Health Benefits
Retiree Reference Guide
(EUTF and HSTA VB)

Retiree Benefit Plans
Effective January 1, 2018 - December 31, 2018

Medicare Part B information enclosed
See page 2 for more information on this important topic

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

Aloha Retirees,

We are pleased to present the 2018 Reference Guide for Retirees. This Reference Guide provides information on the health benefit plans available to you for the calendar year January 1, 2018 through December 31, 2018. You may make changes to your enrollment in these plans during the October 9-31, 2017 open enrollment period or if you have a qualifying event during the year. Any changes you make during open enrollment will take effect on January 1, 2018.

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

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

Newly available is the ability for retirees to pay their monthly premiums electronically. See page 22 for additional information.

This Reference Guide is also posted on the EUTF website at eutf.hawaii.gov. If you need any assistance, please call one of our helpful staff at 1-808-586-7390 or toll-free at 1-800-295-0089.

Mahalo,

Gordon Murakami, Chair EUTF Board of Trustees

IMPORTANT

Mandatory Medicare Part B Enrollment

All Medicare Eligible Retirees and Covered Dependents

The Hawaii Revised Statutes 87A-23(4) requires that State and county retirees and their eligible dependents who are enrolled in EUTF retiree medical and/or prescription drug benefits plans, must be enrolled in Medicare Part B when they become eligible. Active employees considering retirement who are eligible for Medicare should enroll in Medicare Part B prior to retirement to ensure that their Medicare Part B is effective on the date of their retirement in order to participate in any EUTF retiree medical and/or prescription drug plans.

Proof of Medicare Part B Enrollment

If you do not provide proof of Medicare Part B enrollment to the EUTF within 60 days of becoming eligible or enrolling into an EUTF retiree medical and/or prescription drug plan, your and/or your dependent's EUTF retiree medical and/or prescription drug plans **will be cancelled**. Please note that your Medicare eligible dependents must be enrolled in Medicare Part B in order to be covered under the EUTF retiree medical and/or prescription drug plan regardless of whether they are retired or actively working.

Documentation Submission

If you and/or your dependent(s) are Medicare eligible (age 65+ or qualified disabled) and covered under EUTF retiree medical and/or prescription drug plans you must submit the following to the EUTF:

- Copy of your and/or your dependent's Medicare card (indicating enrollment in Medicare Part B)
- Direct Deposit Agreement Form
- Social Security Administration or Centers for Medicare and Medicaid Services letter for you and/or your spouse/partner indicating the Medicare Part B premium amount

More information can be found under the Medicare section on page 75.

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Introduction

The Hawaii Employer-Union Health Benefits Trust Fund or more commonly known as the **EUTF** provides medical, prescription drug, dental, vision, and life insurance benefits to all eligible State of Hawaii, City and County of Honolulu, Board of Water Supply, County of Hawaii, County of Maui and County of Kauai employees, retirees and their qualified dependents.

The EUTF is a State agency administratively attached to the State of Hawaii Department of Budget and Finance and is governed by a ten member, governor-appointed board of trustees.

The EUTF is responsible for designing the health benefit plans (e.g. coinsurance, copayments and deductibles) subject to federal and state regulations, contracting with insurance carriers and pharmacy benefit managers to provide the services, and developing and/or negotiating premium rates.

If you have any questions regarding the information provided in this guide, you may contact the EUTF Customer Call Center at 1-808-586-7390 or toll-free at 1-800-295-0089 for clarification.

Disclaimer

This Guide offers general information on your health and other benefit plans which are exclusively governed by the Hawaii Revised Statutes, the EUTF Administrative Rules as they are amended from time to time and the carrier plan documents all of which are available at eutf.hawaii.gov. Nothing in this Guide is intended to amend, change, or contradict these documents. 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.

Individuals with Special Needs

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 1-808-586-7390 or toll-free at 1-800-295-0089 for special needs.

New Retirees

If you recently retired from the State or counties, congratulations on your retirement!

This section includes a list of required forms to enroll in retirement health benefits, step-by-step instructions outlining the retiree health benefit enrollment process and information on determining the employer premium contribution.

Required Forms for New Retirees

The following is a list of documents you will need to submit to the EUTF in order to obtain your retiree health and life insurance benefits. The EC-2 form and Direct Deposit Agreement form may be found in the back of this Guide or online at eutf.hawaii.gov/forms.

After filing your retirement application with the Employees' Retirement System (ERS), please submit the following to the EUTF:

- ERS Retirement Estimate Letter
- EUTF EC-2 Enrollment Form (due within 60 days of retirement date)

If you, your spouse/partner or any other dependents are enrolled in the EUTF retiree medical and/or prescription drug plans and eligible for Medicare (age 65+ or qualified disabled) you must also submit:

- Copy of your and/or your dependent's Medicare card (indicating enrollment in Medicare Part B)
- Direct Deposit Agreement Form
- Social Security Administration or Centers for Medicare and Medicaid Services letter for you and/or your spouse/partner indicating the Medicare Part B premium amount

Optional forms:

- HIPAA Authorization for Release of Protected Health Information
- USAble Life Group Term Life Insurance Beneficiary Designation Form – it is recommended that you complete and return a USAble Life Beneficiary Designation form to USAble Life to ensure that you have the correct beneficiary on file

Step-by-Step Instructions for New Retirees

Step 1

Applying for your EUTF Retiree HealthInsurance Benefits:

The EUTF administers your health and life insurance benefits. After filing your retirement application with the ERS, please submit an EC-2 form to the EUTF to enroll in your retiree health and life insurance benefit plans and a copy of your ERS Retirement Estimate Letter.

Step 2

Completing the EC-2 Enrollment Form:

A copy of the EC-2 form and instructions on how to complete the EC-2 form can be found in the back of this Guide. Complete the EC-2 form, sign and submit it to the EUTF within 60 days of your retirement date. Do not submit the EC-2 form until you are certain that you are retiring.

Step 3

Hawaii Revised Statutes:

Hawaii Revised Statues specify that if both you and your spouse/partner are employees and/or retirees of the State of Hawaii or one of the counties, you may enroll in one Family or Two-party plan, or two Self plans.

If your spouse/partner is an employee of the State of Hawaii or one of the counties and you are going to cover your spouse/partner on your retiree plan, your spouse/partner must notify his/her departmental human resource officer or enrollment designee to cancel his/her active employee plans.

If your spouse/partner is a retiree of the State of Hawaii or one of the counties and you are the only dependent listed on your spouse/partner's retiree plan, you may split your plans and enroll in two Self plans or enroll in a Two-party plan. Please check the rates and worksheets starting on page 71 to determine which option is less costly. If you and your spouse/partner decide to enroll in two Self plans, you will both have to fill out an EC-2 form to enroll into Self plans. In addition, both you and your spouse/partner should enroll in the life insurance plan, if enrolling in a Two-party plan, which is paid for by the employer for retirees only.

Step 4

Medicare Part B (Age 65+ or qualified disabled):

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

Retirees and/or their spouse/partner that are enrolled in Medicare must also submit a completed Direct Deposit Agreement form, and the letter from the Social Security Administration indicating your Medicare Part B premium amount. The Direct Deposit Agreement forms may be found at the back of this Guide.

Medicare Part B premiums, excluding any penalties, are reimbursable to all retirees and their spouse/partner, provided you are paying for your Medicare Part B premium and it is not being paid by another entity such as the Medicare Savings Program or Medicaid. Reimbursement begins the later of the effective date of your Medicare Part B coverage or the first day of the month that you provide EUTF with a copy of your Medicare Part B card, a valid Direct Deposit Agreement Form and the letter from Social Security or the Centers for Medicare and Medicaid Services indicating the Medicare Part B premium amount. See page 81 for more information.

Step 5

Canceling your Retirement:

If you decide to cancel your retirement or change the date of your retirement, you must notify your departmental human resource officer or enrollment designee immediately and have them send EUTF an EC-1 form (or EC-1H form for HSTA VB) to re-activate your employee plans.

Step 6

Life Insurance:

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

Determination of Employer Contribution for Retiree Plans

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

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

ERS Retirement Estimate Letter

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

Base Monthly Contribution (BMC)

The BMC is the maximum allowable amount employers will contribute towards retiree health plan premiums. The employer's contribution as a percentage of the BMC varies depending on a retiree's:

- Medicare enrollment
- Coverage tier (Self, Two-party, Family)
- Hire date (ERS Membership date)
- Length of service, taking into account breaks in service and excluding sick leave

The BMC may be adjusted every January 1st depending on the percentage increase or decrease in the Medicare Part B premium rate from the previous year. Since the Medicare Part B premium rate is published later in the year, retirees may refer to the EUTF website towards the end of the year for 2018 BMC amounts.

Retirees should refer to the Employer Contribution Table to determine the employer's contribution as a percentage of the BMC towards their health plan premiums.

Employer Contribution Table

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

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

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

Employer Contribution Percentages

If the retiree falls in the 100% category, they will most likely pay nothing. If the retiree falls in the 50% or 75% category, please complete the EUTF Retiree Premium Worksheet to determine the retiree's share of premiums. If the retiree falls in the 0% category, they will pay the full premium amount.

The retiree pays the difference between the total monthly premium for the plans selected and the amount of the employer contribution set by the BMC calculation. It is important to note that plan premiums usually increase each year and at some point some plan premiums may exceed 100% of the BMC. All retirees including those in the 100% category should review the plan premiums and the BMC amount annually to determine if they will be required to contribute to the cost of coverage.

The BMC is more fully described in Chapter 87A, Hawaii Revised Statutes.

Wellness Programs

The EUTF cares for the health and well-being of our beneficiaries and strives to provide quality health benefits for you and your family. A vital part of EUTF health benefits are our wellness programs. In most cases, these programs are offered to members at no cost and provide tools to help members get healthy and stay healthy. By taking advantage of these benefits, members can experience an increase in wellness and improvements in their overall quality of life. Please review the wellness programs in this section and contact your insurance carrier for information on how you can participate.

HMSA Members

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

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

Disease Management Services

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

QuitNet

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

HMSA's Online Care®

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

Health Coaching

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

What's your RealAge? *Download Sharecare to find out.*

You know your age, but do you know your body's age? The Sharecare app can tell you how old you really are. Download the app and take the RealAge® Test to discover your RealAge and how to improve it.

This clinically validated health-risk assessment asks questions about stress, relationships, and other factors known to predict lifespan. After you find out your RealAge, the app will give you personalized information and tools.

Download Sharecare today!

1. Register on hmsa.com/sharecare. If you're an HMSA member, please use your HMSA subscriber ID.

2. Download Sharecare. If you're asked for an activation code, enter greendays.
3. Take the RealAge Test to discover your body's age.

A web version is available if you don't have access to a smartphone or tablet. If you aren't an HMSA member, download the Sharecare app through the App Store or Google Play.

RealAge® is a registered mark of Sharecare, Inc.

Sharecare, Inc., is an independent company that provides health and well-being programs to engage members on behalf of HMSA.

Kaiser Permanente Members

Preventative Services. *Prevention makes good health possible!*

Many preventive screening tests are covered at no cost to you once per plan 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
- Cholesterol screening
- Blood pressure
- Screenings for breast cancer, cervical cancer, colon cancer
- Depression screening
- Type 2 diabetes screening for adults with high blood pressure
- Hepatitis B screening (for adults at higher risk)
- Hepatitis C screening (for adults born between 1945 and 1965)

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

Kaiser Permanente Fit Rewards. *Earn a free gym membership.*

EUTF non-Medicare retirees can join or renew at a participating gym and pay a $200 annual membership fee (no more monthly gym fees to worry about). Work out at your gym at least 45 days for a minimum of 30 minutes per session by December 31, 2018 and you'll get your $200 back.[1]

Choose a participating gym from our full list at kp.org/fitrewards. You can switch gyms within the network as often as monthly. Gym availability varies by island.

Silver&Fit Exercise and Health Aging Program. *Get moving and get healthy.*

When EUTF Medicare retirees enroll in Kaiser Permanente Senior Advantage, you automatically receive the Silver&Fit program as part of your Senior Advantage plan benefits. You can enroll in one of the following Silver&Fit program options:

- **Silver&Fit Fitness Facility Program** gives you access to a broad network of gyms. Take advantage of all the services and amenities your gym may offer, including cardiovascular and strength-training equipment and exercise classes.[2]
- **The Silver&Fit Home Fitness Program** lets you work out at home. Each year, choose up to 2 of our fitness kits, including: walking, yoga, tai chi, aquatic exercise, cardio strength, and more.

Visit silverandfit.com for more information.

Lifestyle 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 lifestyle coaching by phone. To schedule a convenient telephone session with your personal coach call 1-808-432-2260 or 711 (TTY), Monday – Friday 8:00 a.m. – 4:00p.m.

Online Wellness Programs. *Jump start your health online.*

With our online wellness programs, you'll get advice, encouragement, and tools to help you create positive changes in your life. Our complimentary programs can help you lose weight, eat healthier, quit smoking, reduce stress, and manage ongoing health conditions. Learn more at kp.org/healthylifestyles.

Not sure where to begin? Start with a Total Health Assessment, a simple online survey to give you a complete look at your health. Answer questions about yourself and get a customized action plan to prevent health problems and feel your very best. You can also print the results of your assessment to share and discuss with your doctor. Begin your assessment at kp.org/tha.

Join Health Classes. *Take charge of your health and inspire others.*

With all kinds of health classes and support groups offered right at our facilities, there's something for everyone. Classes vary at each location, and some may require a small fee. Visit kp.org/classes to find a class near you.

Enjoy Member Discounts. *Giving you complementary and alternative care options.*

Get reduced rates on a variety of health-related products and services through ChooseHealthy™. These include:

- Discounts at a contracted acupuncturist, chiropractor, and massage therapist
- Reduced rates on vitamins and supplements

You also have online exercise, nutrition, and healthy living resources to help assess and improve your health. Visit kp.org/choosehealthy.

Tobacco Cessation. *Break the habit for good!*

The tobacco cessation program is provided free of charge to members. Counselors are available by phone to provide quit support and guidance. You are also be eligible to receive free tobacco cessation medications at no cost with a doctor's prescription. To talk to a counselor, call 1-808-643-4622 or 711 (TTY) Monday – Friday 8:30 a.m. – 2:30 p.m.

[1] *Please consult with your own tax advisor about the taxability of the reimbursement. Kaiser Permanente Fit Rewards is available to all Kaiser Permanente Hawaii members, 16 years and older, excluding Medicare and Medicaid (QUEST Integration) members. Gym availability varies by island. Meet the 45-day, 30-minute a session activity requirement by December 31, 2018 to qualify for reimbursement. Reimbursement is limited to your Active&Fit annual program fee each benefit year. Taxes and additional fees you pay your gym for classes, services, or amenities are not included in the Active&Fit program and are not eligible for reimbursement. Except for earning your annual progr am fee back by exercising 45 days a year, for at least 30 minutes a session, your Active&Fit annual program fee is not reimbursable and will not be prorated. The Active&Fit Home Fitness Program annual fee is non-refundable and not eligible for reimbursement. Kaiser Permanente Fit Rewards is a value-added service and not part of your medical benefits. Your annual fee does not count toward your annual out-of-pocket maximum. Please see your Evidence of Coverage or kp.org/fitrewards for details, including condi tions, limitations, and exclusions.*

[2] *Any nonstandard fitness facility service that typically requires an additional fee is not included in your membership. Amenit ies offered by fitness facilities may vary by facility.*

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 or no low cost to members such as nicotine patches and other prescription medications.

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

More information about **Medicare** on page 75

FOR MEDICARE ELIGIBLE RETIREES AND DEPENDENTS

Medicare Prevention & Wellness Benefits

Medicare pays for an annual wellness visit, which includes the creation of a personalized prevention plan and detection of possible cognitive impairment.

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

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

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

Money Saving Tips

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

Pick the Right Facility

The emergency room (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 facility. Cost savings can be significant. For example, the total cost of a typical office visit is around $100 while an ER visit could cost $1,000 or more.

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

Participating Providers

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

Prescription Drug Benefits

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

Another great way to save money is by switching to mail order. In addition to saving money, mail order offers the added convenience of receiving your prescriptions at your doorstep saving you time and money by not having to make

regular trips to the pharmacy. For more information visit caremark.com or call CVS Customer Care toll-free at 1-855-801-8263 or 1-877-878-5715 for SilverScript Customer Care. 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 Kaiser Permanente or call the number on your prescription label.

What's New for 2018

IMPORTANT

UnitedHealthcare (UHC) Retiree Medical Plan

The EUTF UnitedHealthcare Group Medicare Advantage plan will **NO LONGER** be offered effective **January 1, 2018**.

Retirees and dependents enrolled in the EUTF UnitedHealthcare Group Medicare Advantage PPO medical plan (UHC) **will automatically be enrolled** in the EUTF HMSA 90/10 PPO medical plan effective January 1, 2018.

Retirees who wish to enroll in the EUTF Kaiser Senior Advantage plan or disenroll from all EUTF medical plans may do so during retiree open enrollment, October 9 – 31, 2017.

Electronic Payment Options for 2018

If you are currently paying your healthcare premiums via check to the EUTF, you now have three other payment options:

1. Monthly recurring electronic transfers from your bank account initiated and adjusted by the EUTF. No fees are charged. You must complete and submit to the EUTF, the EUTF ACH Deduction Authorization Agreement Form, which can be found at the end of this Guide.
2. Credit card for a fee of $2.50 plus 2.25% of the premium amount. Please visit the EUTF website at eutf.hawaii.gov and click on the link for Payment Options.
3. Electronic transfers from your bank account that you initiate for a fee of $3.50 per transaction. Please visit the EUTF website at eutf.hawaii.gov and click on the link for Payment Options.

