HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

ADMINISTRATIVE RULES

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1.00 GENERAL PROVISIONS

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1.01 Purpose

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

1.02 Definitions

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

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

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

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

"Cancellation Non-Payment Status" means an employee-beneficiary whose plans have been cancelled for the remainder of the plan year due to failure to pay the required semi-monthly or monthly contributions.

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

"Child" means an employee's, spouse's or partner's as defined in these rules, legally adopted child, child placed for adoption, stepchild, foster child, or recognized natural child but excluding a child born or legally adopted more than ten months after the date of death of: (1) an active employee killed in the performance of duty; (2) an active employee who was eligible to retire on the date of death; or (3) a retired employee-beneficiary. For non-excepted benefits, a child may be unmarried or married and does not need to live with or be financially dependent on the employee-beneficiary. For excepted benefits, a child must be unmarried and live with the employee-beneficiary. A child has been placed for adoption when an employee-beneficiary, spouse, or partner has assumed custody of and the obligation to support a child in anticipation of adopting the child. A foster child is a child: (1) who lives with an employee in a regular parent-child relationship; and (2) for whom the employee has become the child's guardian and has been awarded legal and physical custody of the child pursuant to a valid court order.

"Civil Union Partner" means an individual who is a party to a civil union established pursuant to Chapter 572B of the Hawaii Revised Statutes.

"Contribution" or "Contributions" shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

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

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

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

"Domestic partner" shall mean a person in a spouse-like relationship with an employee-beneficiary who meets the following requirements: (1) the employee-beneficiary and the domestic partner intend to remain in a domestic partnership with each other indefinitely; (2) the employee-beneficiary and the domestic partner have a common residence and intend to reside together indefinitely; (3) the employee-beneficiary and the domestic partner are and agree to be jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care; (4) neither the employee-beneficiary nor the domestic partner are married or a member of another domestic partnership; (5) the employee-beneficiary and the domestic partner are not related by blood in a way that would prevent them from being married to each other in the State of Hawaii; (6) the employee-beneficiary and the domestic partner are both at least 18 years of age and mentally competent to contract; (7) the consent of the employee-beneficiary or the domestic partner to the domestic partnership has not been obtained by force, duress or fraud; and (8) the employee-beneficiary and the domestic partner sign and file with the Fund a declaration of domestic partnership in such form as the board shall from time to time prescribe.

"Eligibility" shall have the meaning as meeting the Fund's requirements to participate or be qualified to participate in plans offered by the Fund.

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

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

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

"Excepted Benefits" shall mean benefits not subject to the National Health Care Reform Law (including the Patient Protection and Affordable Care Act [PPACA] of 2010, the Public Health and Safety Act, the Health Care and Education Reconciliation Act [HCERA] of 2010, and all subsequent legislative amendments and guidance). Examples of 'excepted benefits' include stand alone dental and vision plans and retiree-only plans.

"Fraud and Intentional Misrepresentation" includes, but is not limited to, intentionally or knowingly keeping an ineligible dependent enrolled in a Fund benefit plan (for example, an ex-spouse, over age or ineligible dependent child, etc.). Other situations of fraud or intentional misrepresentation of fact can include: failure to submit the required proof dependent status documentation or the documentation submitted does not confirm the dependent is eligible as a dependent for coverage in a Fund benefit plan, or filing fraudulent claims as described in Rule 4.12(b). The Fund will provide at least thirty (30) days advance written notice to each participant who will be affected before coverage is rescinded for fraud or intentional misrepresentation. In accordance with the requirements in the Affordable Care Act, the Fund will not retroactively cancel coverage except when premiums and contributions are not timely paid in full, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Fund.

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

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

"Fund benefit plan" means a benefit plan offered or sponsored by the Fund.

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

"Limiting Age" shall mean: (1) for active employees, pertaining to excepted benefits, as defined in this Rule 1.02, the age a child loses

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eligibility as a dependent-beneficiary is upon reaching age nineteen, unless the child is a full-time student, as defined in this Rule 1.02, which would extend the limiting age to the child's twenty-fourth birthday; (2) for active employees, pertaining to non-excepted benefits, as defined in this Rule 1.02, the age at which a child loses eligibility as a dependent-beneficiary is upon the end of the month that the dependent reaches age twenty-six; (3) for retirees, surviving spouses and surviving partners, the age a child loses eligibility as a dependent-beneficiary is upon reaching age nineteen, unless the child is a full-time student, as defined in this Rule 1.02, which would extend the limiting age to the child's twenty-fourth birthday; (4) for an unmarried child of (a) an employee who is killed in the performance of the employee's duty or (b) deceased retired employee and does not have a surviving parent who is eligible to be an employee-beneficiary, the age a child loses eligibility is upon reaching age nineteen, unless the child is a full-time student, as defined in this Rule 1,02, which would extend the limiting age to the child's twenty-fourth birthday.

"Non-excepted Benefits" shall mean benefits subject to the National Health Care Reform Law (including the Patient Protection and Affordable Care Act [PPACA] of 2010, the Public Health and Safety Act, the Health Care and Education Reconciliation Act [HCERA] of 2010, and all subsequent legislative amendments and guidance). Examples of non-excepted benefits include medical and prescription drug plans for active employees.

"Month" shall mean thirty (30) days.

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

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

"Partner" or "Partnership" shall mean a domestic partner or civil union partner.

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

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"Plan year" shall mean the 12-month period from January 1 through December 31 for retired employees and July 1 through June 30 for active employees.

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

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

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

"Spouse" means a person who is lawfully married pursuant to Hawaii law".

"State or county retirement system" means the employees' retirement system, the county pension system, or the police, fire, or bandsmen pension system of the State or any county.

"Termination of civil union partnership" means the civil union partnership terminates in accordance with applicable state laws and rules.

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

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

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1.03 Public Information

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

Protected health information about employee-beneficiaries and dependent-beneficiaries are not public records. Employee-beneficiaries, dependent-beneficiaries, and others may have access to such information only in conformance with the Health Insurance Portability and Accountability Act of 1996 and the rules passed under that Act ("HIPAA"), and the Fund's HIPAA Privacy Policies and Procedures.

1.04 Computation of Time

Whenever a period of time is stated in these rules as a number of days from or after an event: (a) the period shall be computed in calendar days; (b) the day of the event shall not be included in the calculation; and (c) the last day of the period shall be included in the calculation.

1.05 Officers of the Board

(a) The board shall elect a chairperson, vice-chairperson, and secretary-treasurer.

(b) Both the chairperson and vice-chairperson shall be elected from the same trustee group. The secretary-treasurer shall be elected from the other trustee group.

(c) Officer terms shall be for one year beginning July 1, 2002, and shall rotate between the trustee groups annually. The terms of all elected officers shall terminate on June 30 of each succeeding year and such officers shall vacate their offices at that time.

