.
2. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the “Cancel/Waive” box for each plan that you choose not to select. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.
3. The RSN ChiroPlan and Vision Service Plan (VSP) for vision are included with all medical plans.
4. Life insurance is provided for the employee only.
5. FOR STATE EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://dhrd.hawaii.gov. Please inquire with your Personnel Office (DOE-HBAU), Charter School or DHRD on completing a PCP-2 form

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

INSTRUCTIONS FOR COMPLETING FORM EC-1H (continued)

Please print clearly or type your name in the top right corner of page 2 of 2.

SECTION 4 - DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number (SSN). Social Security Number is not a required field when submitting an initial EC-1H for new birth. Please be sure to submit an EC-1H to update our records for your newborn once the information is received/issued by the Social Security Administration. Otherwise, you may leave the SSN blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 6 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of white letter sized paper to your EC-1H.
2. Use the following Relationship codes:

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

3. For Relationship codes with √ or √√ or √√√ or √√√√, please see below for other required forms.
4. Other EUTF and/or DRHD forms to include with EC-1H (if applicable):
   √ Marriage or Civil Union Certificate issued by the State of Hawaii Department of Health (printed copies of the temporary on-line certificate are acceptable), and Affidavit of "Dependency" for Tax Purposes for Civil Unions
   √√ Legal documents for guardianship or foster child
   √√√ EUTF Declaration of Domestic Partnership and Affidavit of "Dependency" for Tax Purposes
   √√√√ Disability Certification for Dependent Children (Form D-1) for enrolling a disabled child
   √√√√√ Student certification if enrolling child age 19-23 in dental and/or vision plans
5. If you are enrolling a Civil Union Partner (and Civil Union Partner's children) or Domestic Partner (and Domestic Partner's children), you are required to complete all required forms in accordance with the instructions for Civil Union Partner or Domestic Partner. You are responsible to obtain, complete and submit all necessary documentation to the EUTF through your employer within 30 days from your event date. Failure to do so will result in no action taken on your Civil Union Partner or Domestic Partner coverage. Additions of a Civil Union Partner or a Domestic Partner are permitted outside of Open Enrollment. For a New Civil Union submitted within 30 days from the date of the civil union, the effective date of coverage is based on the event date. For a New Domestic Partner submitted within 30 days from the date of notarized signature, the effective date of coverage is based on the date of the notary. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding Civil Union Partnership or Domestic Partnership.
6. Gender – Write/type either M or F.
7. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
8. Dependent and Student certification. 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 on school letterhead, signed by the registrar, as required by the EUTF.

SECTION 5 - EMPLOYEE AUTHORIZATION AND SIGNATURE

Your signature certifies that the information provided in this application is true and complete. You also agree to abide by the terms and conditions of the benefit plans selected. You are authorizing your employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from your salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

For Charter School Employees: You must submit the EC-1H through your personnel office. Your personnel office confirms that you are a current employee and are eligible for health benefits through the EUTF. Your personnel office will forward your EC-1H to EUTF.

For DOE Employees: You must submit your EC-1H to the DOE-HBAU Office at P O Box 2360, Honolulu, HI 96804.

EMPLOYER VALIDATION **[for EMPLOYER USE ONLY]**

1. Department ID # - please enter your appropriate Department ID code; for example, 010021 for Department of Education.
2. Department and School/Office - Please enter the appropriate information.
3. Bargaining Unit number - Please enter the appropriate bargaining unit for this employee.
4. Enter the date the EC-1H was received from the employee. The date recorded should be the date that the **employer** received the Form EC-1H, not the date the Personnel Office (DOE-HBAU) or Charter School / employer designee received it.
5. Please provide contact phone and fax numbers.
6. Personnel Office (DOE-HBAU) or Charter School / employer designee signature certifies that the employee-beneficiary is eligible for coverage through the EUTF as defined in Chapter 87A, Hawaii Revised Statutes.
7. Enter date the EC-1H was signed by the Personnel Office (DOE-HBAU) or Charter School / employer designee.