HMSA HSTA VB Plans Only – Chiropractic Benefit

Effective **January 1, 2018,** HMSA HSTA VB plan members will have a new chiropractic benefit through American Specialty Health Group Inc. (ASH Group). ASH Group is contracted by HMSA to administer chiropractic benefits for HMSA HSTA VB medical plans.

Eligible retirees and their dependents in HMSA HSTA VB plans have access to ASH Group's chiropractic participating providers for a $12 copayment per visit with up to 20 medically necessary visits per calendar year. Present your HMSA membership card to the participating provider and pay your applicable copayment directly to the provider. There are no claim forms, deductibles, medical referrals, or additional paperwork to worry about. The contracted provider is responsible for verifying medical necessity and filing the claim directly to ASH Group. Services are approved for eligible expenses related to covered conditions.

Please see the plan's *Guide to Benefits* for more information on the chiropractic benefit. To find a provider, you can use the Find a Doctor tool on hmsa.com. For questions about eligibility, benefits, or claims, please call ASH Group Customer Service toll-free at 1-800-678-9133, 6 a.m. to 5 p.m., Monday through Friday, Hawaii Standard Time.

Kaiser Permanente HSTA VB Retiree Medical Plan – Chiropractic Benefit

Retirees and dependents enrolled in the Kaiser HSTA VB plan will receive chiropractic coverage through American Specialty Health Group, Inc. effective **January 1, 2018**. HSTA VB retirees get up to 20 visits per calendar year for a $12 copay. No referrals are required for chiropractic services. Visit http://www.ashlink.com/ash/KaiserHIC to find a participating chiropractor near you.

Plan Changes Effective January 1, 2017

EUTF and HSTA VB HMSA and Kaiser Medical Plans

1. Added coverage for gender identity services in accordance with federal and state law.
2. Removal of the dollar ($25,000) and age limit (under age 14) from the autism spectrum disorder benefit in accordance with federal law.
3. Removal of the age limit (under age 26) from the orthodontic services benefit for treatment of orofacial anomalies due to birth defects in accordance with federal law.

Important Enrollment Information

Open Enrollment

Now is the time when you can stop and think about health coverage for yourself and your family and determine which plan offered will best meet your needs. During the open enrollment election period you can:

- Add, change, or drop a plan
- Add or remove dependents
- Change coverage tiers, such as changing from Self to Family or Family to Two-party
- Now is also a good time to tell us if you've had a change of address

Open enrollment is your only opportunity to make changes without a qualifying event such as enrollment of a new dependent due to marriage or a birth. Paperwork must be postmarked by October 31, 2017 for changes to become effective January 1, 2018.

Important Dates

October 9 – 31, 2017	Open Enrollment Election Period
January 1, 2018	Premium changes take effect and the Base Monthly Contribution may change
January 1 - December 31, 2018	Retiree Plan Period

What You Need To Know

- What plans are you enrolled in? Who are the dependents enrolled on your plans? You may contact EUTF at 1-808-586-7390 or toll-free at 1-800-295-0089 to inquire about which EUTF or HSTA VB plans you are enrolled in.
- If you or your dependent are eligible for Medicare or will be this year: Review the Medicare section so you are aware of how this will affect your plans and the statutory Medicare Part B enrollment requirements.
- Learn what's being offered. Read this 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
- Mail your completed enrollment form to the EUTF on or before October 31, 2017. Postmark must be on or before October 31, 2017.

What You Need To Do

Step 1

Review the choices available to you. You can decide whether you want to change or keep your plans. If you decide to keep your current plans, do nothing. You are not required to complete any forms to keep your current plans. Remember though there is **one exception**: if you are enrolled in the EUTF UHC Medicare Advantage Plan, you will automatically be moved to the EUTF HMSA 90/10 PPO Medical Plan effective January 1, 2018. If you wish to enroll in the Kaiser Senior Advantage Plan or disenroll from all EUTF medical plans, you must complete and submit an EC-2 Enrollment Form.

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 30.

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

Step 3

Which Plans do you want to enroll in? Review this Guide and determine which health plans best meets your needs. The EUTF website, eutf.hawaii.gov,

includes links to insurance carriers' web pages along with the latest information regarding the open enrollment. Questions regarding specific plan provisions should be directed to the carriers (see page 128).

Step 4

How much will it cost you? The premium rates can be found beginning on page 71 of this Guide. Premium amounts show the full cost for each plan. If you pay a percentage of the cost, you will also need to review the 2018 BMC amount. More information can be found on "Determination of Employer Contribution for Retiree Plans" beginning on page 10. Keep in mind that the 2018 employer contribution amounts were not available at press time. Please visit the EUTF website at eutf.hawaii.gov in December for the 2018 employer contribution amounts.

Step 5

Who do you need to cover? You may add or remove dependents from your plan, including a spouse/partner or eligible children. Adding a spouse/partner requires additional documentation. Please refer to the "Eligibility" section beginning on page 86 for more information or visit the EUTF website at eutf.hawaii.gov.

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

Step 6

Complete the Enrollment Form: Make your selections on the EC-2 form or EC-2H for those already enrolled in the HSTA VB retiree plans.

See instructions in the back of this Guide.

Last Step

Submit the completed and signed form to the EUTF postmarked no later than October 31, 2017.

FORMS POSTMARKED AFTER OCTOBER 31, 2017 WILL BE REJECTED

The EUTF will send you an enrollment confirmation notice after processing of open enrollment forms is completed. The confirmation notice allows you a one-time opportunity to revise the changes you submitted. If you would like to amend your changes, notify the EUTF in writing within 15 calendar days of the date of the confirmation notice.

Although your coverage changes are effective on January 1, 2018, 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.

IMPORTANT: If any of your dependents are no longer eligible due toa divorce, legal separation, child is no longer a full-time student or is married, they cannot continue to be covered under EUTF or HSTA VB plans. You are required to notify the EUTF and make these terminations when these events occur. Do not wait for open enrollment to submit these terminations. If your child dependent is reaching the maximum age (24), disenrollment will occur automatically and an enrollment form is not necessary.

COBRA PARTICIPANTS

The COBRA Open Enrollment period is October 9 – 31, 2017. See COBRA Open Enrollment instructions on page 124.

HSTA VB Plans

Limited Enrollment

HSTA VB Plan options were created for HSTA retirees who were enrolled in the HSTA VEBA retiree plans prior to January 1, 2011. Membership in HSTA VB retiree plans are limited to only those currently enrolled and maintain continuous enrollment under HSTA VB retiree plans. HSTA VB members must complete an EC-2H enrollment form if making changes.

Leaving HSTA VB Plans

HSTA VB members have the option to leave HSTA VB plans for EUTF retiree plans during open enrollment, but will not be able to switch back to HSTA VB plans in the future. Members who wish to leave HSTA VB plans for EUTF plans will need to complete and submit an EC-2 enrollment form.

HSTA VB and EUTF Plan Enrollment

In cases where HSTA VB members have a spouse/partner covered under active or retiree EUTF plans, members cannot enroll in the same health plan coverages under both EUTF and HSTA VB plans simultaneously (e.g. EUTF medical and HSTA VB medical, or EUTF dental and HSTA VB dental).

Newly Retired Employees

Newly retired employees enrolled under HSTA VB active plans CANNOT enroll in HSTA VB retiree plans upon their retirement and MUST enroll in EUTF retiree health plan options.

Note: The enrollment of HSTA VEBA members into the health plans created as a result of Judge Sakamoto's decision in the Gail Kono lawsuit was done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State has appealed the decision and reserves the right to move former HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Open Enrollment Informational Session Schedule

Island	Date and Time	Meeting Location
Oahu	October 9, 2017 8:30 – 9:30am 10:00 – 11:00am	**State Capitol** Auditorium 415 S. Beretania Street, Honolulu, HI 96813
	October 16, 2017 9:30 – 10:30am 2:00 – 3:00pm	**Windward Community College** Hale Akoakoa, Room 101 & 103 45-720 Keaahala Road, Kaneohe, HI 96744
	October 17, 2017 9:30 – 10:30am 2:00 – 3:00pm	**Aloha Stadium** Hospitality Room 99-500 Salt Lake Boulevard, Aiea, HI 96818
	October 18, 2017 9:30 – 10:30am 2:00 – 3:00pm	**Leeward Community College** Education Building, Room 201 A & B 96-045 Ala Ike Street, Pearl City, HI 96782
Hawaii	October 20, 2017 2:00 – 3:00pm	**West Hawaii Civic Center** Community Meeting Hale, Bldg. G 74-5044 Ane Keohokalole Highway, Kailua-Kona, HI 96740
	October 11, 2017 1:00 – 2:00pm 2:00 – 3:00pm	**Aunty Sally Kaleohano's Luau Hale** 799 Piilani Street, Hilo, HI 96720
Kauai	October 12, 2017 2:00 – 3:00pm	**Kauai War Memorial** Convention Hall 4191 Hardy Street, Lihue, HI 96766
Maui	October 13, 2017 12:30 – 1:30pm 2:00 – 3:00pm	**UH Maui College** Pilina Multi-Purpose Room 310 W. Kaahumanu Avenue, Kahului, HI 96732
Molokai	October 19, 2017 1:30 – 2:30pm	**Kualapuu Park & Community Center** 1 Uwao Street, Kualapuu, HI 96757
Lanai	October 19, 2017 12:00 – 1:00pm	**Lanai Community Center** 8th Street, Lanai City, HI 96763

Webinar Informational Sessions

Webinar	October 10 & 19, 2017 8:00 – 9:00am 3:00 – 4:00pm	**How to Access the Webinar** 1) Go to eutf.hawaii.gov 2) Select "Learning Center" on menu bar 3) Click on "Webinars" 4) Select the desired webinar

Health Plan Information

Health Plan Basics

Medical and Prescription Drug Plans

Medicare has a significant impact on EUTF retiree medical and prescription drug plans; therefore, EUTF separates the retirees into two benefit categories:

- Non-Medicare Retirees
- Medicare Retirees

Non-Medicare Retiree medical and prescription drug plans are available for retirees and their eligible dependents who are not yet eligible for Medicare. State and county employees who retire before becoming Medicare eligible may select Non-Medicare medical and prescription drug plans options for themselves and their eligible dependents.

Medicare Retiree medical and prescription drug plans are available for retirees and their eligible dependents who are enrolled in Medicare. EUTF statute and Administrative Rules requires that you enroll in Medicare Part B when eligible in order to enroll in any EUTF or HSTA VB retiree medical and/or prescription drug plans. Please see page 75 for more information on this important topic.

Premiums are based on the Medicare status of the retiree. Benefits are based on whether the member is or is not enrolled in Medicare.

Dental, Vision and Life Insurance plans are the same for Medicare or Non-Medicare retirees.

Understanding Medical Plan Design

The EUTF offers the following medical plan options for non-Medicare and Medicare eligible Retirees:

- Preferred Provider Organization Plan: HMSA 90/10 plan
- Health Maintenance Organization Plan: Kaiser Comprehensive plan

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

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

Retirees and their dependents eligible for Medicare who are enrolled in the EUTF's Kaiser Comprehensive HMO plan are required to enroll in the EUTF Kaiser Senior Advantage plan. Please contact Kaiser Permanente at

1-808-432-5250 (Oahu) or toll-free at 1-800-966-5955 (neighbor islands) for more information and to learn how to enroll into the Kaiser Senior Advantage plan.

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

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

Your premium reimbursement will be the lesser of:

1) The actual cost of the medical and prescription drug plan; or
2) The amount of the State or county contribution for the most comparable Kaiser health plan.

Reimbursements are paid by the EUTF on a quarterly basis upon receipt of documentation that the premiums for an individual health insurance policy have been paid by the retiree-beneficiary and are limited to a two-year lookback period.

Chiropractic Plan Benefits: HSTA VB

Chiropractic benefits are not offered under the EUTF retiree plans. Only HSTA VB retiree medical plans include chiropractic coverage.

The plan benefit includes the initial exam, any necessary x-rays (when taken in a participating provider's office), therapeutically/medically necessary chiropractic treatment and therapeutic modalities. The copayment is $12 per visit up to 20 visits per calendar year. Visits must be therapeutically/medically necessary and chiropractic services must be received from a participating credentialed plan provider. A complete list of providers and plan information may be obtained from HMSA and Kaiser.

Healthcare Terms and Definitions

The following is a list of important healthcare terms and 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.

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, your 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 at 90% or $90 in this example.

Deductible – The amount you must pay for covered services before your plan begins to pay. The deductible is based on a calendar year and renews every January 1st. Under the EUTF HMSA PPO medical plan, the deductible is $100 per individual or up to $300 for family and applies to services provided by both in-network or participating and out-of-network or non-participating providers. You cannot pay the annual deductible in advance, you must meet the deductible on a claim by claim basis. The deductible does not apply to all services.

If you are seeing an out-of-network provider the coinsurance you pay on the eligible charge amounts will be credited towards the deductible. Any difference between the eligible charge and the actual charge will not be credited towards the deductible.

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

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

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

Out-of-Network or Nonparticipating Provider– A physician, hospital, pharmacy, laboratory or other healthcare provider who has not contracted with your insurance carrier to provide services.

When you receive services from a non-participating provider, you owe the plan's standard copayment or coinsurance based on your insurance carrier's eligible charge plus the difference between the non-participating provider's charge for the services and your insurance carriers' eligible charge.

For example, if the non-participating 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 x 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.

Medicare – A Federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Coordination of Benefits (COB) – The process of determining which of two or more insurance policies or health plans will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute. Coordination of Benefits is intended to prevent the duplication of benefits when a member is covered by more than one insurance carrier or health plan. For more information on Coordination of Benefits, please contact your health insurance carrier.

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.

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. An HMO generally won't cover out-of-network care except in emergency situations. HMOs often provide integrated care and focus on prevention and wellness.

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 treat you on a range of health related issues and may 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

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

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

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

Specialty Drugs – High-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion).

Benefits for Retirees and Dependents Not Yet Eligible For Medicare

Retirees who are not yet eligible for Medicare may enroll in Non-Medicare retiree health plan options. These health plan options include the following:

For EUTF retirees:

EUTF Non-Medicare Retiree Health Plan Options			
Medical Plan	HMSA 90/10 PPO Plan	or	Kaiser HMO Medical Plan (Includes Kaiser Prescription Drug Plan)
Drug Plan	CVS Caremark Prescription Drug Plan		
Dental Plan	Hawaii Dental Service		
Vision Plan	Vision Service Plan		
Life Insurance	USAble Life		

For HSTA VB retirees*:

HSTA VB Non-Medicare Retiree Health Plan Options			
Medical and Chiro Plan	HMSA 90/10 PPO Plan	or	Kaiser HMO Medical Plan (Includes Kaiser Prescription Drug Plan)
Drug Plan	CVS Caremark Prescription Drug Plan		
Dental Plan	Hawaii Dental Service		
Vision Plan	Vision Service Plan		
Life Insurance	USAble Life		

*Please refer to page 28 for more information on HSTA VB retirees.