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(d) Except as otherwise provided by law or by rules or policies adopted by the board, the duties of the officers shall be as provided in the current version of *Robert's Rules of Order, Newly Revised.*

(e) The chairperson or vice-chairperson and secretary-treasurer shall coordinate assignments to the administrator and other Fund staff, requests for information, and other matters concerning the administration and operation of the board.

1.06 Committees of the Board

(a) Standing committees shall be established by the board to address critical issues in the major functional areas of the Fund:

(1) The Administrative Committee will have combined administrative and finance committee functions;

(2) The Benefits Committee will have benefits and communication committee functions.

(3) The Investment Committee will review the reports of the Investment Consultant and report to the Board of Trustees on the Fund's investments.

(b) The board may establish other committees to address matters related to the operation or administration of the Fund or to investigate issues that impact the Fund.

(c) Committees shall operate informally and shall make recommendations to the full board. Meetings of all standing committees will comply with Part I of Chapter 92 of the Hawaii Revised Statutes.

(d) A minimum of four trustees (two trustees from each trustee group) shall be assigned to a committee. The assigned number of trustees may be larger for certain committees provided that an equal number of trustees are assigned from each trustee group.

(e) Attendance of at least one trustee from each trustee group shall be necessary to convene a committee meeting.

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(f) Committees may select a chairperson and any other officers as deemed necessary by the board.

(g) Committee chairpersons shall coordinate assignments to the administrator and other Fund staff for their respective committees.

(h) Trustees in attendance shall agree within their working committees on recommendations made to the full board. When there is no agreement by the trustees in attendance, the committee shall present a summary of the disagreement(s) to the full board.

1.07 Meetings of the Board

(a) To the extent permitted by applicable federal or state law, the meetings of the board shall be open to the public. Without limiting the foregoing, board meetings shall comply with Part I of Chapter 92 of the Hawaii Revised Statutes, including the provisions therein requiring: (1) written and electronic notice of board meetings at least six days prior to each meeting; and (2) written minutes.

(b) The board shall designate the administrator or some other member of the Fund's staff to be responsible for preparing agendas for future board meetings. Any trustee may place a question or subject on the agenda of a future board meeting by notifying the administrator or other designated staff person by 12:00 noon, seven days prior to the board meeting. All board meeting agendas shall be transmitted to the chairperson for review prior to public notice.

(c) Unless otherwise required by the board or applicable law, the parliamentary procedure to be used by the board in the conduct of its meetings shall be in accordance with the current version of *Roberts Rules of Order, Newly Revised.*

(d) Voting procedures for board meetings and the criteria for a quorum are established in Section 87A-11 of the Hawaii Revised Statutes. In addition, the following voting procedures shall apply:

(1) After a motion is made and seconded, the presiding officer shall read the motion and open the question to discussion and debate by the trustees. When ready to put the motion to a vote, the presiding officer shall call for the public employer and employee-beneficiary

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trustee votes to determine whether there are three votes from each trustee group in favor of the motion. If so, the motion shall be recorded as having been approved by one vote from the public employer trustees and one vote from the employee-beneficiary trustees.

(2) For routine or procedural matters, the presiding officer may ask if there is any opposition to a motion after it has been made, and to the extent required, seconded and debated. If no opposition is voiced, the motion shall be recorded as having been unanimously approved by one vote by the public employer trustees and one vote from the employee-beneficiary trustees.

(3) If the voting is not unanimous by each side, the names of the trustees who voted in favor of the motion, voted against the motion, or abstained from voting shall be recorded in the minutes.

(4) In the event of a deadlock in the vote of the board, the board may vote on the same question or resolution at the next two successive meetings of the board. In the event of a deadlock in the vote of the board on the same question or resolution at the two successive meetings of the board, the board shall vote on whether or not to engage in dispute resolution. If six trustees of the board vote to engage in dispute resolution, the two trustee groups shall enter into mediation to attempt to resolve the question or resolution upon which the board has deadlocked.

The mediation shall be handled by a mediator appointed by the Federal Mediation and Conciliation Service. If the Federal Mediation and Conciliation Service fails or refuses to appoint a mediator within ten (10) days of the date on which the six trustees voted to engage in dispute resolution, the mediation shall be handled by a mediator mutually agreeable to the two trustee groups. If the two trustee groups do not agree on a mediator within twenty (20) days of the date on which the six trustees voted to engage in dispute resolution, either trustee group may petition the Administrative Judge of the First Circuit, Circuit Courts of the State of Hawaii, to appoint a mediator. Upon the appointment of a mediator, the two trustee groups shall in good faith enter into mediation on the question or resolution upon which the board has deadlocked. Nothing in this rule is meant to preclude the board

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from voting to engage in other forms of alternate dispute resolution to resolve a question or resolution upon which it has deadlocked.

(5) Whenever any statute or other law requires a vote of a majority, two-thirds or other percentage or fraction of the trustees or members to which the board is entitled, the motion or other action shall be approved if it receives two votes in favor of the motion or action as provided in subsection (d)(1) of this Rule, regardless of the total number of votes in favor of the motion or action.

For example, if a statute or other law requires a two-thirds vote of the members to which the board is entitled, the motion or other action will be approved if three trustees from each trustee group vote in favor of the motion or other action, even if the remaining four trustees vote against the motion or other action.

1.08 Appearances Before the Board

(a) All persons shall comply with this rule when appearing before the board. Unless otherwise required by applicable federal or state law, the board shall have the discretion to prescribe additional standards and procedures for all appearances and proceedings before the board. The board may waive or suspend the provisions of this rule with respect to any particular appearance or proceeding before it.

(b) Any person appearing before the board may appear in person, by an officer, partner or regular employee of the party, or be represented by an authorized representative. The board may at any time require any person transacting business with the board in a representative capacity to prove or authenticate the person's authority and qualification to act in such capacity.

(c) The board shall afford all interested persons an opportunity to present oral testimony or submit data, views, or arguments, in writing, on any agenda item.

(1) Persons providing written testimony shall provide thirty copies of their testimony of which twenty (20) copies shall be made available to the public. Twenty (20) copies of materials provided to the board for or during a meeting that are determined to be disclosable shall be made available for distribution to the public.

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(2) The board shall hear oral testimony on an agenda item after it has completed discussion of that item. At that time, the presiding officer shall invite members of the public to ask questions or provide comments on the agenda item prior to any action by the board. After the public has had an opportunity to provide input on the agenda item, the board may discuss the agenda item further and act on the item or move on to the next agenda item.

(3) A person may speak at a board meeting only when recognized to do so by the presiding officer. Comments are limited to three minutes per speaker. Time limitations may be adjusted at the discretion of the presiding officer or at the request of any three trustees. A person may not speak a second time on the same question unless authorized by the presiding officer to do so.

(4) The board may refuse to hear any testimony that is irrelevant, immaterial, or unduly repetitious and may from time to time impose additional conditions as are necessary or desirable for the orderly, efficient, and convenient presentation of oral testimony to the board. The board may request that the person providing oral testimony submit the testimony in writing to the board.