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: HBAU 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)

_____

Home Phone (____) _____
Mobile Phone (____) _____
Work Phone (____) _____

Email _____

Mailing Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

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

____/____/_____

☐ Open Enrollment (effective 07/01/2016)

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

____/____/_____

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

_____

Gender ☐ Male ☐Female
Birth Date: (MM/DD/YYYY)

____/____/_____

☐ 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, 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: _____ DOB: ____/____/_____ 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 — 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, RSN Chiro	☐	☐	☐	☐
	PPO-80/20 HMSA Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	PPO-75/25 HMSA Medical, CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
HMO	HMO-HMSA CVS Prescription Drug, RSN Chiro	☐	☐	☐	☐
	HMO-Kaiser Standard Prescription Drug, RSN Chiro	☐	☐	☐	☐
	HMO-Kaiser Comprehensive Prescription Drug, RSN Chiro	☐	☐	☐	☐
Supplemental	Supplemental- Royal State National Insurance Company (Includes Supplemental Drug Coverage), Chiro *** To be eligible for coverage under the Royal State Supplemental plan, you and your eligible dependent(s) must be covered under a non- EUTF health plan. See Section 5 on "Instructions for Completing Form EC-1"	☐	☐	☐	☐

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

For STATE Employees ONLY: 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.

Employee's Name _____

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

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

Continue Coverage	Add	Delete	Dependent: Last Name, First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐

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

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

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

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

EC-1H Rev. April 2016	Hawaii Employer-Union Health Benefits Trust Fund	Please submit this completed form to the DOE-HBAU Office at: P O Box 2360 Honolulu HI 96804 Or Charter School Personnel Office

EC-1H: Enrollment Form for HSTA VB Active BU 05/45 Employees

DUE DATE: This form must be submitted to the DOE-HBAU within 30 days (180 days for newborns) of the event date.

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-1H"

Name (Last Name, First Name, Middle Initial)

_____

Home Phone (_____) _____
Mobile Phone (_____) _____
Work Phone (_____) _____

Email _____

Mailing Address (☐ Check this box if your address has changed)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

Residence Address (if different from above)

Street _____

Line 2 _____

City _____ State _____ Zip Code _____

☐ Open Enrollment (effective 07/01/2016)

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

_____/_____/_____

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

_____

Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY)

_____/_____/_____

☐ 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)

_____ / _____ / _____

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: _____ DOB: _____/_____/_____ 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, 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 — 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, Vision, RSN Chiro	☐	☐	☐	☐
	PPO-80/20 HMSA Medical, CVS Prescription Drug, Vision, RSN Chiro	☐	☐	☐	☐
HMO	HMO-Kaiser Comprehensive Medical, Prescription Drug, Vision, RSN Chiro	☐	☐	☐	☐

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

For STATE Employees ONLY: 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.

Employee's Name _____

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

Please list all dependents you want enrolled

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

Continue Coverage	Add	Delete	Dependent: Last Name, First Name, Middle Initial	Birth Date (MM/DD/YYYY)	Social Security Number **	Relationship *	Gender M / F	Medical/ Drug	Dental	Vision
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐
☐	☐	☐		/ /				☐	☐	☐

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

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

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

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

SECTION 5: 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: _____ Date Signed: _____

Department ID#	Department	School/Office	Bargaining Unit
Date EC-1H Received in DOE-HBAU/Charter School (or employer designee's) / /		DOE-HBAU/Charter School Phone Number	DOE-HBAU/Charter School Fax Number
DOE-HBAU/Charter School (or employer designee's) Printed Name DOE-HBAU/Charter School (or employer designee's) Signature:			Date of DOE-HBAU/Charter School Signature / /
Remarks:			