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

EUTF — MEDICAL PLAN BENEFITS FOR NON-MEDICARE RETIREES AND NON-MEDICARE DEPENDENTS

Benefits will be administered as described in each plan's Guide to Benefits

	Plan Benefits	HMSA 90/10 PPO		Kaiser HMO
GENERAL	Calendar Year Deductible Single/Family	$100 per person Maximum $300 per family		None/None
	Calendar Year Out-of-Pocket Limit Single/Family	$2,500 per person Maximum $7,500 per family		$2,000 per person Maximum $6,000 per family
	Lifetime Benefit Maximum	None		None
PHYSICIAN SERVICES		In-Network	Out-of-Network	
	Primary Care Office Visit	10%*	30%	$15
	Specialist Office Visit	10%*	30%	$15
	Annual Wellness Exams (Covered under Medicare for Dependents with Medicare)	No Charge	No Charge	No Charge
	Annual Physical Exams	No Charge*	30%*	No Charge
	Mammography	20%*	30%*	No Charge (If Preventive)
	Second Opinion – Surgery	10%*	30%	$15
	Emergency Room (ER care)	10%*	10%*	$50 in area / 20% out
	Ambulance	20%	30%	20%
INPATIENT SERVICES	Hospital Room & Board	10%*	30%	No Charge
	Ancillary Services	10%*	30%	No Charge
	Physician Services	10%*	30%	No Charge
	Surgery	10%* (Cutting)	30%	No Charge
	Anesthesia	10%*	30%	No Charge
	Mental Health Care	10%*	30%	No Charge
OUTPATIENT SERVICES	Chemotherapy	20%	30%	$15
	Radiation Therapy	20%*	30%	$15
	Surgery	10%* (Cutting)	30%	$15
	Allergy Testing	20%	30%	$15
	Other Diag. Lab, X-ray & Psych Testing	20%*	30%	$15
	Anesthesia	10%*	30%	$15
	Mental Health Care	10%*	30%	$15
OTHER SERVICES	Durable Medical Equipment	20%	30%	20%
	Home Health Care	No Charge*; 150 visits per year	30%; 150 visits per year	No Charge
	Hospice Care	No Charge*	Not Covered	No Charge
	Nursing Facility - Skilled Care	10%*, 120 days per year	30%, 120 days per year	No Charge, 100 days per benefit period
	Physical & Occupational Therapy	20%	30%	$15

*Deductible does not apply

HSTA VB	MEDICAL PLAN BENEFITS FOR NON-MEDICARE RETIREES AND NON-MEDICARE DEPENDENTS Benefits will be administered as described in each plan's Guide to Benefits			
	Plan Benefits	**HMSA 90/10 PPO**		**Kaiser HMO**
GENERAL	Calendar Year Deductible Single/Family	$100 per person Maximum $300 per family		None/None
	Calendar Year Out-of-Pocket Limit Single/Family	$2,000 per person Maximum $6,000 per family		$2,000 per person Maximum $6,000 per family
	Lifetime Benefit Maximum	$2,000,000		None
PHYSICIAN SERVICES		**In-Network**	**Out-of-Network**	
	Primary Care Office Visit	10%*	30%	$15
	Specialist Office Visit	10%*	30%	$15
	Annual Wellness Visit (Covered under Medicare for Dependents with Medicare)	No Charge	No Charge	No Charge
	Annual Physical Exams	No Charge* Limits apply	No Charge* Limits apply	No Charge
	Mammography	10%*	30%*	No Charge (If Preventive)
	Second Opinion – Surgery	10%*	30%	$15
	Emergency Room (ER care)	10%*	10%*	$50 in area / 20% out
	Ambulance	10%*	30%	20%
INPATIENT SERVICES	Hospital Room & Board	10%*	30%	No Charge
	Ancillary Services	10%*	30%	No Charge
	Physician Services	10%*	30%	No Charge
	Surgery	10%*	30%	No Charge
	Anesthesia	10%*	30%	No Charge
	Mental Health Care	10%*	30%	No Charge
OUTPATIENT	Chemotherapy	10%*	30%	$15
	Radiation Therapy	10%*	30%	$15
	Surgery	10%*	30%	$15
	Allergy Testing	10%*	30%	$15
	Other Diag. Lab, X-ray & Psych Testing	10%*	30%	$15
	Anesthesia	10%*	30%	$15
	Mental Health Care	10%*	30%	$15
OTHER SERVICES	Durable Medical Equipment	10%*	30%	20%
	Home Health Care	No Charge*; 150 visits per year	30%; 150 visits per year	No Charge
	Hospice Care	No Charge*	Not Covered	No Charge
	Nursing Facility – Skilled Care	10%*, 120 days per year	30%, 120 days per year	No Charge, 100 days per benefit period
	Physical & Occupational Therapy	10%*	30%	$15
	Chiropractic Treatment	$12*; 20 visits per year	Not Covered	$12; 20 visits per year

*Deductible does not apply

EUTF

PRESCRIPTION DRUG PLAN BENEFITS FOR NON-MEDICARE RETIREES AND NON-MEDICARE DEPENDENTS

Benefits will be administered as described in each plan's Guide to Benefits

	Plan Benefits	CVS PPO*						Kaiser HMO	
RETAIL		CVS In-Network Pharmacy COPAYMENT			Out-of-Network Pharmacy** COPAYMENT			Kaiser Pharmacy COPAYMENT	
	Maintenance Medication	Must be filled in a 90 day supply after the first 3-30 day initial fills+						Same as Generic and Brand	
	Day Supply	30 DAYS	60 DAYS	90 DAYS	30 DAYS	60 DAYS	90 DAYS	30 DAYS	90 DAYS
	Generic	$5	$10	$15	$5 + 20%	$10 + 20%	$15 + 20%	$15	$30 Mail Order
	Preferred Brand	$15	$30	$45	$15 + 20%	$30 + 20%	$45 + 20%	$15	$30 Mail Order
	Non-Preferred Brand	$30	$60	$90	$30 + 20%	$60 + 20%	$90 + 20%	$15	$30 Mail Order
	Specialty Drugs & Injectables	20% of eligible charges; Up to $250 maximum per prescription fill; $2,000 out-of-pocket maximum per calendar year; $30 copay oral oncology specialty medications. Specialty drugs are not available through mail-order and only dispensed up to a 30-day supply.						Injectable Drugs: 30 days: $15 not available through mail-order Eligible Specialty Drugs: 30 days: $15	
DIABETIC SUPPLIES	Preferred Insulin	$5	$10	$15	$5 + 20%	$10 + 20%	$15 + 20%	$15	Not available thru mail Order
	Other Insulin	$15	$30	$45	$15 + 20%	$30 + 20%	$45 + 20%	$15	Not available thru mail Order
	Preferred Diabetic Supplies	No Copayment			$0 + 20%			$15	$30 Mail Order
	Other Diabetic Supplies	$15	$30	$45	$15 + 20%	$30 + 20%	$45 + 20%	$15	$30 Mail Order

RETAIL 90 & MAIL ORDER	
Day Supply	90 DAYS
Generic	$10
Preferred Brand	$30
Non-Preferred Brand	$60
Preferred Insulin	$10
Other Insulin	$30
Preferred Diabetic Supplies	No Copayment
Other Diabetic Supplies	$30

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

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

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

HSTA VB

PRESCRIPTION DRUG PLAN BENEFITS FOR NON-MEDICARE RETIREES AND NON-MEDICARE DEPENDENTS

Benefits will be administered as described in each plan's Guide to Benefits

	Plan Benefits	CVS PPO*						Kaiser HMO	
RETAIL & MAIL ORDER		CVS In-Network Retail Pharmacy COPAYMENT			Out-of-Network Retail Pharmacy** COPAYMENT			Kaiser Pharmacy COPAYMENT	
	Day Supply	30 DAYS	60 DAYS	90 DAYS	30 DAYS	60 DAYS	90 DAYS	30 DAYS	90 DAYS
	Generic	$5	$9	$9	$5 + 30%	$9 + 30%	$9 + 30%	$10	$20 Mail Order
	All Covered Brand Name	$15	$27	$27	$15 + 30%	$27 + 30%	$27 + 30%	$10	$20 Mail Order
	Specialty Drugs & Injectables	Specialty medications are subject to the applicable Generic/Brand copayment. Specialty drugs are not available through mail-order and only dispensed up to a 30-day supply						Injectable Drugs: 30 days: $10 not available through mail-order Eligible Specialty Drugs: 30 days: $10	
DIABETIC SUPPLIES	Insulin	$5	$9	$9	$5 + 30%	$9 + 30%	$9 + 30%	$10	Not available through mail order
	Lancets, Strips & Meters	No Copayment						50%	

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

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

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

Non-Medicare PPO Prescription Drug Plan Provisions

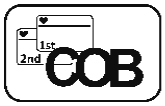
The PPO prescription drug plan for all Non-Medicare participants includes many programs that offer a financial incentive for participants to use the generic or preferred brand medication without compromising care as these medications have been determined to provide the same or similar level of effectiveness.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

Web Service

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

Customer Care

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



Coordination of Benefits (COB)

Some participants may be enrolled in additional prescription drug coverage outside of the EUTF. 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.

Under Coordination of Benefits, all EUTF plan parameters and guidelines will still apply and may conflict with your other benefits in some cases.

Required Documentation for Paper Claims

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

All paper claim reimbursement requests should be mailed within one year from the date of purchase to:

CVS Caremark

P.O. Box 52136

Phoenix, Arizona 85072-2136

Drug 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.

1. **Quantity Limitations** – Ensures participants receive the medication in the quantity considered safe by the 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)** – 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 GSTP in place for all Non-Medicare members. For certain non-preferred brand drugs, GSTP may require that you try a generic drug prior to the use of a brand drug. In some situations you may pay a higher copayment, please contact CVS Caremark Customer Care at 1-855-801-8263 for more information. Also see section labeled – Dispensed as Written Program (DAW 1 and/or 2) on page 46 of this Guide.

3. **Prior Authorization** – Authorization process to ensure medical necessity of targeted drugs/classes before they are covered by the plan. **Prior Authorization is required for Compound Medications that cost $300 or more.**
4. **Specialty Drug Program** – Specialty medications you receive at your doctor's office or specialty medication that is self-administered in a home setting are covered under the pharmacy drug benefit. Specialty medications you receive at an inpatient hospital setting or in a hospital based outpatient treatment center are covered under your medical plan.

   Specialty medications may be obtained from a specialty pharmacy or any retail pharmacy that participates in the CVS Caremark network that will supply the medication. CVS Caremark has a specialty pharmacy called CVS Specialty, located here in Hawaii. Members or physicians can contact CVS Specialty Pharmacy at 1-800-896-1464 or locally at 1-808-

254-2727 for assistance in ordering specialty medications. At your doctor's office visit, please present your ID card to your physician prior to treatment to ensure your medication is properly covered. Please refer to your medical plan description for additional information about coverage for specialty drugs.

EUTF participates with 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 1-808-254-4414 to obtain prior authorization.

If you have questions about your prescription drug benefits, call CVS Caremark at 1-855-801-8263. Representatives are available 24 hours a day, 7 days a week to assist with your questions.

You can also view the CVS Caremark Specialty Drug List found on caremark.com for a full listing of specialty therapeutic classes and medications.

EUTF Non-Medicare Prescription Drug Plan Provisions

In addition to the previously listed programs, the following benefits and programs also apply to the CVS Caremark prescription drug plan for EUTF Non-Medicare members only:

Dispensed as Written (DAW 1&2) Program

The Dispensed as Written Program requires that participants use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic 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.

Filing prescriptions at a Retail 90 Pharmacy or through the voluntary Mail Order Program for Maintenance Medications

Maintenance medications are those prescriptions taken for an extended period of time to treat such chronic conditions as high blood pressure, diabetes, heart disease, or high cholesterol. 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 three (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.

Non-FDA approved topical analgesics, and high cost bulk powders and creams used in compound medications are not covered under the plan.

Advanced Control Specialty Formulary (ACSF)

Effective 7/1/17, the CVS prescription drug plan adopted the Advanced Control Specialty Formulary. There were changes in coverage for some specialty medications and you may have been required to use a preferred specialty drug for continued coverage. You and your doctor should have received a written notification if you were impacted by this change.

Specialty

Medications that fall within the Tier 4 (specialty drugs) will be subject to a 20% participant co-insurance up to a maximum $250 copayment per prescription fill.

There is a $2,000 out-of-pocket maximum per person, per calendar year for specialty drug copayments. Exception: Oral oncology medications provided under the Specialty Drug Program will have a Tier 3 copayment instead of a Tier 4 copayment.

HSTA VB Non-Medicare Prescription Drug Plan Provisions

Dispensed as Written (DAW 2) Program

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

Benefits for Retirees Eligible for Medicare

Retirees who are eligible for Medicare may enroll in Medicare retiree health plan options. These health plan options include the following:

For EUTF retirees:

EUTF Medicare Retiree Health Plan Options			
Medical Plan	HMSA 90/10 PPO Plan	or	Kaiser HMO Senior Advantage Medical Plan (Includes Kaiser Prescription Drug Plan)**
Drug Plan	SilverScript Prescription Drug Plan		
Dental Plan	Hawaii Dental Service		
Vision Plan	Vision Service Plan		
Life Insurance	USAble Life		

For HSTA VB retirees*:

HSTA VB Medicare Retiree Health Plan Options			
Medical and Chiro Plan	HMSA 90/10 PPO Plan	or	Kaiser HMO Senior Advantage Medical Plan (Includes Kaiser Prescription Drug Plan)**
Drug Plan	SilverScript Prescription Drug Plan		
Dental Plan	Hawaii Dental Service		
Vision Plan	Vision Service Plan		
Life Insurance	USAble Life		

*Please refer to page 28 for more information on HSTA VB retirees.

**Please refer to the next page for more information on Kaiser Senior Advantage Plan enrollment.

Kaiser Senior Advantage Plan

The following applies to all retirees and dependents enrolled in the EUTF Kaiser HMO medical and prescription drug plan who:

- Are enrolled in Medicare Part A & B
- Reside in the EUTF Kaiser Senior Advantage Plan service area. This area excludes residents living on Kauai, Molokai, Lanai and parts of Hawaii Island which include Pahala, Naalehu and Hawaii Volcanoes National Park.

Retirees who enroll in Medicare Part B

Retirees under Kaiser medical and prescription drug plan enrolled in Medicare Part A & B must enroll in Kaiser Permanente EUTF Senior Advantage. Retirees will be mailed a Kaiser Permanente EUTF Senior Advantage enrollment kit and their rates will be adjusted to the Kaiser Senior Advantage Plan premiums.

Covered Dependents who enroll in Medicare Part B

Covered dependents under Kaiser medical and prescription drug plan enrolled in Medicare Part A & B must enroll in Kaiser Permanente EUTF Senior Advantage. Covered dependents will be mailed a Kaiser Permanente EUTF Senior Advantage enrollment kit and must enroll in the EUTF Kaiser Senior Advantage Plan.

If the retiree is not yet Medicare eligible but their covered dependent enrolls in Medicare Part B, the covered dependent must enroll in Kaiser Senior Advantage. The retiree will remain on the Kaiser HMO medical plan.

Note: Enrollment in the EUTF Kaiser Senior Advantage Plan will automatically enroll you into the Medicare Part D plan. Failure to enroll into the Kaiser Senior Advantage Plan will result in cancellation of your EUTF medical and prescription drug plans. If in the future you enroll in another Medicare Part D or Medicare Advantage plan, you will be disenrolled from Kaiser Senior Advantage Plan.

Medicare Medical Plan Benefits

The summary chart is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions apply. For complete information on plan benefits, please refer to the HMSA or Kaiser Guide to Benefits, which may be obtained from HMSA or Kaiser directly or from, eutf.hawaii.gov.

In the case of a discrepancy between the information provided in this Guide and that contained in the carriers' Guide to Benefits, the language in the carriers' Guide to Benefits will take precedence.

EUTF

MEDICAL PLAN BENEFITS FOR MEDICARE RETIREES AND MEDICARE DEPENDENTS

Benefits will be administered as described in each plan's Guide to Benefits

	Plan Benefits	HMSA 90/10 PPO		Kaiser HMO Senior Advantage**
GENERAL	Calendar Year Deductible Single/Family	$100 per person Maximum $300 per family		None/None
	Calendar Year Out-of-Pocket Limit Single/Family	$2,500 per person Maximum $7,500 per family		$2,000 per person Maximum $6,000 per family
	Lifetime Benefit Maximum	None		None
PHYSICIAN SERVICES		In-Network	Out-of-Network	
	Primary Care Office Visit	10%*	30%	$15
	Specialist Office Visit	10%*	30%	$15
	Annual Wellness Exams (Covered under Medicare for Dependents with Medicare)	No Charge	No Charge	No Charge
	Annual Physical Exams	No Charge*	30%*	No Charge
	Mammography	20%*	30%*	No Charge
	Second Opinion – Surgery	10%*	30%	$15
	Emergency Room (ER care)	10%*	10%*	$50
	Ambulance	20%	30%	20%
INPATIENT SERVICES	Hospital Room & Board	10%*	30%	No Charge
	Ancillary Services	10%*	30%	No Charge
	Physician Services	10%*	30%	No Charge
	Surgery	10%* (Cutting)	30%	No Charge
	Anesthesia	10%*	30%	No Charge
	Mental Health Care	10%*	30%	No Charge
OUTPATIENT SERVICES	Chemotherapy	20%	30%	$15
	Radiation Therapy	20%*	30%	$15
	Surgery	10%* (Cutting)	30%	$15
	Allergy Testing	20%	30%	$15
	Other Diag. Lab, X-ray & Psych Testing	20%*	30%	No Charge
	Anesthesia	10%*	30%	$15
	Mental Health Care	10%*	30%	$15
OTHER SERVICES	Durable Medical Equipment	20%	30%	20%
	Home Health Care	No Charge*; 150 visits per year	30%; 150 visits per year	No Charge
	Hospice Care	No Charge*	Not Covered	No Charge
	Nursing Facility – Skilled Care	10%*, 120 days per year	30%, 120 days per year	No Charge, 100 days per benefit period
	Physical & Occupational Therapy	20%	30%	$15

*Deductible does not apply,

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

See examples on page 55 for integration of Medicare benefits for retirees enrolled in the HMSA 90/10 PPO Plan.

HSTA VB

MEDICAL PLAN BENEFITS FOR MEDICARE RETIREES AND MEDICARE DEPENDENTS

Benefits will be administered as described in each plan's Guide to Benefits

	Plan Benefits	HMSA 90/10 PPO		Kaiser HMO Senior Advantage**
GENERAL	Calendar Year Deductible Single/Family	$100 per person Maximum $300 per family		None/None
	Calendar Year Out-of-Pocket Limit Single/Family	$2,000 per person Maximum $6,000 per family		$2,000 per person Maximum $6,000 per family
	Lifetime Benefit Maximum	$2,000,000		None
PHYSICIAN SERVICES		**In-Network**	**Out-of-Network**	
	Primary Care Office Visit	10%*	30%	$15
	Specialist Office Visit	10%*	30%	$15
	Annual Wellness Visit (Covered under Medicare for Dependents with Medicare)	No Charge	No Charge	No Charge
	Annual Physical Exams	No Charge* Limits apply	No Charge* Limits apply	No Charge
	Mammography	10%*	30%*	No Charge
	Second Opinion – Surgery	10%*	30%	$15
	Emergency Room (ER care)	10%*	10%*	$50
	Ambulance	10%*	30%	20%
INPATIENT SERVICES	Hospital Room & Board	10%*	30%	No Charge
	Ancillary Services	10%*	30%	No Charge
	Physician Services	10%*	30%	No Charge
	Surgery	10%*	30%	No Charge
	Anesthesia	10%*	30%	No Charge
	Mental Health Care	10%*	30%	No Charge
OUTPATIENT SERVICES	Chemotherapy	10%*	30%	$15
	Radiation Therapy	10%*	30%	$15
	Surgery	10%*	30%	$15
	Allergy Testing	10%*	30%	$15
	Other Diag. Lab, X-ray & Psych Testing	10%*	30%	No Charge
	Anesthesia	10%*	30%	$15
	Mental Health Care	10%*	30%	$15
OTHER SERVICES	Durable Medical Equipment	10%*	30%	20%
	Home Health Care	No Charge*; 150 visits per year	30%; 150 visits per year	No Charge
	Hospice Care	No Charge*	Not Covered	No Charge, Home Care Only
	Nursing Facility – Skilled Care	10%*, 120 days per year	30%, 120 days per year	No Charge, 100 days per benefit period
	Physical & Occupational Therapy	10%*	30%	$15
	Chiropractic Treatment	$12*; 20 visits per year	Not Covered	$12; 20 visits per year

*Deductible does not apply

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

See examples on page55 for integration of Medicare benefits for retirees enrolled in the HMSA 90/10 PPO Plan.