(d) Nothing herein shall require the board to hear or receive any oral testimony or documentary evidence from a person on any matter which is the subject of another proceeding pending before the board.

1.09 Delegation of Authority

To the extent permitted by law, the board may delegate authority to act on its behalf in accordance with board policies and standards to a committee of the board, an administrator, a carrier, a third party administrator, or to such other persons and entities as it deems necessary or reasonable for the effective and efficient administration of the Fund and the provisions of Chapter 87A of the Hawaii Revised Statutes; provided, however, that nothing in this rule shall permit the board to delegate its power to adopt, amend or repeal any rules.

1.10 State Ethics Code

All trustees and employees of the Fund shall comply with Chapter 84 of the Hawaii Revised Statutes.

1.11 Controlling Law

To the extent that federal or state law governs any matter covered by these rules, the Fund and the board shall comply with and follow such federal or state law. To the extent that any matter is not completely governed by federal or state law, the Fund and the board shall apply these rules to the extent reasonable and practicable.

1.12 Authority of the Board to Waive Rule Provisions

Subject to statutory requirements and limitations, the Board may waive an employee-beneficiary's compliance with any provision of the Fund's rules when the Board determines that: (a) good cause exists for such a waiver; and (b) such waiver does not involve any increase in the obligations or liabilities of the Fund beyond that which would have been involved if the employee-beneficiary had fully complied with the Fund's rules. Each waiver by the Board must be in writing and supported by documentation of the pertinent facts and grounds.

1.13 Responsibilities of Employee-Beneficiaries and Public Employers; Enforcement Actions of the Fund

(a) Employee-beneficiaries are responsible for:

(1) Providing current and accurate personal information as per Rules 4.06 and 4.07 within the times prescribed in these Rules;

(2) Paying the employee's premium contributions in the amount or amounts provided by statute, an applicable bargaining unit agreement, or by the applicable Fund benefit plan;

(3) Paying the employee's premium contributions at the times and in the manner designated by the board; and

(4) Complying with the Fund's rules.

(b) Any public employer whose current or former employees participate in Fund benefit plans is responsible for:

(1) Providing information, as requested by the Fund under section 87A-24(9) of the Hawaii Revised Statutes, within the times prescribed by the Fund;

(2) Determining that employees are eligible to participate in Fund benefit plans pursuant to the definition of employee-beneficiary found in these rules and section 87A-1 of the Hawaii Revised Statutes;

(3) Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;

(4) Assisting the Fund in distributing information to and collecting information from the employee-beneficiaries; and

(5) Complying with the Fund's rules.

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

2.00 ADMINISTRATIVE PROCEDURES

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2.01 Adoption, Amendment or Repeal of Rules

(a) The board may adopt, amend or repeal any rule of the Fund upon a motion of any trustee or upon the petition of an interested person or organization.

(b) In the case of an interested person or organization, the petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain:

(1) The petitioner's name, address, and telephone number;
(2) A statement of the nature of the petitioner's interest;
(3) A statement of the reasons for the proposed rule, amendment or repeal;
(4) A draft of the proposed rule, amendment or repeal; and
(5) The signature of the petitioner.

The board may reject any petition that does not contain the foregoing information.

(c) The board shall determine whether to deny or proceed with a petition within ninety (90) days. If the petition is denied, the board shall notify the interested person or organization in writing of the denial.

(d) If the board decides to proceed with any proposed rule change, whether by a trustee or interested person or organization, it shall consult with public employers and affected employee organizations with regard to the proposed rule change as follows. First, it shall transmit the proposed rule change to the public employers, exclusive employee organizations,

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exclusive representatives, retiree organizations, and all other employee organizations registered with the board for consultation prior to adoption. Second, it shall provide the employers, representatives and organizations a reasonable amount of time for review and comment on the proposed change prior to final action by the board.

(e) After the consultation provided for in subsection (d), the proposed rule change shall be considered for adoption at an open meeting of the board that permits the attendance of interested persons.

(f) All proposed rule changes shall be adopted by the board in accordance with the provisions of section 87A-26 of the Hawaii Revised Statutes.

(g) New rules, amendments or repeals of rules that are adopted by the board shall be submitted to the governor for approval and filed with the lieutenant governor's office.

(h) Unless some other date is expressly selected by the board, a new rule, amendment of a rule, or repeal of a rule shall be effective the first day after the rule, amendment, or repeal is filed with the lieutenant governor's office.

2.02 Policies, Standards, and Procedures

Policies, standards and procedures to be adopted amended or repealed may, at the discretion of the board, be transmitted to public employers and affected employee organizations for consultation purposes. Nothing herein shall require the board to consult with public employers or affected employee organizations concerning the board's adoption, amendment or repeal of policies, standards and procedures or to transmit any such policies, standards or procedures to public employers or affected employee organizations for consultation purposes.

2.03 Declaratory Rulings

(a) Any interested person may petition the board for a declaratory ruling as to the applicability of any statutory provision administered by the board or of any rule or order of the Fund.

(b) Every petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain the following:

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(1) The petitioner's name, address, and telephone number;
(2) A designation of the specific statute, rule or order in question;
(3) A statement of the nature of the petitioner's interest, including the reasons for the submittal of the petition;
(4) A complete statement of the relevant and material facts;
(5) A statement of the position or contentions of the petitioner; and
(6) A full discussion of the reasons, including any legal authorities, in support of the petitioner's position or contention.

The board may reject any petition that does not contain the foregoing information.

(c) Petitions to intervene and become a party to a declaratory ruling proceeding may be submitted in writing to the board. Such petitions shall contain the same information as required under subsection (b) and the grounds and reasons on which intervention is sought. The Board may deny intervention where the petition to intervene raises issues not reasonably pertinent to the issues already presented or the petition raises issues that would broaden the issues to be decided. If intervention is granted, the petitioner shall become a party to the proceeding to the degree permitted by the order granting intervention.

(d) The board may dismiss any petition for a declaratory ruling for good cause. Without limiting the generality of good cause, the board may dismiss a petition if:

(1) The question raised is purely speculative or hypothetical;
(2) The petitioner's interest is not of the type or nature that would give the petitioner standing to maintain an action if the petitioner were to seek judicial relief;
(3) The issuance of a declaratory ruling may adversely affect the interests of the employer, the board, any of the trustees, the Fund, or any of the Fund's officers or employees in litigation which is pending or reasonably expected to arise in the future; or
(4) The matter is not within the jurisdiction of the board.

(e) Subject to applicable federal and state law, the board at its discretion shall:

(1) Render a decision on the petition for a declaratory ruling without a hearing; or

(2) Hold a hearing and thereafter render its decision on the petition; or

(3) Refer the petition for consideration or hearing to the administrator, a special or standing committee of the board or any other person or entity duly designated by the board. After considering the recommendation of the administrator, committee or designated person or entity, the board shall render its decision on the petition.