FORMS SUBMITTED TO YOUR EMPLOYER'S OPEN ENROLLMENT DESIGNEE AFTER FRIDAY, APRIL 29, 2016 WILL BE REJECTED

Contact Information

For Questions About	Please Contact
Eligibility & EUTF Information	**eutf@hawaii.gov** EUTF Customer Service Call Center 808-586-7390 or Toll Free: 1-800-295-0089 Monday through Friday, 7:45 a.m. – 4:30 p.m. HST
CVS/caremark (CVS)	**www.caremark.com/** **www.caremark.com/eutf/** 1-855-801-8263 TTY - 711 (24 hours a day, 7 days a week) Walk-in Service: Pauahi Tower 1003 Bishop Street, Suite 704 Hours of Operation: Monday – Friday 7:45 a.m. – 4:30 p.m. HST
Hawaii Dental Service (HDS)	**www.hawaiidentalservice.com** 808-529-9310 or Toll Free: 1-866-702-3883 Over the phone: Monday through Friday, 7:00 a.m. – 7:00 p.m. HST, Saturday 9:00 a.m. – 1:00 p.m., except Federal and State observed holidays Walk In Hours Monday through Friday, 8:00 a.m. – 4:30 p.m., except Federal and State observed holidays Office located: Topa Financial Center, Bishop Street Tower, 700 Bishop Street, Suite 700
Hawaii Medical Service Association (HMSA)	**www.hmsa.com/eutf** **On Oahu:** Walk in service at our Downtown office (City Financial Tower, 18th floor) Monday through Friday, 8 a.m. – 4 p.m. HMSA Center @ Honolulu is open Monday through Friday, 8 a.m. – 6 p.m. and on Saturday from 9 a.m. – 2 p.m. HMSA Center @ Pearl City is open Monday through Friday, 9 a.m. – 7 p.m. and Saturday from 9 a.m. – 2 p.m. Or call customer service at 808-948-6499 Monday through Friday, 7 a.m. – 7 p.m. HMSA Center @ Honolulu - 818 Keeaumoku St. HMSA Center @ Pearl City - Pearl City Gateway 1132 Kuala St., Suite 400 **On Hawaii Island:** Walk in service at our HMSA Center @ Hilo, Monday through Saturday, 9 a.m. – 7 p.m., and Saturday, 9 a.m. – 2 p.m. Our Kailua Kona office is open Monday through Friday from 8 a.m. – 4 p.m. Or call our Kona office at 808-329-5291 during those hours. HMSA Center @ Hilo - Waiakea Center 303A E. Makaala St. Kailua Kona office - 75-1029 Henry St., Suite 301 **On Maui:** Walk in service at our Kahului office, Monday through Friday from 8 a.m. – 4 p.m. Or call our Kahului office at 808-871-6295 during those hours. Kahului office - 33 Lono Ave., Suite 350 **On Kauai:** Walk in service at our Lihue office, Monday through Friday from 8 a.m. – 4 p.m. Or call our Lihue office at 808-245-3393 during those hours. Lihue office - 4366 Kukui Grove St., Suite 103 **From any island:** Call Toll Free 1-800-776-4672, Monday through Friday from 7 a.m. – 7 p.m.

For Questions About	Please Contact
Kaiser Permanente (Kaiser)	**www.kp.org/eutf** 808-432-5955 (Oahu) or Toll Free: 1-800-966-5955 (Neighbor Islands) Monday through Friday, 7:00 a.m. – 7:00 p.m. HST Saturdays 8:00 a.m. – 1:00 p.m. HST Walk-in Service: 711 Kapiolani Blvd Honolulu, HI 96813 Monday through Friday, 8:00 a.m.– 4:30 p.m. excluding State observed holidays.
Royal State National (RSN)	**Chiropractic Benefit** 808-621-4774 or Toll Free: 1-800-414-8845 **www.chiroplanhawaii.com** Monday through Friday, 7:00 a.m. – 7:00 p.m. HST; Saturdays 9:00 a.m. – 1:00 p.m. HST, excluding State observed holidays Walk-in Service: ChiroPlan Hawaii, Inc. 711 Kilani Avenue, Suite 3 Wahiawa, HI 96786 **Monday through Friday, 8:00 a.m. – 4:30 p.m. excluding State observed holidays.** **Supplemental Plan** 808-539-1621 or Toll Free: 1-888-942-2447 **www.royalstate.com** Monday through Friday, 7:00 a.m. – 7:00 p.m. HST Saturdays 9:00 a.m. – 1:00 p.m. HST, excluding State observed holidays. Walk-in Service: Royal State Insurance 819 S. Beretania Street Honolulu, HI 96813 **Monday through Friday, 8:00 a.m. – 4:30 p.m. excluding State observed holidays.**
USAble Life	**www.usablelife.com/portal/eutf** 808-538-8920 or Toll Free 1-855-207-2021 (Monday through Friday, 7:45 a.m. – 4;30 p.m. except State observed holidays) Walk-in Service: First Hawaiian Bank Building 999 Bishop St. Suite 2701 Honolulu, HI 96813 Questions may be sent to us via email. General Customer Service inquiries - EUTF.custserv@usablelife.com Claims Inquiries – EUTF.claims@usablelife.com

For Questions About	Please Contact
Vision Service Plan (VSP)	**www.vsp.com** Toll Free: 1-866-240-8420 <u>As of Sunday 3/13/16 – Daylight Savings BEGINS:</u> (Monday through Friday, 2:00 a.m. – 5:00 p.m. HST Saturdays 4:00 a.m. – 5:00 p.m. HST Sundays 4:00 a.m. – 4:00 p.m. HST) <u>Effective Sunday 11/6/16 – Daylight Savings ENDS:</u> (Monday through Friday, 3:00 a.m. – 6:00 p.m. HST Saturdays 5:00 a.m. – 6:00 p.m. HST Sundays 5:00 a.m. – 5:00 p.m. HST) Oahu: 808-532-1600 or Toll Free: 1-800-522-5162 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST) Walk-in Service: 1003 Bishop St., #890 Honolulu, HI 96813

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