Coordination of Benefits for Medicare and HMSA 90/10 PPO Medical Plans

When a retiree is covered by more than one insurance carrier, Coordination of Benefits (COB) applies which is the process health insurance companies use to determine who should be the primary and secondary payer for services.

Medicare Secondary Payer

When a retiree has Medicare and another medical insurance plan, Medicare Secondary Payer (MSP) rules are used to determine COB. MSP rules state that in most cases, Medicare will be the primary payer if a Medicare beneficiary is also covered under an employer retirement group health plan. Information on MSP is available online at Medicare.gov.

Medicare Annual Deductible

The Medicare annual deductible is applied for most Part A and B services and must first be satisfied before Medicare benefits can be applied. Medicare annual deductibles are based on a calendar year and are adjusted annually. Medicare annual deductibles for 2017* are as follows:

2017 Medicare Part A Hospital Deductible	$1,316.00
2017 Medicare Part B Medical Deductible	$183.00

*Medicare annual deductibles for 2018 were not available at the time of print.

Coordination of Benefits (COB)

For retirees with Medicare Part A and B enrolled in the EUTF HMSA 90/10 PPO plan, COB is available when services are received from an HMSA participating provider who also accepts Medicare assignment.

To help in the coordination, please inform your provider by giving them information about both medical plans. COB examples are provided on the next page. Retirees will be responsible for any non-covered charges such as taxes.

Coordination of Medicare Benefits Example

Example 1: Medicare/HMSA Coordination with Medicare Part BAnnual Deductible

Claim #1: Member received services from an HMSA Participating Provider, who accepts Medicare assignment. There will be no payment by Medicare as Medicare will apply $183.00 towards the annual Medicare Part B deductible*. HMSA will process the claim at 90% of eligible charges with member owing the 10% balance plus any non-covered charges such as taxes.

Claim	Service	Date of Service	Charge	Medicare Part B Payment	HMSA 90/10 PPO Plan Payment	Member Owes
#1	Office Visit	01/02/2018	$100.00	$ 0.00	$ 90.00	$ 10.00
	Diagnostic Test	01/02/2018	$ 83.00	$ 0.00	$ 74.70	$ 8.30
			$183.00*	$ 0.00	$ 164.70	**$ 18.30**
#2	Office Visit	02/02/2018	$100.00	$ 80.00	$ 20.00	$ 0.00

Claim #2: The annual Medicare Part B deductible was met with the previous claim (claim #1), therefore Medicare will apply plan benefits and HMSA will coordinate payment of the remaining balance of eligible charges. Although member owes a zero balance in eligible charges, the member may be responsible for any non-covered charges such as taxes.

Example 2: Medicare/HMSA Coordination with Medicare Part A Hospital Deductible

Claim #3: Member received services from an HMSA Participating Facility, who accepts Medicare assignment. Member has not had any previous inpatient visits within the last 60 days. Medicare Part A will process 100% of facility charges less the Medicare Part A deductible of $1,316.00. HMSA will coordinate payment of the remaining balance of eligible charges. Although member owes a zero balance in eligible charges, the member may be responsible for any non-covered charges such as taxes.

Claim	Service	Date of Service	Charge	Medicare Part B Payment	HMSA 90/10 PPO Plan Payment	Member Owes
#3	Inpatient Hosp. – Room & Board	02/20/2018	$15,000	$ 13,684	$ 1,316	$ 0.00

Example 3: Medicare/HMSA Coordination with HMSA Annual Deductible

Claim #4: Member received services from an HMSA Participating Provider who accepts Medicare assignment. The annual Medicare Part B deductible was met with the previous claim (claim #1), therefore Medicare will apply plan benefits. Durable Medical Equipment benefits under the EUTF HMSA 90/10 PPO plan is subject to a $100 annual deductible* and therefore $100 is applied to the HMSA deductible. Member owes $100 in addition to any non-covered charges such as taxes.

Claim	Service	Date of Service	Charge	Medicare Part B Payment	HMSA 90/10 PPO Plan Payment	Member Owes
#4	Prosthesis	02/20/2018	$ 500.00	$ 400.00	$ 0.00*	$ 100.00

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

EUTF

PRESCRIPTION DRUG PLAN BENEFITS FOR MEDICARE RETIREES AND MEDICARE DEPENDENTS

Benefits will be administered as described in each plan's Guide to Benefits

	Plan Benefits	PPO Drug Plan SilverScript Medicare Part D			HMO Drug Plan Kaiser Senior Advantage with Prescription Drug Plan		
RETAIL		In-Network Pharmacy COPAYMENT			Kaiser Pharmacy COPAYMENT		
	Day Supply	30 DAYS	60 DAYS	90 DAYS	30 DAYS	60 DAYS	90 DAYS
	Generic	$5	$10	$10	$15	$30	$45
	Preferred Brand	$15	$30	$30	$15	$30	$45
	Non-Preferred Brand	$30	$60	$60	$15	$30	$45
	Specialty Drugs & Injectables	20% of eligible charges; Up to $250 maximum per prescription fill; $2,000 out-of-pocket maximum per calendar year Specialty drugs are only dispensed up to a 30-day supply			$15	$30	$45
DIABETIC SUPPLIES	Covered Insulin Products	$5	$10	$10	$15	$30	$45
	Lancets, Strips and Meters	No Copayment			$15	$30	$45
MAIL ORDER	Generic	$5	$10	$10	$15	$30	$30
	Preferred Brand	$15	$30	$30	$15	$30	$30
	Non-Preferred Brand	$30	$60	$60	$15	$30	$30
	Specialty Drug	Not available through mail order			$15	$30	$30
	Covered Insulin Products	$5	$10	$10	$15	$30	$30

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

HSTA VB

PRESCRIPTION DRUG PLAN BENEFITS FOR MEDICARE RETIREES AND MEDICARE DEPENDENTS

Benefits will be administered as described in each plan's Guide to Benefits

	Plan Benefits	PPO Drug Plan SilverScript Medicare Part D			HMO Drug Plan Kaiser Senior Advantage with Prescription Drug Plan		
RETAIL		In-Network Pharmacy COPAYMENT			Kaiser Pharmacy COPAYMENT		
	Day Supply	30 DAYS	60 DAYS	90 DAYS	30 DAYS	60 DAYS	90 DAYS
	Generic & Covered Insulin	$3	$9	$9	$10	$20	$30
	All Covered Brand	$9	$27	$27	$10	$20	$30
	Specialty Drugs & Injectables	Specialty medications are subject to the applicable Generic/Brand copayment. Specialty drugs are only dispensed up to a 30-day supply			$10	$20	$30
DIABETIC SUPPLIES	Lancets, Strips and Meters	No Copayment			20%		
MAIL ORDER	Generic	$3	$9	$9	$10	$20	$20
	All Covered Brand Name	$9	$27	$27	$10	$20	$20
	Specialty Drug	Not available through mail order			$10	$20	$20
	Diabetic Supplies	Not available through mail order			20%		

The HSTA VB's Medicare Part D prescription drug plan is administered by SilverScript, the Medicare Part D administrator for CVS Caremark.

This plan is the prescription drug coverage for Medicare retirees enrolled in the HMSA PPO medical plan option. The Kaiser Medicare Part D prescription drug coverage is included under the Kaiser Senior Advantage Medical Program.

EUTF and HSTA VB Medicare Part D Prescription Drug Plans

Effective January 1, 2018, the EUTF will implement formulary (drug) changes to the PPO Prescription Drug's preferred medication list as approved by the Centers for Medicare and Medicaid Services (CMS). Formulary changes and other plan changes are outlined in the Annual Notice of Change (ANOC) that is mailed directly to you in the month of September. The ANOC serves as your official notice of plan changes and is also available online at eutf.hawaii.gov. Please take the time to thoroughly review the plan documents, and you should also refer to the Evidence of Coverage (EOC) which is an Abridged Formulary List for additional details on your plan benefits. You may also contact SilverScript's Customer Care at 1-877-878-5715.

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

Prior Authorization

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

Quality Limits

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

Step Therapy

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

B vs. D Determination

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

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

If the medication you are taking is affected by the plan changes that take effect on January 1, 2018, you may be eligible for a temporary supply of your medication during the first 90-days of the plan year. The EUTF and HSTA VB SilverScript plans will allow up to 3-30 day fills or 1-90 day temporary fill during this period. The 90-day transition period will allow you to consult with your physician on getting any required approvals or review other drug therapy options. Please refer to the EOC for details on temporary fills.

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

The EUTF and HSTA VB Prescription Drug Plan provided for Medicare retirees and/or dependents is a MEDICARE PART D plan. You can only enroll in one Medicare Part D plan. If you enroll in a Medicare Part D plan other than the EUTF or HSTA VB plan, your EUTF or HSTA VB prescription drug plan or your Kaiser Senior Advantage plan if applicable, will be cancelled.

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

Notice of Creditable Coverage (see page 102)

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 or HSTA VB prescription drug plan, your prescription drug benefits are as good as or better than the standard Medicare Part D drug benefits.** 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 or HSTA VB and the alternative plans. Not all Medicare Part D plans cover the same drugs, nor provide the same out-of-pocket cost.

The EUTF will enroll all Medicare participants enrolled in EUTF and HSTA VB prescription drug plans into the EUTF's Medicare Part D prescription drug plan under SilverScript. Please contact the EUTF for information on the process involved. What this means to you is, if you are a Medicare participant, you do not need to leave the EUTF or HSTA VB prescription drug plan and enroll in another Medicare Part D plan to obtain prescription drug benefits.

If you are a Kaiser member and are enrolled in Medicare Parts A and B, you must enroll in Kaiser's Senior Advantage plan (unless you live in Kauai, Molokai, Lanai and parts of Hawaii Island which include Pahala, Naalehu, and Hawaii Volcanoes National Park). Retirees and their eligible dependents will be required to complete a Kaiser Permanente Senior Advantage enrollment form and may contact Kaiser at 1-808-432-5955 or toll-free at 1-800-966-5955. For more information please refer to Kaiser Senior Advantage Plan Enrollment on page 50.

Frequently Asked Questions

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

CMS allows all Medicare Part D plans to reach out to Medicare participants, beginning October 15 of each year. Other Medicare Part D plans may contact you to encourage enrollment in their plan during this time, thereby disenrolling

you from the EUTF or HSTA VB's Medicare Prescription Drug plan or Kaiser Senior Advantage medical and prescription drug plans, as applicable.

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

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

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

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

All Medicare Part D plans must offer minimum coverage to meet Standard Medicare Part D plan requirements. The EUTF and HSTA VB Medicare Part D plans under SilverScript and Kaiser Senior Advantage exceeds these minimum by offering participants:

- No annual deductibles
- Additional coverage during the Initial Coverage and Coverage Gap phases.

A comparison chart on the next page provides a basic comparison between Standard Medicare Part D plan coverage and coverage under EUTF Medicare Part D plans.

Standard Medicare Part D vs EUTF Medicare Part D Plan

2018 Standard CMS Approved Medicare Part D Plan

$0 - $405	$406 - $3,750	$3,751 - $5,000	$5,001 and up
Deductible Patient pays the full drug cost until reaching their initial Deductible. **You Pay: 100%**	**Initial Coverage** The Initial Coverage phase starts when the patient has met the $405 deductible and ends when the patient's Total Drug Spend (including the Deductible) reaches $3,750. **You Pay: 25%**	**Coverage Gap** The patient enters the Coverage Gap when the Total Drug Spend reaches $3,750 and exits the Coverage Gap when the Out-of-Pocket Limit reaches $5,000. **You Pay: 100%**	**Catastrophic Coverage** The patient enters Catastrophic Coverage when the Out-of-pocket Limit reaches $5,000. **You Pay: 5%**
Medicare Pays: 0%	**Medicare Pays: 75%**	**Medicare Pays: 0%**	**Medicare Pays: 95%**

January — **Calendar Year** — December

EUTF and HSTA VB Medicare Part D Plans

$0 - $405	$406 - $3,750	$3,751 - $5,000	$5,001 and up
Deductible No deductible under EUTF and HSTA VB Medicare Part D plans. Members will pay their regular copay amounts **You Pay: Copay***	**Initial Coverage** EUTF members will receive additional coverage during the Initial Coverage and will see no changes in copays **You Pay: Copay***	**Coverage Gap** EUTF members will receive additional coverage during the Coverage Gap and will see no changes in copays **You Pay: Copay***	**Catastrophic Coverage** EUTF members enter Catastrophic Coverage when their Out-of-pocket Limit reaches $5,000 **You Pay the greater of** • 5% or • $3.35 generic • $8.35 all other drugs
EUTF Plans pay 100% less copay	**EUTF Plans pay 100% less copay**	**EUTF Plans pay 100% less copay**	**EUTF Plans pay 100% less copay or 95%**

January — **Calendar Year** — December

*Please refer to pages 56 and 57 for more information on member copayments and other out-of-pocket expenses.

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

Please notify the EUTF in writing that you have enrolled in another Medicare Part D plan. You will be terminated from the EUTF Medicare Part D plan, HSTA VB Medicare medical and Part D plan, or the Kaiser Senior Advantage medical and prescription drug plan.

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

All Medicare members are enrolled in the Medicare Part D plan through Kaiser Senior Advantage. The EUTF enhances the Medicare Part D coverage with supplemental drug benefits that makes your Kaiser prescription drug coverage better than the standard Medicare Part D plan.

How do SilverScript and Kaiser choose prescription drugs for their preferred drug lists (formulary)?

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

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

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

No.

What happens to my spouse's/ partner's EUTF or HSTA VB coverage if my spouse/partner chooses to enroll in a non-EUTF Medicare Part D plan?

Your spouse/partner will be terminated from the EUTF or HSTA VB Medicare Part D plan or the Kaiser Senior Advantage medical and prescription drug plan, as applicable.

I have multiple medical and prescription drug plans through different employers. How is it determined how much each plan pays and how much I pay?

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

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

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

I am enrolled in the Kaiser medical plan. What will happen if I enroll in a Medicare Part D plan other than Kaiser.

If you enroll in a non-EUTF Medicare Part D plan, you will be automatically terminated from the Kaiser medical and prescription drug plan. The Medicare

Part D prescription drug plan is part of the Senior Advantage plan. You cannot have one without the other.

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

No, but EUTF encourages you to use mail order as it saves you time and money.

I am a retiree enrolled in the HSTA VB plan. If I enroll in a non-EUTF Medicare Part D prescription drug plan, will I lose medical, vision, and chiropractic benefits?

Yes. These are bundled together and cannot be separated.

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

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

Benefit for All Retirees

Dental, Vision and Life Insurance plans are available to both Medicare and Non-Medicare retirees and eligible dependents. Life insurance is available to the retiree only.

Hawaii Dental Service (HDS)

The Hawaii Dental Service benefit chart is located on the next page. The HDS public website at www.HawaiiDentalService.com includes a section exclusively for EUTF members. In this section, you will find valuable information on your HDS dental plan including your dental benefits and plan brochure.

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

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

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

Vision Service Plan (VSP)

The Vision Service Plan benefit chart is located on page 68. 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. Before seeing an out-of-network provider, call VSP at 1-866-240-8420, or go on-line at www.vsp.com to search for a VSP doctor near you.

Dental Benefits for EUTF & HSTA VB Retirees and Dependents

HAWAII DENTAL SERVICE (HDS)

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

Vision Benefits for EUTF & HSTA VB Retirees and Dependents

VISION SERVICE PLAN (VSP)

Vision Exam & Eye Wear Benefits

Members can have an eye exam and choose between a pair of lenses or contact lenses every calendar year.
Frames are covered every other calendar year.

Service	Frequency	In-Network	Out-of-Network
Exam	Every calendar year	100% after $10 copay	Up to $45.00
Prescription Glasses – Lenses: – Single Vision Lenses – Lined Bifocals – Lined Trifocals – Polycarbonate (children up to age 18) – UV Coating	Every calendar year	100% after $25 copay	Single Lens - up to $45.00 Bifocal Lens - up to $65.00 Trifocal Lens up to $85.00
Prescription Glasses – Frames	Every other calendar year	$120 allowance plus 20% off out-of-pocket cost *Costco - $65 allowance	Up to $47.00
Contact Lenses *Elective (Instead of Glasses)*	Every calendar year	$120 allowance (applies to cost of contacts and fitting & evaluation)	Up to $105.00

Extra Discounts and Savings from VSP Providers

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 20% off any VSP doctor within 12 months of your last exam.*

Retinal Screening

- Guaranteed pricing on retinal screening as an enhancement to your exam; $39 maximum copay.

Contact Lenses

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

Laser Vision Correction

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

*Costco pricing applies; there are no additional discounts. All other affiliate provider locations 20% off additional glasses and 15% off contact lens services within one year.

Life Insurance Benefits for EUTF & HSTA VB Retirees

Your retiree life insurance benefit is $2,235.