Where any question of law is involved, the board may seek the assistance of the state attorney general in reviewing the matter. The board may also seek the assistance of other government agencies when necessary or desirable.

Any petitioner who desires a hearing shall submit a written request for a hearing together with the petition for a declaratory ruling. The written request shall set forth in detail the reasons why the matters alleged in the petition, together with supporting affidavits or other written evidence and briefs or memoranda of legal authorities, will not permit the fair and expeditious disposition of the petition and, to the extent that the request for a hearing is dependent upon factual assertions, shall submit affidavits or certificates establishing those facts.

(f) The petition for a declaratory ruling shall either be rejected in accordance with subsection (d) or acted upon by issuance of an order within ninety (90) days. Upon the disposition of the petition, the board shall promptly notify the petitioner.

(g) Orders disposing of petitions for a declaratory ruling will have the same status as other agency orders. An order shall be applicable only to the fact situation alleged in the petition or as set forth in the order. An order shall not be applicable to different fact situations or where additional facts exist that were not considered in the order.

2.04 Administrative Appeals (not related to Claim Filing and Appeals Information for Self-Insurance Plan Administered Benefits, which are discussed in Rule 2.06)

(a) A person aggrieved by one of the following eligibility decisions by the Fund may appeal to the board for relief from that decision:

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

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

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

(c) If the aggrieved person is dissatisfied with the administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within thirty (30) days of its being filed in the Fund's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the board. A written appeal to the board must be filed in duplicate in the Fund's office within ninety (90) days of the administrator's action. If no action is taken by the administrator within thirty (30) days of the written appeal to the administrator being filed in the Fund's office, then the written appeal to the Board must be filed in duplicate in the Fund's office within one-hundred twenty (120) days of the written appeal to the administrator being filed in the Fund's office. The

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written appeal need not be in any particular form but shall contain the following information:

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

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

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

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

(f) At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the Rule by submitting such a waiver in writing to the Fund's office. The board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

2.05 Emergency Appeals of Eligibility

(a) The Board may appoint a sub-committee made up of two trustees, one from the employer group and one from the employee group, to hear and make final decisions on emergency appeals. The Board Chair shall appoint the sub-committee chair, which shall rotate between employer trustee and employee trustee every six months.

(b) An employee-beneficiary ("appellant") who is aggrieved by a plan administrator's decision denying or limiting eligibility for benefits provided under a plan offered by the Fund to the employee-beneficiary or a dependent-beneficiary enrolled by the employee beneficiary may make an emergency appeal directly to the Board where a delay in following the Fund's normal appeal process could in the opinion of a physician with knowledge of the medical condition of the employee-beneficiary or dependent-beneficiary:

(1) Seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary;
(2) Seriously jeopardize the employee-beneficiary's or dependent-beneficiary's ability to regain maximum functioning; or
(3) Subject the employee-beneficiary or dependent-beneficiary to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

(c) Any appellant or designee desiring to make an emergency appeal under this Rule shall contact the Fund administrator and be prepared to provide the following information:

(1) The name, address, and telephone number of the appellant;
(2) A description of the decision with respect to which relief is requested; a statement as to why the appellant is appealing the decision, including all reasons that support the appellant's position or contentions; and any relevant and material facts;
(3) Why the appellant's appeal qualifies as an emergency appeal, i.e., why the appeal meets one or more of the conditions stated in subsection (b) above;
(4) Information that supports the appellant's appeal, including, but not limited to, any opinions from physicians that show that the appeal should be handled as an emergency appeal; and

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(5) If appellant is going to be represented by a designee, proof the designee may act on behalf of the appellant.

Notwithstanding the foregoing, the Fund administrator may waive the foregoing requirements if the Fund administrator finds that the criteria for making an emergency appeal are present and circumstances prevent the appellant from providing information or documents required in 1 through 5 above.

(d) The Fund administrator shall expeditiously, but in no event later than two business days, determine whether the request for emergency appeal qualifies as an emergency appeal under the criteria stated in this Rule. If the Fund administrator determines that the request for emergency appeal does not qualify as an emergency appeal, the appellant's appeal shall be handled as a normal appeal. Appellant may appeal the Fund administrator's denial of a request for emergency appeal by submitting a request to the Fund Administrator. No particular form is required for such a request so long as it can be understood that the appellant is seeking to appeal the Fund administrator's decision to the Board.

(e) Upon determining that an appeal qualifies as an emergency appeal or upon receipt of an appeal of the Fund administrator's denial of a request for emergency appeal, the Fund administrator shall take the following actions:

(1) Set a time and date of a hearing when the sub-committee can meet either in person or via phone. The hearing shall be set as soon as possible.
(2) Notify the appellant and his or her representative, if any, of the time and date of the hearing;
(3) The Fund administrator may request the parties to provide the Fund administrator with copies of any documents, records, written testimony, or other written evidence that they wish the sub-committee to consider at the hearing; and
(4) Prior to the hearing, the Fund administrator shall provide each member of the sub-committee with copies of any materials provided by the appellant.

(f) Unless the appellant expressly requests a public hearing, any hearing under this Rule shall be closed to the public. At the hearing, the following procedures shall apply:

(1) The sub-committee shall hear and consider all relevant testimony and documents;
(2) At any time during the hearing, the sub-committee may enter executive session to consult counsel regarding any legal issues involved in the appeal; and
(3) Prior to the conclusion of the hearing, the sub-committee shall announce its decision on the appeal to the Fund administrator. The sub-committee shall subsequently issue its decision in writing. A certified copy of the written decision shall be sent by certified mail to the appellant within a reasonable time after the hearing.

(g) The Fund administrator may designate one or more EUTF staff members to perform any or all of the Fund administrator's duties under this Rule when the Fund administrator is unavailable or otherwise unable to perform such duties.

2.06 Claim Filing and Appeals Information for Self-Insured Plan Administered Benefits

(a) This section describes the self-insured plans appeals timing and processes if an employee-beneficiary or dependent-beneficiary receives an adverse benefit determination. The process will be in conformance with 29CFR 2560.503 and amendments thereto. The processes are comprised of the following:

(1) Internal standard appeal;
(2) External Appeal using the Independent Review Organization (IRO);
(3) Internal expedited appeal for urgent care;
(4) External appeal using an IRO for urgent care.

(b) Definitions pertinent to claims and appeals.
(1) "Adverse benefit determination", a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Fund benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Fund benefit based on the application of a utilization review. An adverse benefit determination also includes a failure to cover a Fund benefit

because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate.

(2) "Fund Benefit", when referenced in this Section 2.06, a Fund benefit refers specifically to a self insured plan administered benefit.

(3) "Claim", a request for a Fund benefit that is made in accordance with the Fund's established procedures for filing benefit claims.