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

- Repatriation Benefit – benefits are payable to your beneficiary for expenses incurred to transport your remains to a mortuary near your permanent residence if you pass away while traveling over 200 miles away from home or outside the territorial boundaries of the United States. This benefit will reimburse up to 10% of your life insurance benefit, or approximately $223.

Beneficiary changes – if you would like to change your beneficiary designation:

- Contact USAble Life at 1-808-538-8920 or toll-free at 1-855-207-2021.

  USAble Life can provide a beneficiary change form upon request and does not verbally accept beneficiary designations.

- Download the beneficiary designation form from their website at www.usablelife.com/portal/eutf.

- Complete the beneficiary designation form and return it back to USAble Life via mail, fax or email. Changes will be effective upon receipt by USAble Life.

Their office is located at 999 Bishop Street, Suite #2701, Honolulu, Hawaii 96813 and opens from 7:45 am – 4:30 pm Hawaii Standard Time, Monday through Friday, except State observed holidays.

Monthly Health Plan Premiums

Health Plan Premium Rates

Retirees who receive less than 100% employer contribution toward the BMC may be responsible for monthly premium payments to the EUTF. A list of the monthly health plan rates for EUTF and HSTA VB plan options and the Retiree Premium Worksheet can be found in this section. You may use the Retiree Premium Worksheet to calculate your monthly premium cost. Details on determining employer premium contribution amounts can be found on page 10 of this Guide.

Premium Payment to the EUTF

Retirees who owe a monthly premium can submit payment payable to the EUTF to the address below:

EUTF
P.O. Box 30700
Honolulu HI 96820

Electronic Premium Payment

Retirees who make monthly premium payments to the EUTF can now pay directly through their bank account using ACH payment or via credit or debit card. If you'd like to enroll in automated monthly deductions initiated by EUTF from your bank account at no fee, please complete the ACH Deduction Authorization Agreement located at the back of this Guide. For more information on one-time electronic payment options at a fee visit our website at eutf.hawaii.gov/credit-card-payment.

EUTF Monthly Retiree Premiums

Effective January 1, 2018 through December 31, 2018

Benefit Plan	Type of Enrollment	Total Premium[1]
MEDICAL AND PRESCRIPTION DRUG PLANS - MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$234.22
	Two-Party	$456.38
	Family	$676.56
SilverScript Prescription Drug Plan	Self	$164.80
	Two-Party	$320.90
	Family	$475.80
Kaiser Senior Advantage Medical and Prescription Drug Plan	Self	$483.16
	Two-Party	$942.12
	Family	$1,396.24
MEDICAL AND PRESCRIPTION DRUG PLANS – NON-MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$520.18
	Two-Party	$1,013.62
	Family	$1,502.68
CVS Caremark Prescription Drug Plan	Self	$181.50
	Two-Party	$353.50
	Family	$524.12
Kaiser HMO Comprehensive Medical and Prescription Drug Plan	Self	$797.76
	Two-Party	$1,611.44
	Family	$2,377.30
DENTAL PLAN		
HDS Dental	Self	$39.48
	Two-Party	$77.04
	Family	$94.38
VISION PLAN		
VSP Vision	Self	$4.96
	Two-Party	$9.94
	Family	$13.34
LIFE INSURANCE		
USAble Life Insurance (Retiree only)	Self	$4.12

[1] The 2018 Retiree premiums do not include an EUTF administrative fee.

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
EFFECTIVE JANUARY 1, 2018

		Monthly Premium	Monthly Premium	Monthly Premium
1A	**MEDICAL/PRESCRIPTION DRUG**	**HMSA**	**Kaiser**	
A.	Non-Medicare - Self	☐ $701.68	☐ $797.76	
B.	Non-Medicare - 2-Party	☐ $1,367.12	☐ $1,611.44	
C.	Non-Medicare - Family	☐ $2,026.80	☐ $2,377.30	
D.	Medicare - Self	☐ $399.02	☐ $483.16	
E.	Medicare - 2-Party	☐ $777.28	☐ $942.12	
F.	Medicare - Family	☐ $1,152.36	☐ $1,396.24	

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

1B	**MEDICAL ONLY**	**HMSA**	
A.	Non-Medicare - Self	☐ $520.18	
B.	Non-Medicare - 2-Party	☐ $1,013.62	
C.	Non-Medicare - Family	☐ $1,502.68	
D.	Medicare - Self	☐ $234.22	
E.	Medicare - 2-Party	☐ $456.38	
F.	Medicare - Family	☐ $676.56	

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

1C	**PRESCRIPTION DRUG ONLY**		
A.	Non-Medicare - Self	☐ $181.50	
B.	Non-Medicare - 2-Party	☐ $353.50	
C.	Non-Medicare - Family	☐ $524.12	
D.	Medicare - Self	☐ $164.80	
E.	Medicare - 2-Party	☐ $320.90	
F.	Medicare - Family	☐ $475.80	

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

2	**DENTAL**	**HDS**	
	Non Medicare/Medicare		
	Self	☐ $39.48	
	2-Party	☐ $77.04	
	Family	☐ $94.38	

Select one plan and enter premium amount **2** $ _____

3	**VISION**	**VSP**	
	Non Medicare/Medicare		
	Self	☐ $4.96	
	2-Party	☐ $9.94	
	Family	☐ $13.34	

Select one plan and enter premium amount **3** $ _____

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

5	**EMPLOYER CONTRIBUTION**	**0%**	**50%**	**75%**	**100%**
A.	Non Medicare - Self	☐ $0.00	☐ $470.34	☐ $705.52	☐ $940.70
B.	Non Medicare - 2-Party	☐ $0.00	☐ $948.06	☐ $1,422.10	☐ $1,896.14
C.	Non Medicare - Family	☐ $0.00	☐ $1,387.60	☐ $2,081.40	☐ $2,775.20
D.	Medicare - Self	☐ $0.00	☐ $335.06	☐ $502.58	☐ $670.12
E.	Medicare - 2-Party	☐ $0.00	☐ $671.56	☐ $1,007.34	☐ $1,343.12
F.	Medicare - Family	☐ $0.00	☐ $978.12	☐ $1,467.18	☐ $1,956.24

Check your medical selection on line 1A or 1B. (For example, if you selected 1AA, your employer contribution will be non medicare self.) Enter your employer contribution amount (0% or 50% or 75%). **5** $ _____

6 Line 4 minus line 5, enter the AMOUNT YOU OWE monthly **6** $ _____

Please keep this sheet for your records. We do not send monthly billings or statements. Your monthly amounts will be on your confirmation notice. Payments are due by the first of the month, you may pay for more than one month of premiums on one check. Please make checks payable to EUTF and mail to P.O. Box 30700, Honolulu, HI 96820-0700.

HSTA VB Monthly Retiree Premiums

Effective January 1, 2018 through December 31, 2018

Benefit Plan	Type of Enrollment	Total Premium[2]
MEDICAL AND PRESCRIPTION DRUG PLANS - MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, SilverScript Prescription Drug, and VSP Vision Plans	Self	$398.10
	Two-Party	$776.00
	Family	$1,147.60
Kaiser Senior Advantage Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$496.00
	Two-Party	$967.38
	Family	$1,432.32
MEDICAL AND PRESCRIPTION DRUG PLANS – NON-MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, CVS Caremark Prescription Drug, and VSP Vision Plans	Self	$631.20
	Two-Party	$1,230.04
	Family	$1,820.74
Kaiser HMO Comprehensive Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$787.56
	Two-Party	$1,591.20
	Family	$2,346.10
DENTAL PLAN		
HDS Dental	Self	$47.52
	Two-Party	$92.52
	Family	$113.44
VISION PLAN		
VSP Vision	Self	$4.96
	Two-Party	$9.94
	Family	$13.34
LIFE INSURANCE		
USAble Life Insurance (Retiree only)	Self	$4.12

[2] The 2018 Retiree premiums do not include an EUTF administrative fee.

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
P.O. BOX 2121
HONOLULU, HI 96805
HSTA VB RETIREES
EFFECTIVE JANUARY 1, 2018

		Monthly Premium HMSA	Monthly Premium Kaiser
1	**MEDICAL/PRESCRIPTION DRUG/CHIRO/VISION**		
A.	Non-Medicare - Self	☐ $631.20	☐ $787.56
B.	Non-Medicare - 2-Party	☐ $1,230.04	☐ $1,591.20
C.	Non-Medicare - Family	☐ $1,820.74	☐ $2,346.10
D.	Medicare - Self	☐ $398.10	☐ $496.00
E.	Medicare - 2-Party	☐ $776.00	☐ $967.38
F.	Medicare - Family	☐ $1,147.60	☐ $1,432.32

Select one plan and enter premium amount **1** $ _____

		HDS
2	**DENTAL**	
	Non Medicare/Medicare	
	Self	☐ $47.52
	2-Party	☐ $92.52
	Family	☐ $113.44

Select one plan and enter premium amount **2** $ _____

3 Add lines 1 and 2 **3** $ _____

		0%	50%	75%	100%
4	**EMPLOYER CONTRIBUTION**				
A.	Non Medicare - Self	☐ $0.00	☐ $470.34	☐ $705.52	☐ $940.70
B.	Non Medicare - 2-Party	☐ $0.00	☐ $948.06	☐ $1,422.10	☐ $1,896.14
C.	Non Medicare - Family	☐ $0.00	☐ $1,387.60	☐ $2,081.40	☐ $2,775.20
D.	Medicare - Self	☐ $0.00	☐ $335.06	☐ $502.58	☐ $670.12
E.	Medicare - 2-Party	☐ $0.00	☐ $671.56	☐ $1,007.34	☐ $1,343.12
F.	Medicare - Family	☐ $0.00	☐ $978.12	☐ $1,467.18	☐ $1,956.24

Check your medical selection on line 1. (For example, if you selected 1A, your employer contribution will be non medicare self.) Enter your employer contribution amount (0% or 50% or 75%). **4** $ _____

5 Line 3 minus line 4, enter the AMOUNT YOU OWE monthly **5** $ _____

Please keep this sheet for your records. We do not send monthly billings or statements. Your monthly amounts will be on your confirmation notice. Payments are due by the first of the month, you may pay for more than one month of premiums on one check. Please make checks payable to EUTF and mail to P.O. Box 30700, Honolulu, HI 96820-0700.

Medicare

Medicare Basics

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

What is Medicare?

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

Medicare has four parts:

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

Who is eligible for Medicare?

Medicare Part A – Hospital Insurance

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

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

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

Medicare Part B – Medical Insurance

Medicare Part B requires a monthly premium payment.

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

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

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

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

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

Medicare Part C – Medicare Advantage Plans

If you have enrolled in Medicare Part A and B, you can join a Medicare Advantage plan.

The EUTF and HSTA VB Kaiser Senior Advantage Plan is a Medicare Part C plans. However, Medicare Part A is not required to enroll in EUTF and HSTA VB Kaiser Senior Advantage Plans.

Medicare Part D – Prescription Drug Coverage

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

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

Signing up for Medicare

When should I enroll in Medicare Part B?

EUTF Retirees and Their Covered Dependents Reaching Age 65:

Contact the Social Security Administration or Centers for Medicare and Medicaid Services three months prior to your 65th birthday to initiate enrollment into Medicare Part B. EUTF will send a courtesy letter to retirees and their eligible spouse/partner who are enrolled in EUTF plans three months prior to their 65th birthday also reminding you to enroll into Medicare Part B. Start the Medicare enrollment process as soon as you become eligible and submit appropriate documents to the EUTF in order to continue your EUTF or HSTA VB retiree medical and/or prescription drug plans.

Employees Who Will Be Retiring and Their Covered Dependents:

Employees and/or their covered dependent(s) who are eligible to enroll in Medicare should begin the Medicare Part B enrollment process three months prior to your retirement by contacting the Social Security Administration at 1-800-772-1213. Eligible retirees and their covered dependents must submit proof of Medicare Part B enrollment to the EUTF within 60 days of your retirement date in order to be covered under the EUTF retiree medical and/or prescription drug plans.

How to enroll in Medicare Part B

Enrollment is handled by the Social Security Administration and can be done online, in-person or through the mail. If you're receiving Social Security Income (which becomes possible from age 62) you'll automatically be enrolled in Medicare Part A and B when you turn 65. If you're not collecting Social Security Income you must take the initiative to contact Social Security and complete the necessary forms to enroll into Medicare. You will be required to pay Medicare Part B premiums directly to Medicare in order to maintain your Medicare Part B coverage. If you fail to pay your Medicare Part B premium and your Medicare Part B coverage terminates, your EUTF medical and/or prescription drug coverage will also be terminated.

The initial Medicare enrollment period is a 7-month period as follows:

- The three months before the month you turn 65 (coverage begins first day of the month you turn 65, or the first of the month prior if born on the 1st of the month)
- The month you turn 65 (coverage will be delayed)
- The three months after the month you turn 65 (coverage will be delayed)

If you did not enroll in Part A and B when you were first eligible because you were enrolled under an active employee group plan, the special enrollment period for Medicare is as follows:

- An eight month period that begins the month after employment or after the coverage ends
- COBRA coverage from an active employee plan does not constitute coverage under an active employee group plan and therefore does not extend the Special Enrollment Period

If you miss the enrollment periods, the general enrollment period for Medicare Part A and B are between January 1st and March 31st each year with a plan effective date of July 1st.

If you do not enroll in Medicare Part B when you first become eligible, either at age 65 or when coverage under an active employee group health plan ends, a late enrollment penalty may be assessed. The penalty is equal to 10% of the premium for each full 12-month period that you could have had Medicare Part B, but did not enroll. The penalty is assessed for as long as you have Medicare Part B. EUTF will not reimburse for any late enrollment penalties.

To enroll in Medicare Part B contact the Social Security Administration at 1-800-772-1213 or visit their website at www.ssa.gov.

When does my enrollment in Medicare Part B become effective?

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

Reminder: Retirees and their covered dependents must provide the EUTF with proof of Medicare Part B enrollment within 60 days of becoming eligible. Failure to do so will result in cancellation of EUTF or HSTA VB retiree medical and/or prescription drug plans. Medicare Part B coverage must be in effect on the date of retirement for new retirees or the date when retirees and/or their covered dependents become eligible for Medicare Part B, in order to participate in EUTF retiree medical and/or prescription drug plans. Please refer to page 2 of this Guide for more information.

Medigap & Other Medicare Advantage and Prescription Drug Plans

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

Medicare enrollment and active employment

If you are covered under an EUTF or HSTA VB active employee plan, you are not required to enroll in Medicare. Medicare enrollment is only required for coverage under EUTF and HSTA VB retiree plans. However, if you are enrolled in an EUTF or HSTA VB retiree medical and/or prescription drug plan as a dependent and are eligible for Medicare Part B, you are required to enroll in Medicare B even if you are still actively working. If during your retirement, you are actively employed and covered by another employer's health plan, you will still be required to enroll in Medicare Part B in order to continue coverage under the EUTF or HSTA VB retiree medical and/or prescription drug plans.

Medicare Premium Payment and Reimbursement

As a retiree, you and your spouse/partner qualify for reimbursement of your Medicare Part B premiums (minus any penalties) provided you are paying for your Medicare Part B premium and it is not being paid by another entity such as the Medicare Savings Program or Medicaid. In order to receive reimbursement you must provide the EUTF with proof of your Medicare Part B enrollment, a copy of the letter from the Social Security Administration showing the Medicare Part B premium that you pay, and a completed Direct Deposit Agreement Form (available at the back of this Guide). EUTF will automatically reset your Medicare Part B premium reimbursement to the Medicare standard amount every January 1st. If you are paying above the Medicare standard amount you must notify the EUTF of the amount you are paying every year in order to receive full reimbursement.

Reimbursement begins the later of the effective date of your Medicare Part B coverage or the first day of the month that you provide EUTF with a copy of your Medicare Part B card, a copy of the letter from the Social Security Administration showing the Medicare Part B premium you pay and your completed Direct Deposit Agreement Form. Retirees who pay a higher income-related monthly adjusted premium will be reimbursed the higher amount. Please note that EUTF will not reimburse for any late enrollment penalties.

Dependent Children and Active EUTF Employees

Medicare Part B premium reimbursement does not apply to dependent children. Medicare Part B premium reimbursement does not apply to Medicare eligible active EUTF employees and their dependents covered by EUTF or HSTA VB active employee plans. However, if you are an active employee enrolled in Medicare Part B and covered by an EUTF or HSTA VB retiree plan through your spouse or partner, your spouse or partner is entitled to Medicare Part B reimbursement on your behalf.

Medicare Part D

CMS may assess a Medicare Part D premium if your modified adjusted gross income is above a certain amount, also referred to as the Part D income-related monthly adjustment amount (Part D-IRMAA). A late enrollment penalty may also apply for Medicare beneficiaries who do not enroll in Medicare Part D when you first become eligible. **The EUTF does not reimburse for Medicare Part D premiums or penalties.**

Frequently Asked Questions:

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

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

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

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

How and when will I be reimbursed for my Medicare Part B premiums?

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

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

Retirees and their eligible spouse/partner must be enrolled in Medicare Part B in order to be covered under EUTF or HSTA VB retiree medical and/or prescription drug plans, regardless of if they are still actively working or covered through another non-EUTF employer group health insurance.

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

EUTF Administrative Rule 5.04 (a) states;

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

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

I didn't apply for Medicare when I turned 65 even though I did not have health coverage from my job or through my spouse's/partner's employer. What should I do?

If you missed the initial enrollment (a seven-month period starting three months before your 65th birthday and ending three months after your birth month), you may be required to wait to apply for Medicare until the general enrollment period from January through March of each year for a start date of July 1. You should contact the Social Security Administration to apply for Medicare by calling 1-800-772-1213 or visit their website at SocialSecurity.gov. You will likely pay a 10

percent Medicare Part B premium penalty for each year you delayed signing up. Your EUTF Medicare Part B reimbursements will not include payment for any penalties.

Will I be charged a higher Medicare B premium if I delay Medicare Part B enrollment due to being covered under an active employee plan as the subscriber or dependent?

No. If you don't enroll in Medicare Part B when you first become eligible because you or your spouse/partner were working and had group health plan coverage through that employer, you can sign up for Medicare Part B during a special enrollment period when that coverage ends. If you are Medicare eligible, you and your dependents will not be allowed to enroll in EUTF plans until you and any eligible dependents enroll in Medicare Part B.

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

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

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

Where is a retiree's spouse's/partner's Medicare reimbursement deposited?

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

Medicare Part D Prescription Drug and Medicare Advantage Plan Enrollment

Medicare requires that you are enrolled in only one Medicare Part D or Medicare Advantage Plan. EUTF Medicare Part D and Medicare Advantage plan options include:

- Medicare Part D prescription drug plan administered by SilverScript
- EUTF Kaiser Permanente Senior Advantage Medical and Prescription Drug Plan (includes Medicare Part D)

If you or your covered dependent(s) are enrolled in Medicare Part B and enrolled in the EUTF retiree CVS prescription drug plan, you will automatically be enrolled in the Medicare Part D prescription drug plan administered by SilverScript (CVS).

If you or your covered dependent(s) are enrolled in Medicare Part B and enrolled in the EUTF retiree Kaiser medical and prescription drug plan, you will be mailed a Kaiser Senior Advantage enrollment kit and you must enroll in the EUTF Kaiser Senior Advantage Plan (unless you live in Kauai, Molokai, Lanai and parts of Hawaii Island which include Pahala, Naalehu and Hawaii Volcanoes National Park). Upon completion and submission of the enrollment kit, Kaiser will automatically enroll you into the Kaiser Senior Advantage Plan including the Medicare Part D plan. Failure to enroll into the Kaiser Senior Advantage Plan will result in cancellation of your EUTF medical and prescription drug plans.

If in the future you enroll in a non-EUTF Medicare Part D or Medicare Advantage plan, you will be disenrolled from EUTF's Medicare Part D plans, including the Kaiser Senior Advantage medical plan. CMS may assess a Medicare Part D premium:

- If your modified adjusted gross income is above a certain amount, also referred to as the Part D income-related monthly adjustment amount (Part D-IRMAA)
- If you do not enroll in Medicare Part D when you first become eligible, a late enrollment penalty may be assessed.

The EUTF does not reimburse for Medicare Part D premiums or penalties.

Eligibility

Retiree and Dependent Eligibility

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

Retiree Eligibility:

- A retired employee. You do not need to be covered under an EUTF or HSTA VB Active Employee Plan at the time of retirement to be eligible to enroll in EUTF or HSTA VB retiree plans. If you return to work you must notify the EUTF.
- The surviving spouse/partner of a deceased retired employee, provided the spouse/partner does not remarry or enter into another domestic partnership.
- The unmarried surviving child of a deceased retired employee, provided the child is under age 19 with no surviving parent.

Dependent Eligibility:

- The retiree's legal spouse/partner
- You and/or your spouse/partner's unmarried children under age 19. This includes children by birth, marriage or adoption. Dependent children by legal guardianship are covered to age 18.
- You and/or your spouse/partner's unmarried children age 19 to 23 provided they are full-time students attending an accredited school, college, university or technical school
- An unmarried child, regardless of age, who is incapable of self-support because of mental or physical incapacity that existed prior to the child reaching the age of 19
- An unmarried child for whom a retiree must provide health benefit coverage under the terms of a qualified medical child support order (QMCSO)

NOTE: The Affordable Care Act, including the dependent eligibility provisions extending coverage to age 26, does not apply to retiree-only plans such as the EUTF or HSTA VB retiree plans.

Special Eligibility: Requirements for Domestic Partners and Civil Unions

- **Domestic Partner:** Person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:
  1. Intends to remain in a domestic partnership with each other indefinitely.
  2. Have a common residence and intend to reside together indefinitely.
  3. Jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care.
  4. Neither are married or a member of another domestic partnership.
  5. Not related by blood in a way that would prevent them from being married to each other in the State of Hawaii.
  6. Both at least 18 years of age and mentally competent to contract.
  7. Consent to the domestic partnership has not been obtained by force, duress or fraud.
  8. Both sign and file a declaration of domestic partnership (affidavit) with the EUTF.
- **Civil Union:** A person who has entered into a civil union under the rules established by the State of Hawaii Department of Health.

NOTE: There may be Federal and State Income Tax consequences with employer paid coverage for domestic partners and civil unions.

If your domestic partner or civil union spouse does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic partner or civil union spouse will be deemed taxable income and reported to you on the appropriate federal or state tax form. Consult your tax advisor to determine your domestic partner or civil union spouse's status. If you determine that your domestic partner or civil union spouse 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.

ID Cards

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

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

Dual Enrollment

Dual Enrollment Is Not Allowed

No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled by more than one retiree/active employee (dual enrollment).

Family Enrollment

If you and your spouse/partner are both retirees/active employees, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. However, both retirees/active employees are able to select EUTF Self plans.

End of Coverage

For Retiree/Surviving Spouse/Partner

Common situations resulting in the loss of coverage are:

1. You do not make required premium payments (if applicable) on time and in full.
2. You die, subject to exceptions for your surviving spouse/partner and unmarried surviving children under age 19.

3. You fail to comply with the EUTF Administrative Rules.
4. You file fraudulent claims.
5. Your surviving spouse/partner remarries.

For Dependents

1. Your dependent is no longer eligible for coverage, such as due to a divorce, legal separation, overage children, or termination of Domestic partnership or civil union partnership.
2. Dependent child no longer meets the eligibility rules of the Plan (explained on page 86)

Rejection of Enrollment

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

An enrollment application shall be rejected if:

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

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

Special Enrollment Period

Special Enrollment Period Due to a Qualifying Event (See Common Qualifying Events That Allow Enrollment Changes forRetirees)

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

1. You marry and want to enroll your spouse and/or newly eligible dependent children. A copy of your marriage certificate is required.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide appropriate documents verifying the adoption in order to have the application accepted. To enroll a newborn you do not need to attach a copy of the birth certificate or submit the Social Security Number with your EC-2 or EC-2H form. A copy of the birth certificate is required only if the child has a different last name from the retiree. A Social Security Number is required within 60 days of submitting your enrollment form to the EUTF.
3. You have a change in family status involving the loss of eligibility of a family member (e.g., legal separation; divorce; death; child loses student status, or turns age 19 if not a student, or turns age 24 if a student).
4. Your spouse/partner or eligible dependent's employment status changes resulting in a loss of health coverage. Submit a copy of the Loss of Coverage letter from the previous employer/plan detailing the type of coverage lost (e.g. medical, dental, prescription drug, vision), the effective date of the loss of coverage, and the name(s) of dependent(s) who lost the coverage.
5. If you and/or your dependents acquire coverage through a non-EUTF employer or Medicaid plan you have 30 days from the effective date of the other coverage to disenroll from the EUTF plans. You must provide the EUTF with a copy of a letter from the new employer/plan detailing the type of coverage acquired (e.g. medical, dental, prescription drug, vision), the effective date of coverage, and the name(s) of covered dependent(s).
6. You move out of your plan’s service area.

Common Qualifying Events

The following chart lists common qualifying events that allow you to add or remove dependents. The events are listed by dependent additions and deletions and include required documents, submission deadlines and plan effective dates. Please note that the deadline for submitting the EC-2/EC-2H form may differ from the deadline to submit required documents, therefore be sure to submit your EC-2/EC-2H even if you may have not yet received required proof documents in order to meet the EC-2/EC-2H submission deadline.

Common Qualifying Events – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date (Pay periods occur on the 1st and 16th)
Adoption	EC-2 /EC-2H form within **30** days of adoption date Adoption decree or placement for adoption documents submitted within **60** days from the adoption date	Retiree can choose: the event date, first day of the pay period following the event date or first day of the 2nd pay period following the event date.
Birth	EC-2/EC-2H form within **180** days of birth date Birth certificate: only if child has a different last name from the retiree Social Security Number: within **60** days from date of submission of enrollment form.	Retiree can choose: the event date, first day of the pay period following the event date or first day of the 2nd pay period following the event date.
Civil Union	EC-2 /EC-2H form within **30** days of civil union Civil Union Certificate and Affidavit of Dependency submitted within **60** days from the civil union date	Retiree can choose: the event date, first day of the pay period following the event date or first day of the 2nd pay period following the event date.
Domestic Partnership	EC-2 /EC-2H form within **30** days of notarized signature Notarized Declaration of Domestic Partnership & Affidavit of Dependency & Acknowledgement form submitted within **60** days from the domestic partnership date	Retiree can choose: the event date, first day of the pay period following the event date or first day of the 2nd pay period following the event date.
Geographic Relocation (Kaiser members who move outside the Kaiser service area)	EC-2 /EC-2H form indicating change of address within **30** days of Relocation date	Date of relocation.
Loss of Coverage (Retiree and/or dependent loses health coverage and wishes to enroll in EUTF or HSTA VB plans)	EC-2 /EC-2H form within **30** days of loss of coverage Letter from previous employer or carrier detailing type of coverages lost (i.e. medical, drug, dental, vision), date of loss of coverage, and names of any covered dependents within **60** days	The first day following the day non-EUTF coverage was lost.
Marriage	EC-2 /EC-2H form within **30** days of marriage Marriage certificate submitted within **60** days from the marriage date	Retiree can choose: the event date, first day of the pay period following the event date or first day of the 2nd pay period following the event date.
Newly Eligible Student Dependent (Unmarried dependent age 19 thru 23 becomes a full-time student)	EC-2 /EC-2H form within **30** days from school start date Student certification: a letter from an accredited school on school letterhead with registrar's signature confirming full-time status or letter from National Student Clearinghouse within **60** days of becoming a full-time student. Transcripts not accepted.	Retiree can choose: the event date, first day of the pay period following the event date or first day of the 2nd pay period following the event date.
Retirement	EC-2 /EC-2H form within **60** days of retirement date with the ERS Retirement Estimate Letter. If Medicare eligible, copy of Medicare Part B card, Direct Deposit Agreement from, and Letter from Social Security showing annual Part B premium within **60** days from the date of retirement	Retirement date.

Common Qualifying Events – Deletions

Qualifying Event	Required Documents and Submission Deadline	Effective Date (Pay periods occur on the 1st and 16th)
Acquisition of Coverage (Retiree or dependent gets coverage from another plan and wishes to cancel EUTF or HSTA VB plans)	EC-2 /EC-2H form within **30** days of acquisition of coverage Letter from carrier or employer detailing type of coverages enrolled in (i.e., medical, drug, dental, vision), effective date of coverage, and names of covered dependents within **60** days from the date of acquisition.	End of pay period in which retiree acquires coverage from a non-EUTF plan, except when the retiree acquires coverage from the non-EUTF plan on the first or 16th of the month, in which case coverage ends at the end of the prior pay period.
Death	EC-2 /EC-2H form as soon as reasonably practical Death certificate or copy of obituary as soon as available.	Date of death or last day of pay period in which death occurs for dependents.
Divorce (Retiree must terminate coverage for former spouse)	EC-2 /EC-2H form within **30** days of divorce. Submit pages 1 and 2 of divorce decree along with the signature page and any pages that outline health benefits for children within **60** days from the date of the divorce.	First day of the pay period following the divorce.
Failure to Enroll in Medicare Part B (Retirees and their dependents who are eligible to enroll in Medicare Part B must enroll to be covered under EUTF and HSTA VB medical and prescription drug plans)	None	The date retiree or Medicare eligible dependent first became eligible for Medicare Part B.
Failure to Pay (Retiree owes a shortage, but does not pay shortage by due date. Enrollment will be cancelled)	None	If enrollment is cancelled, retiree may only re-enroll during the next open enrollment period.
Ineligible Student (Dependent child no longer a full-time student)	EC-2 /EC-2H form as soon as the dependent child is no longer enrolled as a full-time student.	First day of the pay period following the date the child was no longer enrolled as a full-time student.
Legal Separation (Retiree must terminate coverage for former spouse)	EC-2 /EC-2H form within 30 days of date of legal separation. Court documents establishing legal separation including any pages outlining health benefits for children within **60** days from separation date.	First day of the pay period following the legal separation.
Surviving Spouse/Partner Remarries or Enters Into Another Partnership (Surviving spouse or partner will be cancelled from EUTF or HSTA VB plans)	EC-2 /EC-2H form within **30** day of marriage or new domestic partnership.	The first day of the pay period following the marriage or new partnership.

Required Notices

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

- **Qualified Medical Child Support Order**– This is to notify participants that your health insurance plan honors qualified medical child support orders (QMCSOs), which means that if a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan.
- **National Medical Support Notices**– The EUTF also honors qualified National Medical Support Notices (NMSNs), which are similar to a QMCSO, but are issued by a state agency pursuant to a medical child support order.
- **Continuation of Group Health Coverage Under COBRA**: Initial Notice – This notice includes information on the federal law, commonly known as "COBRA," that requires most employers to offer employees and their covered dependents the opportunity to elect a temporary continuation of health coverage, at group rates, when coverage would otherwise be terminated, because of a "qualifying event".

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

- **HIPAA Notice: Notice of Privacy Rights** – This notice describes how your prescription drug information may be used and disclosed and how you can get access to this information.
- **Notice of Creditable Covera**ge – This notice has information about your current prescription drug coverage with the EUTF and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

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

- **Women's Health & Cancer Rights Act** – This notice includes information regarding benefits that your health insurance plan is required to provide by the Women's Health and Cancer Rights Act of 1998 for mastectomy-related services.
- **Newborns' & Mothers' Health Protection Act** – This is to notify participants that group health plans and health insurance issuers who offer group insurance coverage may not (under federal law) restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section.
- **HIPAA Notice: Notice of Privacy Rights** – This notice describes how your medical information may be used and disclosed and how you can get access to this information.
- **Patient Protection Disclosure** – This notice provides individuals with information regarding their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization.
- **Massachusetts Health Care Reform Act** (for Retirees residing in Massachusetts only) – In order to help individuals determine if the health coverage they have or intend to purchase is sufficient to satisfy the individual mandate, carriers must disclose to insureds and potential insureds a health plan's Minimum Creditable Coverage status and whether the plan satisfies the individual coverage mandate of the Massachusetts Health Care Reform Law.

EUTF Important Notices

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

CHANGES DURING THE PLAN YEAR TO YOUR HEALTH CARE BENEFIT ELECTIONS

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

- **Special Enrollment Event:**

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

  In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, adoption, or placement for adoption (180 days after the birth).

  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 1-808-586-7390 or toll-free at 1-800-295-0089.

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

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

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

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

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

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

  You or your dependents must promptly furnish to the EUTF Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth or change in status of a dependent child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

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

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

  EUTF will determine if your change request is permitted and the effective date. Failure to give EUTF a timely notice (as noted above) may:

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

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

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

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

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

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

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

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

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

PRIVACY NOTICE REMINDER FROM EUTF

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

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

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

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

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

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

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

Your medical insurance plans honor a valid qualified medical child support orders (QMCSO) in accordance with law. A QMCSO 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 1-808-586-7390 or toll-free at 1-800-295-0089.

COBRA COVERAGE REMINDER

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

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

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

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

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

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

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

When you elect EUTF-sponsored health coverage, EUTF will provide you with a COBRA Initial Notice. If you have questions about COBRA or would like another copy of a COBRA Initial Notice please contact the EUTF Office at 1-808-586-7390 or toll-free at1-800-295-0089.

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

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

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

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

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

Direct Access to OB/GYN Providers:

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

IMPORTANT NOTICES ATTACHED

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

- **Medicare Part D Notice**
- **Notice about Premium Assistance with Medicaid and CHIP**
- The Plan's **HIPAA Privacy notice**.
- General Statement of Nondiscrimination

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

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

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

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

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

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

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

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

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

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

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

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

YOUR RIGHT TO RECEIVE A NOTICE

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

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

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

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

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

WHAT ARE MY CHOICES?

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

If you select or keep EUTF Retiree medical plan coverage with:	What you can do:	What this option means to you:
EUTF HMSA	Select or keep EUTF prescription drug coverage through SilverScript and **DO NOT ENROLL in a non-EUTF Medicare Part D prescription drug plan.**	You will continue to be able to use your EUTF Retiree medical plan and prescription drug benefits through SilverScript. As long as you are enrolled in creditable drug coverage (and the EUTF prescription drug coverage through SilverScript are creditable), you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare Part D prescription drug plan. **WARNING:** If you enroll in a non-EUTF Medicare Part D prescription drug plan while you are also enrolled in an EUTF prescription drug plan through or SilverScript you will then have two prescription drug plans and this will make you **NO LONGER ELIGIBLE for EUTF prescription drug coverage**.
	Enroll in a Medicare Part D prescription drug plan and **DO NOT ENROLL in an EUTF prescription drug plan through SilverScript.** If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D prescription drug plan premium out of your own pocket.	Without having EUTF prescription drug plan coverage through SilverScript (which are creditable coverage) **you will need to enroll in Medicare Part D prescription drug plan (PDP)** to avoid having to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts; • PDPs cover different brand name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail order services.