(4) "Medically Necessary" (Medical Necessity), medications, health care services or products are considered medically necessary if:

i. Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;

ii. Use of the medication, service, or product is based on recognized standards for the health care specialty involved;

iii. Use of the medication, service, or product represents the most appropriate level of care for the individual, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and

iv. Use of medication, service or product is not solely for the convenience of the individual, individual's family, or provider.

(5) "Post-Service Claim", a claim for a Fund benefit that is not a Pre-Service Claim.

(6) "Pre-Authorization", pre-service review of an employee-beneficiary's or dependent-beneficiary's initial request for a particular medication, service or product. The self-insured plan administrator will apply a set of pre-defined criteria to determine whether there is need for the requested medication, service, or product.

(7) "Pre-Service Claim", a claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-service claims include individual requests for pre-authorization.

(8) "Urgent Care Claim", a claim for a medication, service, or product where a delay in processing the claim: (a) could seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary, and/or could result in the employee-

beneficiary's failure to regain maximum function, or (b) in the opinion of a physician with knowledge of the employee-beneficiary's condition, would subject the employee-beneficiary or dependent-beneficiary to severe pain that cannot be adequately managed without the requested medication, service, or product.

(c) Time limit for initial filing of self-insured plan and administered claims.

(1) All post-service self-insured plan administered claims must be submitted to the administrator within one year from the date of service. No plan benefit will be paid for any claim not submitted within this period.

(2) If a self-insured plan claim is not approved, an employee-beneficiary or dependent-beneficiary may appeal that denial by following the steps in this Claim Filing and Appeal section. The Fund has delegated final claims and appeal authority for self-insured plan administered benefits to the independent self-insured plan administrator. This section discusses the claim appeal process for the following types of claims: Pre-Authorization Claim Review Services, Pre-Service Appeals Review Services, and Post-Service Appeals Review Services.

(d) The claims and appeals process

(1) Pre-authorization review. The self-insured plan administrator will implement the cost containment programs by comparing individual requests for certain medicines, services, or products and/or other benefits against pre-defined lists or formularies before those prescriptions, services, or products are approved. If the self-insured plan administrator determines that the employee-beneficiary or dependent-beneficiary's request for pre-authorization cannot be approved, that determination will constitute an adverse benefit determination.

(2) Appeals of adverse benefit determinations of pre-service and urgent care claims. If an adverse benefit determination is rendered on the employee-beneficiary or dependent-beneficiary's self-insured plan administered claim, the employee-beneficiary or dependent-beneficiary may file an appeal of that determination. The individual's appeal of the adverse benefit determination must be made in writing and submitted to the self-insured plan administrator within one hundred eighty (180) days after the

employee-beneficiary or dependent-beneficiary receives notice of the adverse benefit determination.

If the adverse benefit determination is rendered with respect to an urgent care claim, the employee-beneficiary or dependent-beneficiary and/or the employee-beneficiary or dependent-beneficiary's attending physician may submit an appeal by contacting the self-insured plan administrator. The employee-beneficiary or dependent-beneficiary's appeal should include the following information:

(i) Name of the person the appeal is being filed for;
(ii) The prescription drug program identification number, service description and/or code, or product name and number;
(iii) Date of birth;
(iv) Written statement of the issue(s) being appealed;
(v) Prescription drug name(s), service(s), or product(s) being requested; and
(vi) Written comments, documents, records or other information relating to the claim.

The employee-beneficiary or dependent-beneficiary's appeal and supporting documentation should be mailed, emailed, or faxed to the self-insured plan administrator.

If a covered person or their covered dependent does not understand English and has questions about a claim denial, the covered person or covered dependent should contact the appropriate claims administrator to find out if assistance is available.

TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa ang EUTF.
CHINESE (中文): 如果需要中文的帮助，请拨 EUTF.

(3) The self-insured plan administered program's review. The self-insured plan administrator will provide the first-level review of appeals of pre-service claims. If the employee-beneficiary or dependent-beneficiary appeals the self-insured plan administrator's

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decision, the employee-beneficiary or dependent-beneficiary can request an additional second-level medical necessity review. That review will be conducted by an Independent Review Organization ("IRO").

(4) Timing of review.

(i) Pre-Authorization Review. The self-insured plan administrator will make a decision on a pre-authorization request for a Fund benefit within fifteen (15) days after it receives the request. If the request relates to an urgent care claim, the self-insured plan administrator will make a decision on the claim within seventy-two (72) hours.

(ii) Pre-Service Claim Appeal. The self-insured plan administrator will make a decision on a first-level appeal of an adverse benefit determination rendered on a pre-service claim within fifteen (15) days after it receives the employee-beneficiary or dependent-beneficiary's appeal. If the self-insured plan administrator renders an adverse benefit determination on the first-level appeal of the pre-service claim, the employee-beneficiary or dependent-beneficiary may appeal that decision by providing the information described above. A decision on the employee-beneficiary or dependent-beneficiary's second-level appeal of the adverse benefit determination will be made (by the IRO) within fifteen (15) days after the new appeal is received. If the employee-beneficiary or dependent-beneficiary is appealing an adverse benefit determination of an urgent care claim, a decision on such appeal will be made not more than seventy-two (72) hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined).

(iii) Post-Service Claim Appeal. The self-insured plan administrator will make a decision on an appeal of an adverse benefit determination rendered on a post-service claim within sixty (60) days after it receives the appeal.

(5) Scope of review. During its pre-authorization review, first-level review of the appeal of a pre-service claim, or review of a post-service claim, the self-insured plan administrator will:

(i) Take into account all comments, documents, records and other information submitted by the employee-beneficiary or dependent-beneficiary relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination on the claim;

(ii) Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Fund documents;

(iii) Follow reasonable procedures to ensure that the applicable Fund provisions are applied to the employee-beneficiary or dependent-beneficiary in a manner consistent with how such provisions have been applied to other similarly-situated individuals; and

(iv) Provide a review that does not afford deference to the initial adverse benefit determination and is conducted by an individual other than the individual who made the initial adverse benefit determination (or a subordinate of such individual).

If an employee-beneficiary or dependent-beneficiary appeals the self-insured plan administrator's denial of a pre-service claim, and requests an additional second-level medical necessity review by an IRO, the IRO shall:

a) Consult with appropriate health care professionals who were not consulted in connection with the initial adverse benefit determination (nor a subordinate of such individual);

b) Identify the health care professional, if any, whose advice was obtained on behalf of the Fund in connection with the adverse benefit determination; and

c) Provide for an expedited review process for urgent care claims.

(6) Notice of adverse benefit determination. Following the review of an employee-beneficiary or dependent-beneficiary's claim, the self-insured plan administrator will notify the employee-beneficiary or dependent-beneficiary of any adverse benefit determination in writing. (Decisions on urgent care claims will be also communicated by telephone or fax.) This notice will include:

(i) The specific reason or reasons for the adverse benefit determination;

(ii) Reference to the pertinent Fund provision on which the adverse benefit determination was based;

(iii) A statement that the employee-beneficiary or dependent-beneficiary is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;

(iv) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and

(v) If the adverse benefit determination is based on a medical necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Fund to the employee-beneficiary or dependent-beneficiary's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

(7) Authority as claims fiduciary. The self-insured plan administrator has been designated by the Board as the claims fiduciary with respect to all types of claim appeal review of the benefit claims arising under the Fund it administers. The self-insured plan administrator shall have, on behalf of the Fund, sole and complete discretionary authority to determine these claims conclusively for all parties. The self-insured plan administrator is not responsible for the conduct of any second-level medical necessity review performed by an IRO.

(8) Voluntary external review. The Patient Protection and Affordable Care Act ("ACA") imposes external review requirements on group health plans, including outpatient prescription drug benefits. Under the ACA, an employee-beneficiary or dependent-beneficiary who receives a final internal adverse determination of a "Claim" for benefits under a self-insured administered plan may be permitted to further appeal that denial using the voluntary external

review process. The external review process provides employee-beneficiary or dependent-beneficiary's with another option for protesting the denial of their claim.

(9) Standard/non-expedited Federal external review process.

(i) Request for review. An employee-beneficiary or dependent-beneficiary whose claim for self-insured administered benefits is denied may request, in writing, an external review of his or her claim within four (4) months after receiving notice of the final internal adverse benefit determination. The employee-beneficiary or dependent-beneficiary's request should include their name, contact information including mailing address and daytime phone number, individual ID number, and a copy of the coverage denial. The employee-beneficiary or dependent-beneficiary's request for external review and supporting documentation may be mailed, emailed, or faxed to the self-insured plan administrator at their address, email, or fax.

(ii) Preliminary review. Within five (5) days of receiving an employee-beneficiary or dependent-beneficiary's request for external review, the self-insured plan administrator will conduct a "preliminary review" to ensure that the request qualifies for external review. In this preliminary review, the self-insured plan administrator will determine whether:

a) The employee-beneficiary or dependent-beneficiary is or was covered under the Fund at the time the benefit at issue was requested, or in the case of a retrospective review, was covered at the time the benefit was provided;

b) The adverse benefit determination or final internal adverse benefit determination does not relate to the employee-beneficiary or dependent-beneficiary's failure to meet the Fund's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal external review;

c) The employee-beneficiary or dependent-beneficiary has exhausted the Fund's internal appeal process

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(unless the employee-beneficiary or dependent-beneficiary's Claim is "deemed exhausted" under the ACA); and

d) The employee-beneficiary or dependent-beneficiary has provided all the information and forms necessary to process the external review.

Within one (1) day after completing this preliminary review, the self-insured plan administrator will notify the employee-beneficiary or dependent-beneficiary, in writing, that: (1) the employee-beneficiary or dependent-beneficiary's request for external review is complete, and may proceed; (2) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (3) the request for external review is complete, but not eligible for review.

(iii) Referral to IRO. If the employee-beneficiary or dependent-beneficiary's request for external review is complete and the employee-beneficiary or dependent-beneficiary's claim is eligible for external review, the self-insured plan administrator will assign the request to one of the IROs with which the administrator has contracted. The IRO will notify the employee-beneficiary or dependent-beneficiary of its acceptance of the assignment. The employee-beneficiary or dependent-beneficiary will then have ten (10) days to provide the IRO with any additional information the employee-beneficiary or dependent-beneficiary wants the IRO to consider. The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Fund.

The IRO may consider information beyond the records for the employee-beneficiary or dependent-beneficiary's denied Claim, such as:

a) The employee-beneficiary or dependent-beneficiary's medical records;

b) The attending health care professional's recommendations;

c) Reports from appropriate health care professionals and other documents submitted by the Fund, the employee-beneficiary or dependent-beneficiary, or the employee-beneficiary or dependent-beneficiary's treating physician;

d) The terms of the Fund to ensure that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);

e) Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national, or professional medicine societies, boards, and associations;

f) Any applicable clinical review criteria developed and used on behalf of the Fund (unless the criteria are inconsistent with the terms of the Fund or applicable law); and

g) The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the employee-beneficiary or dependent-beneficiary's request for external review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.

(iv) Timing of IRO's determination. The IRO will provide the employee-beneficiary or dependent-beneficiary and the self-insured plan administrator (on behalf of the Fund) with written notice of its final external review decision within forty-five (45) days after the IRO receives the request for external review. The IRO's notice will contain:

a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if available), the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials);

b) The date the IRO received the external review assignment from the self-insured plan administrator, and the date of the IRO's decision;

c) References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;

d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;

e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to the either the Fund or to the individual;

f) A statement that the employee-beneficiary or dependent-beneficiary may still be eligible to seek judicial review of any adverse external review determination; and

g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist the employee-beneficiary or dependent-beneficiary.

(10) Reversal of the Fund's prior decision. If the self-insured plan administrator, acting on the Fund's behalf, receives notice from the IRO that it has reversed the prior determination of the employee-beneficiary or dependent-beneficiary's claim, the self-insured plan administrator will immediately provide coverage or payment for the claim.

(11) Expedited Federal external review process. An employee-beneficiary or dependent-beneficiary may request an expedited external review:

(i) If the employee-beneficiary or dependent-beneficiary receives an adverse benefit determination related to a claim that involves a medical condition for which the timeframe for completion of a an expedited internal appeal would seriously jeopardize the life or health of the employee-

beneficiary or dependent-beneficiary, and/or could result in the employee-beneficiary or dependent-beneficiary's failure to regain maximum function, and the employee-beneficiary or dependent-beneficiary has filed a request for an expedited internal appeal; or

(ii) If the employee-beneficiary or dependent-beneficiary receives a final internal adverse benefit determination related to a claim that involves: (a) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary, and/or could result in the employee-beneficiary or dependent-beneficiary's failure to regain maximum function; or (b) an admission, availability of care, continued stay, or a prescription drug benefit for which the employee-beneficiary or dependent-beneficiary has received emergency services, but has not been discharged from a facility.

(12) Request for review. If the employee-beneficiary or dependent-beneficiary's situation meets the definition of urgent under the law, the external review of the claim will be conducted as expeditiously as possible. In that case, the employee-beneficiary or dependent-beneficiary or the employee-beneficiary or dependent-beneficiary's physician may request an expedited external review by calling the customer care toll-free at the number on their benefit ID card or contacting their benefits office. The request should include the employee-beneficiary or dependent-beneficiary's name, contact information including mailing address and daytime phone number, employee-beneficiary or dependent-beneficiary's ID number, and a description of the coverage denial. Alternatively, a request for expedited external review may be faxed; employee-beneficiary or dependent-beneficiary contact information and coverage denial description, and supporting documentation may be faxed or emailed to the attention the self-insured plan administrator's external review appeals department. All requests for expedited review must be clearly identified as "urgent" at submission.