If you select or keep EUTF Retiree medical plan coverage with:	What you can do:	What this option means to you:
EUTF and HSTA VB Kaiser and **HSTA VB HMSA**	**DO NOT ENROLL in a Medicare Part D prescription drug plan** Prescription drug coverage is automatically included with the Kaiser Senior Advantage medical plan and the HSTA VB HMSA plan.	You will continue to be able to use your Retiree medical plan and prescription drug benefits through EUTF Kaiser or HSTA VB HMSA. As long as you are enrolled in creditable drug coverage (and the prescription drug coverage through Kaiser or HSTA VB HMSA is creditable) you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare Part D prescription drug plan. **WARNING:** If you enroll in a non-EUTF Medicare Part D prescription drug plan while you are also enrolled in a Kaiser or HSTA VB HMSA prescription drug plan you will then have two prescription drug plans and this will make you **NO LONGER ELIGIBLE for Kaiser or HSTA VB HMSA**

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 personalizedhelp
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

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

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

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
P. O. Box 2121
Honolulu, Hawaii 96805-2121
Phone Number: 1-808-586-7390 or toll-free at 1-800-295-0089

As in all cases, EUTF and, when applicable, the medical plan insurance companies, reserve the right to modify benefits at any time, in accordance with applicable law. This document (dated June 12, 2017) is intended to serve as your Medicare Part D Notice of Creditable Coverage, as required by law.

PREMIUM ASSISTANCE
UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

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

To see if any other states have added a premium assistance program since **January 31, 2017,** or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

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, Hawaii Dental Service, Vision Service Plan, and American Specialty Health Group Inc. in order to verify your eligibility for benefits or services.

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

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

Immunizations: To a school about an individual who is a student or prospective student of the school if the protected health information this is disclosed is limited to proof of immunization, the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis of the individual, if the individual is an emancipated minor; or the individual, if the individual is an adult or emancipated.
Organ and Tissue Donation: If you are an organ donor, the EUTF may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Regarding Your Medical Information

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

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

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

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

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

If you request a copy of the information, the EUTF may charge a fee for the costs of copying and mailing the information to you, for creating the PHI or preparing a summary of your PHI, or for other supplies associated with complying with your request.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- What information you want to limit,

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

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

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

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

A Note about Personal Representatives

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

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

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

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

Changes to This Notice

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

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

Minimum Necessary Standard

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

- Disclosures to or requests by a health care provider for treatment,
- Uses by you or disclosures to you of your own medical information,
- Disclosures made to the Secretary of the Department of Health and Human Services,
- Uses or disclosures that may be required by law,
- Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- Uses and disclosures for which the EUTF has obtained your authorization.

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

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

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

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice. You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website (http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html) or this website:

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Or contact the Privacy Officer for more information about how to file a complaint. You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

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

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

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

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

Governing Law
If there is any discrepancy between the information in this notice and the actual HIPAA regulations, the regulations will prevail, and the EUTF will use and disclose your medical information in a manner consistent with the regulations.
You may contact the EUTF Privacy Officer at the following address:

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

Physical Address:
201 Merchant Street, Suite 1700, Honolulu, HI 96813

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

GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EUTF does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. EUTF:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact EUTF's Civil Rights Coordinator.

If you believe that EUTF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

EUTF Civil Rights Coordinator
Mailing Address: P.O. Box 2121, Honolulu, HI 96805

Physical Address: 201 Merchant Street, Suite 1700, Honolulu, HI 96813

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

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the EUTF Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

Free Language Assistance: The following chart displays the top 15 languages spoken by individuals with limited English proficiency in the state of Hawaii.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
1. Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-295-0089.
2. Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-295-0089.
3. French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-295-0089.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
4. German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-295-0089.
5. Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-295-0089.
6. Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-295-0089.
7. Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-295-0089 번으로 전화해 주십시오.
8. Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-295-0089まで、お電話にてご連絡ください。
9. Ilocano	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-295-0089.
10. Samoan	MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-295-0089.
11. Marshallese	LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-800-295-0089.
12. Trukese	MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1-800-295-0089.
13. Tongan	FAKATOKANGA'I: Kapau ‘oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea ‘oku nau fai atu ha tokoni ta’etotongi, pea teke lava ‘o ma’u ia. Telefoni mai 1-800-295-0089.
14. Hawaiian	E NĀNĀ MAI: Inā hoʻopuka ‘oe i ka ‘ōlelo [hoʻokomo ‘ōlelo], loaʻa ke kōkua manuahi iā ‘oe. E kelepona iā 1-800-295-0089.
15. Pohnpeian	Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-800-295-0089.

Administrative Appeals

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

Under EUTF Administrative Rule 2.04, a person aggrieved by one of the following 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 and eighty days (180) of the date of the adverse decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the Administrator nor the Board shall be required to hear any appeal that is filed after the one hundred and eighty day (180) period has expired. The written appeal need not be in any particular form but should contain the following information:

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

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

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

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

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

The Board shall grant or deny the appeal within forty-five (45) days of the date of the postmark of the request for appeal. The Board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the Board may set such hearing before the Board, a special, or standing committee of the Board, a hearings officer,

or any other person or entity authorized by the Board to hear the matter in question. Nothing in the EUTF Administrative Rules shall require the Board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

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

For emergency appeals of eligibility, please refer to the EUTF Administrative Rule 2.05.

COBRA Retiree Open Enrollment

The open enrollment period for members enrolled in the EUTF or HSTA VB COBRA retiree health plans is ***October 9*** through ***October 31, 2017.*** During open enrollment (OE) you can:

- Add, change or drop a plan
- Add or remove a dependent
- Change coverage tiers, such as changing from Self to Family or Family to Two-party
- Now is also a good time to tell us if you've had a change of address

A COBRA packet will be sent to your address on file with the EUTF COBRA OE Enrollment Form or HSTA VB COBRA OE Enrollment Form to provide you an opportunity to make changes to your COBRA health plans. Plan changes properly submitted during this open enrollment period will be effective ***January 1, 2018***.

Your completed EUTF COBRA OE Enrollment Form or HSTA VB COBRA OE Enrollment Form must be postmarked to the EUTF **on or before *October 31, 2017*.**

Enrollment forms postmarked after ***October 31, 2017*** will **NOT be accepted**.

If you do **NOT** want to make changes you do **NOT** need to complete the COBRA OE Enrollment Form.

COBRA Retiree Open Enrollment Rates for EUTF and HSTA VB

The following premium rates for EUTF and HSTA VB COBRA retirees are approved for the period of ***January 1, 2018*** through ***December 31, 2018***. Separate invoices will be billed by each carrier selected. COBRA rates listed do not include the COBRA administration fee.

EUTF Monthly Retiree COBRA Premiums

Effective January 1, 2018 through December 31, 2018

Benefit Plan	Type of Enrollment	Regular COBRA
MEDICAL AND PRESCRIPTION DRUG PLANS - MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$238.90
	Two Party	$465.50
	Family	$690.09
SilverScript Prescription Drug Plan	Self	$166.09
	Two-Party	$323.42
	Family	$479.54
Kaiser Senior Advantage Medical and Prescription Drug Plan	Self	$492.82
	Two-Party	$960.96
	Family	$1,424.16
MEDICAL AND PRESCRIPTION DRUG PLANS – NON–MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$530.58
	Two-Party	$1,033.89
	Family	$1,532.73
CVS Caremark Prescription Drug Plan	Self	$184.73
	Two-Party	$359.80
	Family	$533.46
Kaiser HMO Comprehensive Medical and Prescription Drug Plan	Self	$813.71
	Two-Party	$1,643.66
	Family	$2,424.84
DENTAL PLAN		
HDS Dental	Self	$40.26
	Two-Party	$78.58
	Family	$96.26
VISION PLAN		
VSP Vision	Self	$5.05
	Two-Party	$10.13
	Family	$13.60

HSTA VB Monthly Retiree COBRA Premiums

Effective January 1, 2018 through December 31, 2018

Benefit Plan	Type of Enrollment	Regular COBRA
MEDICAL AND PRESCRIPTION DRUG PLANS - MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic Plan	Self	$204.73
	Two Party	$399.20
	Family	$590.29
SilverScript Prescription Drug Plan	Self	$193.80
	Two-Party	$377.38
	Family	$559.54
Kaiser Senior Advantage Medical, Chiropractic and Prescription Drug Plan	Self	$500.86
	Two-Party	$976.58
	Family	$1,447.35
MEDICAL AND PRESCRIPTION DRUG PLANS – NON–MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic Plan	Self	$436.66
	Two-Party	$850.86
	Family	$1,259.92
CVS Caremark Prescription Drug Plan	Self	$201.27
	Two-Party	$392.03
	Family	$581.24
Kaiser HMO Comprehensive Medical, Chiropractic and Prescription Drug Plan	Self	$798.25
	Two-Party	$1,612.88
	Family	$2,379.41
DENTAL PLAN		
HDS Dental	Self	$48.47
	Two-Party	$94.37
	Family	$115.70
VISION PLAN		
VSP Vision	Self	$5.05
	Two-Party	$10.13
	Family	$13.60

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FOR MORE INFORMATION

For Questions About…	Please Contact…
Eligibility & EUTF Information	**eutf.hawaii.gov** EUTF Customer Service 1-808-586-7390 or Toll-Free: 1-800-295-0089 (Monday through Friday, 7:45 a.m. – 4:30 p.m. HST)
Hawaii Medical Service Association (HMSA)	**www.hmsa.com** 1-808-948-6499 (Oahu) or Toll-Free: 1-800-776-4672 (Neighbor Islands) (Monday through Friday, 7 a.m. – 7 p.m. HST) In person at the following locations: **HMSA EUTF Office** City Financial Tower 201 Merchant St., Suite 1840 Honolulu, HI 96813 (Hours of Operation: Monday – Friday, 7:45 a.m. – 4:30 p.m. HST) **HMSA Center @ Honolulu** HMSA Building 818 Keeaumoku St. Honolulu, HI 96814 (Hours of Operation: Monday through Friday, 8 a.m. – 6 p.m. HST Saturday: 9 a.m. – 2 p.m. HST) **HMSA Center @ Pearl City** Pearl City Gateway 1132 Kuala St., Suite 400 Pearl City, HI 96782 (Hours of Operation: Monday – Friday, 9 a.m. – 7 p.m. HST Saturday: 9 a.m. – 2 p.m. HST) **HMSA Center @ Hilo** Waiakea Center 303A E. Makaala St. (Hours of Operation: Monday – Friday, 9 a.m. – 7 p.m. HST Saturday: 9 a.m. – 2 p.m. HST) **Kailua-Kona Office** 75-1029 Henry St., Suite 301 Kailua-Kona, HI 96740 (Hours of Operation: Monday – Friday, 8 a.m. – 4 p.m. HST)

For Questions About…	Please Contact…
	Maui Office 33 Lono Ave., Suite 350 Kahului, HI 96732 (Hours of Operation: Monday – Friday, 8 a.m. – 4 p.m. HST)
American Specialty Health Group, Inc.	**HMSA Chiropractic Benefit (HSTA VB only)** **www.ashcompanies.com** Member Servicing: 1-800-678-9133 (Monday through Friday 6:00 a.m. ough Friday HST, excluding federal observed holidays) Claims Mailing Address: American Specialty Health, P.O. Box 509001, San Diego, CA 92150-9001
Kaiser Permanente (Kaiser)	**www.kp.org/eutf** 1-808-432-5250 (Oahu) or Toll-Free: 1-844-276-6628 (Neighbor Islands) (Monday through Friday, 7:00 a.m. – 7:00 p.m. HST Saturdays 8:00 a.m. – 12:00 p.m. HST) Excluding State observed holidays Walk-in service: 711 Kapiolani Blvd. Honolulu, HI 96813 Monday through Friday, 8:00 a.m. – 4:30 p.m. Excluding State observed holidays
CVS Caremark (CVS) Non-Medicare Retirees **SilverScript (SSI)** Medicare Retirees	**CVS Caremark (CVS)**: Non-Medicare Retirees **www.caremark.com** 1-855-801-8263 **SilverScript (SSI)**: Medicare Retirees **eutf.silverscript.com** **hstavb.silverscript.com** 1-877-878-5715 **CVS/Caremark Walk In Customer Service Center:** **Location: 1003 Bishop St, Pauahi Tower, Suite 704** **Hours of Operation:** Monday through Friday, 7:45 a.m. – 4:30 p.m. HST **except State observed holidays**
Hawaii Dental Service (HDS)	**www.HawaiiDentalService.com** 1-808-529-9310 or Toll-Free: 1-866-702-3883 (Over the phone: Monday through Friday, 7:00 a.m. – 7:00 p.m. HST) Saturday 9:00 a.m. – 1:00 p.m., except Federal and State observed holidays) (Walk in hours: Monday through Friday, 8:00 a.m. – 4:30 p.m. HST, except Federal and State observed holidays) Office located: Topa Financial Center, Bishop Street Tower 700 Bishop Street, Suite 700 Honolulu, HI 96813

For Questions About…	Please Contact…
Vision Service Plan (VSP)	**www.vsp.com** Toll-Free: 1-866-240-8420 (Monday through Friday, 5:00 a.m. – 8:00 p.m. PST Saturday 7:00 a.m. – 8:00 p.m. PST Sunday 7:00 a.m. – 7:00 p.m. PST) Oahu: 1-808-532-1600 or Toll-Free: 1-800-522-5162 Office located: 1003 Bishop Street, Pauahi Tower, Suite 890, Honolulu, HI 96813 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST) – walk-in location
USAble Life (USAble)	**www.usablelife.com/portal/eutf** 1-808-538-8920 or Toll-Free: 1-855-207-2021 (Monday through Friday, 7:45 a.m. – 4:30 p.m. HST, except State observed holidays) USAble Life Full Service Walk In Office: First Hawaiian Center Building 999 Bishop St. Suite 2701 (Monday through Friday, 7:45 a.m. – 4:30 p.m. HST, except State observed holidays) Email: Service or General Inquiries: EUTF.CustServ@USAbleLife.com Claims Inquiries: EUTF.Claims@USAbleLife.com
Social Security Administration Office	**www.ssa.gov** 1-800-772-1213
Centers for Medicare and Medicaid Services	**cms.gov** 1-800-MEDICARE

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EC-2 Enrollment Form Instructions

Enrollment Type

Select the event for which you are submitting the enrollment form. Mark the Retirement box if you're newly retired, Qualifying Event box if you are making changes outside of the Open Enrollment period, or the Open Enrollment box during the annual or limited open enrollment period. If submitting the enrollment form for a qualifying event, give a brief description of the event and input the date the qualifying event occurred.

I. Retiree Data

Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

This section only needs to be completed if filing for adoption/placement for adoption, birth, marriage, domestic partner, guardianship or new eligible student, and you pay towards health plan benefits. Select one of the three choices for when your coverage and premium contributions will begin. If no selection is made, the first option will be the default option used.

III. Plan Selection

Mark all plans you wish to be enrolled in. You may only enroll in ONE medical plan. If you select Kaiser, your medical selection will include Kaiser Prescription drug coverage. If you select HMSA and wish to enroll in prescription drug coverage, you must select the CVS Caremark prescription drug plan (if you do not make a selection you will not have any prescription drug coverage). If you wish to dis-enroll from plans, mark the "Cancel/Waive" box. If no selection is made, EUTF will assume no changes are being made.

IV. Dependent Information

Complete dependent information and indicate plan selection if adding or removing dependents. If you are adding/removing more than three dependents and additional rows are needed, please attach another sheet to your enrollment form. Required supporting documents (i.e., court order, birth certificate, etc.) must be submitted to the EUTF within 60 days of the event date. Please review the section on required supporting documents, which may be found in the Retiree Reference Guide on pages 92-93, or online at eutf.hawaii.gov.

Reminder: Please submit student certification for dependent children ages 19 through 23 who are unmarried and a full-time student.

V. Medicare

If you and/or your dependent(s) are eligible to enroll in Medicare Part B, complete the name and Medicare Claim Number of the individuals enrolled. Additionally, you must submit proof of Medicare Part B enrollment to the EUTF in order to be enrolled in EUTF retiree medical and/or prescription drug coverage. Submit a copy of your Medicare card (indicating enrollment in Medicare Part B), letter from the Social Security Administration indicating your Medicare Part B premium, and EUTF Direct Deposit Agreement form. Failure to comply may result in loss of EUTF medical and/or prescription drug coverage.

VI. Other Insurance Information

If you or your dependents are covered under another health plan, you are required to complete this section. The information that you provide does not determine how your benefits are coordinated. Coordination of Benefits rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioner (www.naic.org).

VII. Retiree Signature

Read, sign and date the form.

Submit your EC-2 form to the EUTF office. Please see addresses printed on the bottom of page 2 of the enrollment form. To ensure proper processing, all required fields must be completed and proper documentation submitted timely.

EC-2H Enrollment Form Instructions

Enrollment Type

Select the event for which you are submitting the enrollment form. Mark the Retirement box if you're newly retired, Qualifying Event box if you are making changes outside of the Open Enrollment period, or the Open Enrollment box during the annual or limited open enrollment period. If submitting the enrollment form for a qualifying event, give a brief description of the event and input the date the qualifying event occurred.

I. Retiree Data

Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

This section only needs to be completed if filing for adoption/placement for adoption, birth, marriage, domestic partner, guardianship or new eligible student, and you pay towards health plan benefits. Select one of the three choices for when your coverage and premium contributions will begin. If no selection is made, the first option will be the default option used.

III. Plan Selection

Mark all plans you wish to be enrolled in. You may only enroll in ONE medical plan and ONE dental plan. Your choice of the prescription drug and vision plan will depend on the medical plan that you select. If you select Kaiser, your medical selection will include Kaiser Prescription drug coverage. If you select HMSA, your medical selection will include CVS Caremark drug coverage. If you wish to dis-enroll from plans, mark the "Cancel/Waive" box. If no selection is made, EUTF will assume no changes are being made.