(13) Preliminary review. Immediately on receipt of an employee-beneficiary or dependent-beneficiary's request for expedited

external review, the self-insured plan administrator will determine whether the request meets the reviewability requirements described above for standard external review. Immediately upon completing this review, the self-insured plan administrator will notify the employee-beneficiary or dependent-beneficiary that: (i) the employee-beneficiary or dependent-beneficiary's request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.

(14) Referral to IRO. Upon determining that an employee-beneficiary or dependent-beneficiary's request is eligible for expedited external review, the self-insured plan administrator will assign an IRO to review the employee-beneficiary or dependent-beneficiary's claim. The self-insured plan administrator will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for external review, the IRO will review the employee-beneficiary or dependent-beneficiary's claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Fund during the internal claims and appeals process.

(15) Timing of the IRO's determination. The IRO must provide the employee-beneficiary or dependent-beneficiary and the self-insured plan administrator, on behalf of the Fund, with notice of its determination as expeditiously as the employee-beneficiary or dependent-beneficiary's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the employee-beneficiary or dependent-beneficiary's request for external review. If this notice is not provided in writing from the IRO and is provided orally, within forty-eight (48) hours after providing the oral notice, the IRO will provide the employee-beneficiary or dependent-beneficiary and the self-insured plan

administrator, on behalf of the Fund, with written confirmation of its decision.

(16) Authority for review. The self-insured plan administrator will be responsible only for conducting the preliminary review of an employee-beneficiary or dependent-beneficiary's request for external review, ensuring that the individual is timely notified of the decision as to eligibility for external review, and for assigning the request for external review to an IRO. The actual external review of an employee-beneficiary or dependent-beneficiary's appeal will be conducted by the assigned independent review organization (IRO). The self-insured plan administrator is not responsible for the conduct of the external review performed by an IRO.

(e) Facility of payment. If the Fund administrator or its designee determines that an employee-beneficiary or dependent-beneficiary cannot submit a claim or prove that an employee-beneficiary or dependent-beneficiary paid any or all of the charges for health care services that are covered by the Fund because an employee-beneficiary or dependent-beneficiary is incompetent, incapacitated or in a coma, the Fund may, at its discretion, pay Fund benefits directly to the health care provider(s) who provided the health care services or supplies, or to any other individual who is providing for an employee-beneficiary or dependent-beneficiary care and support. Any such payment of Fund benefits will completely discharge the Fund's obligations to the extent of that payment. Neither the Fund, administrator, claim administrator nor any other designee of the Fund administrator will be required to see to the application of the money so paid.

(f) Discretionary authority of Fund administrator and designees. In carrying out their respective responsibilities under the Fund, the Fund administrator or its designee, other plan fiduciaries, and the self-insured plan administrator, have full discretionary authority to interpret the terms of the plan and to determine eligibility and entitlement to Fund benefits in accordance with the terms of the Fund. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(g) Elimination of conflict of interest. To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

(h) Limitation on when a lawsuit may be started. An employee-beneficiary or dependent-beneficiary or any other claimant may not start a lawsuit to obtain Fund benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Fund's claim appeal review procedures described in this document) for every issue deemed relevant by the claimant, or until ninety (90) days have elapsed since an employee-beneficiary or dependent-beneficiary filed a request for appeal review if an employee-beneficiary or dependent-beneficiary have not received a final decision or notice that an additional sixty (60) days will be necessary to reach a final decision. No lawsuit may be started more than three years after the end of the year in which services were provided.

3.00 ELIGIBLITY FOR ENROLLMENT

3.01 Health Benefits
3.02 Group Life Insurance

3.01 Health Benefits

(a) Employee-beneficiaries. The following persons shall be eligible to enroll as employee-beneficiaries in the benefit plans offered or sponsored by the Fund:

(1) An employee;
(2) A retired employee;
(3) The surviving spouse or partner of an employee who is killed in the performance of the employee's duty or of a deceased retired employee, provided the surviving spouse or partner does not remarry or enter into another partnership;
(4) The unmarried child of an employee who is killed in the performance of the employee's duty, provided the child is under the limiting age, as defined in Rule 1.02 or is an adult disabled child in accordance with Rule 3.01(b)(3) and does not have a surviving parent who is eligible to be an employee-beneficiary; and
(5) The unmarried child of a deceased retired employee, provided the child is under the limiting age, as defined in Rule 1.02, and does not have a surviving parent who is eligible to be an employee-beneficiary.

With respect to subsection (3) above, a surviving spouse or partner ceases to be an eligible employee-beneficiary once the spouse or partner remarries or enters into another partnership even though the spouse or partner may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of partnership, termination of a civil union or death. A surviving partner shall not cease to be eligible under subsection (3) because the death of the employee or retired employee prevents him or her from further meeting the requirements of parts (1), (2), (3), (6), and (8) of the definition of "domestic or civil union partner" in Rule 1.02. With respect to subsection (4) and (5), an unmarried child ceases to be eligible as of midnight of the birthday in which the child reaches the limiting age, as defined in Rule 1.02.

Notwithstanding any other provision in these rules to the contrary, a retired employee-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for medical or prescription drug coverage offered or sponsored by the Fund until the employee-beneficiary's Medicare Part B medical insurance plan is effective and provides satisfactory proof to the Fund of that enrollment as defined by the Fund.

An employee-beneficiary who is in Cancellation Non-Payment Status is not eligible for enrollment in Fund health benefit plans until the plan year following the cancellation. The employee-beneficiary may enroll during the Fund's open enrollment period or upon experiencing a mid-year qualifying event in a plan year following the cancellation.

(b) Dependent-beneficiaries of active employees. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund for active employees:

(1) An employee-beneficiary's spouse or partner;
(2) An employee-beneficiary's, spouse's or partner's child, provided the child is under the limiting age, as defined in Rule 1.02 for excepted and non-excepted benefits;
(3) An employee-beneficiary's, spouse's or partner's unmarried child regardless of age, who is incapable of self-support because of a mental or physical incapacity that existed prior to the child reaching the age of nineteen. A child under this Rule is not required to live with the employee-beneficiary; but, ceases to be an eligible dependent-beneficiary once he/she marries or enters into a partnership even though he/she may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of partnership, termination of civil union or death; and
(4) A child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order provided the child is under the limiting age as defined in Rule 1.02.

With respect to subsection (2) above, an unmarried child ceases to be eligible as of midnight of the child's nineteenth or twenty-fourth birthday for excepted benefits as defined in Rule 1.02, as applicable. For non-excepted benefits, coverages are terminated at the end of the month in

which the child turns twenty-six. With respect to subsections (2) and (3), the child of a spouse or partner ceases to be eligible upon a divorce, the dissolution of the domestic partnership or termination of the civil union partnership. In addition, as a condition of eligibility for any child age nineteen up to twenty-four for excepted benefits as defined in Rule 1.02, the employee-beneficiary shall provide the Fund with written proof reasonably satisfactory to the Fund of the full-time student status of such child. Such written proof shall be provided at such times and in such form as the Fund may from time to time direct.