IV. Dependent Information

Complete dependent information and indicate plan selection if adding or removing dependents. If you are adding/removing more than three dependents and additional rows are needed, please attach another sheet to your enrollment form. Required supporting documents (i.e., court order, birth certificate, etc.) must be submitted to the EUTF within 60 days of the event date. Please review the section on required supporting documents, which may be found in the Retiree Reference Guide on pages 92-93, or online at eutf.hawaii.gov.

Reminder: Please submit student certification for dependent children ages 19 through 23 who are unmarried and a full-time student.

V. Medicare

If you and/or your dependent(s) are eligible to enroll in Medicare Part B, complete the name and Medicare Claim Number of the individuals enrolled. Additionally, you must submit proof of Medicare Part B enrollment to the EUTF in order to be enrolled in EUTF retiree medical and/or prescription drug coverage. Submit a copy of your Medicare card (indicating enrollment in Medicare Part B), letter from the Social Security Administration indicating your Medicare Part B premium, and EUTF Direct Deposit Agreement form. Failure to comply may result in loss of EUTF medical and/or prescription drug coverage.

VI. Other Insurance Information

If you or your dependents are covered under another health plan, you are required to complete this section. The information that you provide does not determine how your benefits are coordinated. Coordination of Benefits rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioner (www.naic.org).

VII. Retiree Signature

Read, sign and date the form.

Submit your EC-2 form to the EUTF office. Please see addresses printed on the bottom of page 2 of the enrollment form. To ensure proper processing, all required fields must be completed and proper documentation submitted timely.

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Hawaii Employer-Union Health Benefits Trust Fund

EC-2 RETIREE HEALTH BENEFITS ENROLLMENT FORM

Complete each section thoroughly, please print clearly			
Enrollment Type (*check one*):	Retirement ❑	Qualifying Event ❑	Open Enrollment ❑
Retirement or Qualifying Event Date:	Qualifying Event Description:		

I. RETIREE DATA

Full Name: _____ Social Security No.: _____
Last *First* *M.I.*

Mailing Address: _____ Residence Address: _____
_____ _____
City *State* *Zip Code* *City* *State* *Zip Code*

Marital Status: ❑ Single ❑ Married ❑ Domestic Partner Gender: ❑ Male ❑ Female Birthdate: ___/___/___
Marriage Date: ___/___/___

Home Phone: ( ) _____ Cell Phone: ( ) _____ Email: _____

Spouse/Partner Name: _____ SSN: _____ Birthdate: ___/___/___

II. COVERAGE START DATE

Complete this section if filing for adoption/placement for adoption, birth, marriage, domestic partner, guardianship, or newly eligible student.

❑ 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 (1st or the 16th of the month)

❑ Coverage and premium contributions start 1st day of the second pay period following event (1st or the 16th of the month)

III. PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Choose only one box in each type category.

Type	Carrier Selection	Cancel/waive	Self	2-Party	Family
Medical: *Choose ONE*	*HMSA PPO-90/10 Medical (No Prescription Drug Coverage)*	❑	❑	❑	❑
	Kaiser HMO Medical (Includes Kaiser Prescription Drug)	❑	❑	❑	❑
Prescription Drug:	*CVS Caremark Prescription Drug (Not a valid selection with Kaiser)*	❑	❑	❑	❑
Dental:	*Hawaii Dental Service*	❑	❑	❑	❑
Vision:	*Vision Service Plan*	❑	❑	❑	❑
Life:	*USAble Life Insurance*	❑	❑	***Not available to dependents***	

Retiree's Name:

State and County Contributions: No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled by more than one retiree/active employee (dual enrollment). In addition, if you and your spouse/partner are both retirees/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. Both retirees/active employees are able to select EUTF Self-only plans, but not Self-only and 2-Party plans or Self-only and Family plans.

IV. DEPENDENT INFORMATION

Complete dependent information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First, Middle Initial	Birthdate	SSN	Relationship	Gender	Medical	Drug	Dental	Vision
❑	❑	❑						❑	❑	❑	❑
❑	❑	❑						❑	❑	❑	❑
❑	❑	❑						❑	❑	❑	❑

If dependents are ages 19 to 23 please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at/eutf.hawaii.gov

V. MEDICARE

Are you and/or any of your dependents eligible for Medicare Part B? ❑ Yes (Complete section below) ❑ No

Name:	Medicare Claim Number:
Name:	Medicare Claim Number:

State law requires that retirees and their covered dependents enroll in Medicare Part B when they become eligible in order to be enrolled in EUTF/HSTA VB retiree medical and/or prescription drug coverage, HRS Chapter 87A-23(4). Please submit a copy of your Medicare card.

VI. OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide data below.

Type of Plan: (i.e. medical, dental)	Name of the Plan: (i.e. HMSA, Quest)	Subscribers Name(s):

VII. RETIREE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect 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 elected.

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. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions 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 penalties for perjury.

Retiree Signature *Date*

Please submit your signed EC-2 form by mail to:

EUTF
PO BOX 2121
Honolulu, HI 96805

Or you may hand deliver to:

EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

Customer Service Call Center

Oahu (808) 586-7390
Toll Free 1(800) 295-0089

Hawaii Employer-Union Health Benefits Trust Fund

EC-2H RETIREE HEALTH BENEFITS ENROLLMENT FORM
HSTA VB Retirees Only

Complete each section thoroughly, please print clearly			
Enrollment Type (*check one*):	Retirement ❑	Qualifying Event ❑	Open Enrollment ❑
Retirement or Qualifying Event Date:		Qualifying Event Description:	

I. RETIREE DATA

Full Name: _____ Social Security No.: _____
Last *First* *M.I.*

Mailing Address: _____ Residence Address: _____
_____ _____
City *State* *Zip Code* *City* *State* *Zip Code*

Marital Status: ❑ Single ❑ Married ❑ Domestic Partner Gender: ❑ Male ❑ Female Birthdate: ___/___/___
Marriage Date: ___/___/___

Home Phone: ( ) _____ Cell Phone: ( ) _____ Email: _____

Spouse/Partner Name: _____ SSN: _____ Birthdate: ___/___/___

II. COVERAGE START DATE

Complete this section if filing for adoption/placement for adoption, birth, marriage, domestic partner, guardianship, or newly eligible student.

❑ 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 (1st or the 16th of the month)

❑ Coverage and premium contributions start 1st day of the second pay period following event (1st or the 16th of the month)

III. PLAN SELECTION

Make your selection by checking all the boxes of the appropriate benefit plans below. Choose only one box in each type category.

Type	Carrier Selection	Cancel/Waive	Self	2-Party	Family
Medical, Prescription Drug, Vision, and Chiro: *Choose ONE*	*HSTA VB - HMSA PPO-90/10 Medical and Chiro (CVS Prescription Drug, VSP Vision)*	❑	❑	❑	❑
	HSTA VB - Kaiser HMO Medical and Chiro (Kaiser Prescription Drug, VSP Vision)	❑	❑	❑	❑
Dental:	*HSTA VB - Hawaii Dental Service*	❑	❑	❑	❑
Life:	*HSTA VB - USAble Life Insurance*	❑	❑	**Not available to dependents**	

Note: The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of the 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 the decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.

Retiree's Name:

State and County Contributions: No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled by more than one retiree/active employee (dual enrollment). In addition, if you and your spouse/DP/CUP are both retirees/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. Both retirees/active employees are able to select EUTF Self-only plans, but not Self-only and 2-Party plans or Self-only and Family plans.

IV. DEPENDENT INFORMATION

Complete dependent information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First, Middle Initial	Birthdate	SSN	Relationship	Gender	Medical	Drug	Dental	Vision
❑	❑	❑						❑	❑	❑	❑
❑	❑	❑						❑	❑	❑	❑
❑	❑	❑						❑	❑	❑	❑

If dependents are ages 19 to 23 please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. (Detailed eligibility information is available at http://eutf.hawaii.gov)

V. MEDICARE

Are you and/or any of your dependents eligible for Medicare Part B? ❑ Yes (Complete section below) ❑ No

Name:	Medicare Claim Number:
Name:	Medicare Claim Number:

State law requires that retirees and their covered dependents enroll in Medicare Part B when they become eligible in order to be enrolled in HSTA VB retiree medical and/or prescription drug coverage, HRS Chapter 87A-23(4). Please submit a copy of your Medicare card.

VI. OTHER INSURANCE INFORMATION

If you or any of your dependents are covered under another non-EUTF health plan(s), provide data below.

Type of Plan: (i.e. medical, dental)	Name of the Plan: (i.e. HMSA, Quest)	Subscribers Name(s):

VII. RETIREE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect 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 elected.

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. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions 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 penalties for perjury.

Retiree Signature *Date*

Please submit your signed EC-2 form by mail to:

EUTF
PO BOX 2121
Honolulu, HI 96805

Or you may hand deliver to:

EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

Customer Service Call Center

Oahu (808) 586-7390
Toll Free 1(800) 295-0089

Clear Form

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

Direct Deposit Agreement Form

- ✓ I request reimbursement for my Medicare Part B Premium. A copy of my Medicare card and a copy of the letter from the Social Security Administration or Centers for Medicare & Medicaid Services showing the Medicare Part B Premium I pay are attached (for initial requests only). I understand that reimbursement of Medicare Part B Premiums will not begin until the EUTF receives a copy of the letter from the Social Security Administration or Centers for Medicare & Medicaid Services showing the Medicare Part B Premium I pay.
- ✓ I certify that my Medicare Part B premiums are not paid by any other entity, e.g. the Medicare Savings Program or Medicaid. Should my Part B premiums be paid by another entity in the future, I will notify the EUTF within 30 days of being notified by the other entity.
- ✓ If my enrollment in Medicare Part B stops I will notify the EUTF within 30 days. I understand that disenrollment from Medicare Part B means I will no longer be eligible for Part B premium reimbursement, as well as medical and prescription drug coverage.

Retiree Name:		**SSN or EUTF ID Number:**
Retiree Mailing Address:		**Phone:**

SECTION A – Deposit Authorization

Hawaii law (Act 039, SLH2006) requires all individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to designate a financial institution account into which the State of Hawaii EUTF shall be authorized to deposit their quarterly Medicare Part B reimbursements.

By signing in Section D, I/We hereby authorize the State of Hawaii EUTF to automatically and directly deposit my Medicare Part B premium reimbursements to my/our account at the financial institution named below:

SECTION B – Account Information (see your financial institution for help in completing this section)

Name of Account Holder(s):		
Name of Financial Institution:		
Routing Number:	**Account Number:**	☐ **Checking*** ☐ **Savings**
Financial Institution Certification (Required for Savings; Optional for Checking): **Name of Agent:**_____ **Signature**_____ **Date:**_____		

SECTION C – Agreements of All Account Holders

By signing in Section D, the Account Holder(s):

- Certify all information is accurate and authorize the EUTF to make withdrawals from my/our account in the event that the EUTF benefits have been deposited to the account in error, e.g., overpayments.
- Consent to the disclosure by the Financial Institution to the EUTF of any information that the EUTF requests to effectuate, administer, or enforce the transactions authorized in Sections A and C.
- Agree not to hold the EUTF responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me/us or by Financial Institution or due to an error on the part of Financial Institution in depositing funds to the account

SECTION D – Signatures of All Account Holders

Authorized Signature (Primary):	**Date:**
Authorized Signature:	**Date:**

***Please attach a VOIDED check and return this form to the EUTF**

Instructions Direct Deposit Agreement Form

The Social Security Administration or Centers for Medicare & Medicaid Services will periodically (when you begin receiving Social Security or enroll in Medicare and at least annually) mail you a letter showing the Medicare Part B Premium you pay. Additionally, you can print out a letter from the Social Security Administration showing the Medicare Part B Premium you pay by going to www.ssa.gov or you can request a letter from the Social Security Administration by calling 1-800-772-1213 (TTY 1-800-325-0778).

The 2006 State Legislature passed Act 39 which was signed into law by the Governor on April 27, 2006. The act establishes the requirement for all individuals who become eligible for Medicare Part B reimbursements on or after July 1, 2006 to designate a financial institution into which the EUTF shall be authorized to deposit their Medicare Part B reimbursements.

All portions of the Direct Deposit Agreement Form must be completed, except where optional, in order for the form to be valid. This form must not be altered.

You must submit a new form if there are any changes to your account (i.e., account number, account holder, financial institution). The most recently dated form submitted to EUTF will apply.

Section B – Account Information
The name of the retiree or surviving spouse name must appear on the account. You may ask the representative of the financial institution to help complete this section. For deposits into a savings account, Financial Institution certification is required. For checking accounts, the certification is optional, but a voided check must be attached.

Section C – Agreements of All Account Holders
This section contains the agreements of everybody who is on the account, including the EUTF retiree or spouse or domestic partner or civil union partner. The agreements in Section C apply to all Account Holders even if they are not the retiree or spouse receiving Medicare Part B reimbursements.

Section D – Signatures of All Account Holders
By signing the Medicare Part B Premium Reimbursement Request and Direct Deposit Agreement, the retiree, spouse, and/or surviving spouse certify the information is accurate and confirms that they understand and agree to the agreements in Section C.

The retiree or surviving spouse signs as primary account holder. If the account is a joint account, please have all account holder(s) sign the form. Use an additional sheet if necessary. If you are representing the retiree or surviving spouse or surviving domestic partner or civil union partner, please ensure that you have any authorizing document(s) attached to the Direct Deposit Agreement.

Please be sure to attach a VOIDED check if depositing into a ***checking*** account or have the financial institution complete Section B, if depositing into a ***savings*** account and return this form to the EUTF.

If you have any questions, please contact the EUTF customer call center at:

Oahu: (808)586-7390
Toll-free: (800)295-0089

EUTF website: www.eutf.hawaii.gov

Mailing Address: EUTF
PO Box 2121
Honolulu, HI 96805

Street Address: EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
ACH Deduction Authorization Agreement
Automated Electronic Payment of Health Benefit Premiums

____ New Agreement OR ____ Updated Agreement *(please check one)*

Member Information [*Please Print*]:

Member Name _____Last 4 digits of SSN or EUTF ID Number_____

Mailing Address _____

Home Phone Number _____ Mobile Phone Number_____

Work Phone Number _____E-mail Address_____

SECTION A – Account Information (see your financial institution for help in completing this section)

Name of Account Holder(s):		
Name of Financial Institution:		
Routing Number:		
Account Number:	☐ Checking* (attach a VOIDED check)	☐ Savings
Financial Institution Certification (Required for Savings; Optional for Checking): Name of Agent:_____ Phone:_____ Signature:_____ Date:_____		

SECTION B – Authorization

By signing in Section C, the Account Holder(s):

- Certify all information is accurate and I/we hereby authorize the EUTF to begin deduction of health benefit premiums and/or adjust the deduction amounts as necessary (e.g. due to change in premiums) from my account with the financial institution named above for payment of my EUTF health benefit premiums. This authorization will remain in full force until the EUTF has received written notification from me of its termination in such time and in such manner as to afford EUTF and the Financial Institution a reasonable opportunity to act on it.
- Consent to the disclosure by the Financial Institution to the EUTF of any information that the EUTF requests to effectuate, administer, or enforce the transactions authorized in Section B.
- Agree not to hold the EUTF responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me/us or by Financial Institution or due to an error on the part of the Financial Institution in withdrawing funds from the account.

SECTION C – Signatures of All Account Holders

Authorized Signature (Primary):	**Date:**
Authorized Signature:	**Date:**

***Please attach a VOIDED check and return this form to the EUTF**

Instructions for ACH Deduction Authorization Agreement

All portions of the ACH Deduction Authorization Agreement must be completed, except where optional, in order for the form to be valid. In addition, if there is any alteration of this form, a new form must be completed.

You must submit a new form if there are any changes to your account (i.e., account number, account holder, financial institution). The most recently dated ACH Deduction Authorization Agreement submitted to EUTF will apply.

Section A – Account Information
The name of the active employee, retiree or surviving spouse must appear on the account. You may ask the representative of the financial institution to help complete this section. For withdrawals from a savings account, financial institution certification is required. For withdrawals from checking accounts, a voided check must be attached. If you do not have a voided check, financial institution certification is required.

Section B – Agreement of All Account Holders
This section contains the agreement of all Account Holders, including the EUTF member, retiree or surviving spouse, domestic partner or civil union partner; and other Account Holders. The agreements in Section B apply to all Account Holders even if they are not the member, retiree or surviving spouse plan subscriber.

Section C – Signatures of All Account Holders
By signing the ACH Deduction Authorization Agreement, the signer certifies the information is accurate and confirms that they understand and agree to the agreement in Section B.

The active employee, retiree or surviving spouse signs as primary account holder. If the account is a joint account, please have all Account Holder(s) sign the form. Use an additional sheet if necessary. If you are representing the active employee, retiree or surviving spouse, domestic partner or civil union partner, please ensure that you have any authorizing document(s) attached to the ACH Deduction Authorization Agreement.

Please be sure to attach a VOIDED check if withdrawing from a checking account or have the financial institution complete Section B if you do not have any checks or are withdrawing from a savings account. Please return this form to the EUTF.

If you have any questions, please contact the EUTF customer call center at

Oahu: (808)586-7390 Ext. 3
Toll-free: (800)295-0089 Ext. 3

EUTF website: www.eutf.hawaii.gov

Mailing Address: EUTF
PO Box 2121
Honolulu, HI 96805

Street Address: EUTF
201 Merchant Street, Suite 1650
Honolulu, HI 96813

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State of Hawaii
Department of Budget and Finance
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, Hawaii 96805-2121