(c) Dependent-beneficiaries of retired employees. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund for retired employees:

(1) An employee-beneficiary's spouse or partner;
(2) An employee-beneficiary's, spouse's or partner's unmarried child, provided the child is under the limiting age, as defined in Rule 1.02;
(3) An employee-beneficiary's, spouse's or partner's unmarried child, regardless of age, who is incapable of self support because of a mental or physical incapacity that existed prior to the child reaching the age of nineteen. A child under this Rule is not required to live with the employee-beneficiary; but, ceases to be an eligible dependent-beneficiary once he/she marries or enters into a partnership even though he/she may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of partnership, termination of civil union or death; and
(4) A child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order provided the child is under the limiting age as defined in Rule 1.02.

With respect to subsection (2) above, an unmarried child ceases to be eligible as of midnight of the child's nineteenth or twenty-fourth birthday, as applicable. With respect to subsections (2) and (3), the child of a spouse or partner ceases to be eligible upon a divorce, the dissolution of the domestic partnership or termination of the civil union partnership. In addition, as a condition of eligibility for any child age nineteen up to twenty-four, the employee-beneficiary shall provide the Fund with written proof reasonably satisfactory to the Fund of the full-time student status of

such child. Such written proof shall be provided at such times and in such form as the Fund may from time to time direct.

Notwithstanding any other provisions in these rules to the contrary, a dependent-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for medical or prescription drug coverage under any retiree benefit plan offered or sponsored by the Fund until the dependent-beneficiary's Medicare Part B medical insurance plan is effective and provides satisfactory proof to the Fund of that enrollment as defined by the Fund.

3.02 Group Life Insurance

Employees and retired employees are eligible to enroll for any group life insurance plans offered or sponsored by the Fund.

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4.00 ENROLLMENT PROCEDURES

4.01 Application for Enrollment
4.02 Rejection of an Enrollment Application
4.03 Dual or Multiple Enrollment
4.04 Date of Filing
4.05 Failure to File Properly Completed Enrollment Application Within the Prescribed Time; Effect on Coverage Dates
4.06 Notification of Changes in Personal Information
4.07 Verification of Eligibility
4.08 Regular Open and Additional Limited Enrollment Periods
4.09 Continuation of Coverage
4.10 Contribution Shortage
4.10.5 Contribution Refund
4.11 Cancellation of Enrollment; Effective Dates of Cancellation
4.12 Termination of Enrollment; Effective Dates of Termination
4.13 Reinstatement of Enrollment
4.14 Mandatory Enrollment in Recurring Electronic Premium Deductions
4.15 Overpayments

4.01 Application for Enrollment

(a) An employee-beneficiary shall file an enrollment application, in the form prescribed by the board or by the board's policy, to enroll, change or cancel an enrollment in any benefit plan offered or sponsored by the Fund. Unless otherwise provided by the board or by the board's policy, all enrollment applications shall be filed by the employee-beneficiary with: (1) in the case of an employee, the employee's employer; and (2) in all other cases, the Fund. Notwithstanding the foregoing, upon retirement and thereafter, an employee-beneficiary shall file an enrollment application to enroll or change enrollment in the benefit plans offered or sponsored by the Fund with the Fund.

(b) Where an employee-beneficiary files more than one enrollment application, the enrollment application bearing the latest filing date shall be the one used by the Fund to process the employee-beneficiary's enrollment, provided the employee-beneficiary is eligible for such enrollment.

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(c) With due consideration of appropriate federal or state laws, the board shall set the standards and procedures for filing such enrollment applications, including, but not limited to, the form of such enrollment applications, the information required to be provided by the employee-beneficiary on such enrollment applications, and the method for filing such enrollment applications. Enrollment applications shall include the employee-beneficiary's authorization to the state comptroller or the appropriate county director of finance to assign sufficient compensation to the Fund in payment of all contributions due from such employee-beneficiary for enrollment or coverage in any and all Fund benefit plans.

(d) A representative of an employee-beneficiary may file an enrollment application for the employee-beneficiary if:

(1) The representative has a written authorization signed by the employee-beneficiary that authorizes the representative to file such enrollment applications as provided by State and Federal law; or
(2) A valid court order authorizes the representative to file such enrollment applications.

4.02 Rejection of an Enrollment Application

(a) Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

(b) An enrollment application shall be rejected if:

(1) The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
(2) The application is not filed within the time limitations prescribed by these rules;
(3) The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
(4) The employee-beneficiary is ineligible due to outstanding past due contributions or other amounts to the Fund, or is ineligible due to Cancellation Non-Payment Status; or
(5) Acceptance of the application would violate applicable federal or state law or any other provision of these rules.

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(c) Notification shall be provided to the employee-beneficiary of the rejection of any enrollment application.

4.03 Dual or Multiple Enrollment

No person may be enrolled simultaneously in any benefit plan offered or sponsored by the Fund as both an employee-beneficiary and a dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary. The Fund shall cancel such dual coverage enrollments.

4.04 Date of Filing

An employee-beneficiary's enrollment application, beneficiary designation, or any other form required to be filed with the Fund shall be deemed to have been filed with the Fund on the date that the following entities, as applicable, actually receive such forms: (1) the employee's employer; (2) in the case of a retired employee, surviving spouse or partner under Rule 3.01, and unmarried child under Rule 3.01, the Fund; (3) or others, as specified by the Fund. However, if filed before the time or times prescribed in these rules, an enrollment application, or other form shall be deemed to have been filed on the date that the person would have been first eligible to file that document.

4.05 Failure to File Properly Completed Enrollment Application Within the Prescribed Time; Effect on Coverage Dates

Except as otherwise provided in these rules or by applicable federal or state law, the following shall apply to all applications to enroll in the benefit plans offered or sponsored by the Fund, to add or delete dependent-beneficiaries, or to change enrollments or coverages:

(a) No enrollment of an employee-beneficiary, addition or deletion of a dependent-beneficiary, or change in an enrollment or coverage shall be effective without the filing of a properly completed enrollment application and any required proof documents within forty five (45) days of the specified event that allows the filing of the application except for the following events: (1) termination of employment for which the enrollment application must be filed within thirty (30) days of the termination of employment; (2) newborns for which the enrollment application and required proof documents must be filed within one hundred eighty (180) days of the birth; (3) retirement, and surviving spouse, partner or child who become eligible as an employee-beneficiary under Rule 3.01 for

which an enrollment application and required proof documents must be filed within sixty (60) days of the event.

(b) An employee-beneficiary who fails to file an enrollment application and required proof documents within the time prescribed by subsection (a) above or any otherwise applicable rule shall result in the rejection of the requested enrollment changes and not be permitted to file that application until the next regular open or additional limited enrollment period.

4.06 Notification of Changes in Personal Information

Each employee-beneficiary shall immediately notify the Fund in writing of any changes in the employee-beneficiary's name or address or marital or partnership status, the birth or adoption of a child or any other changes in the family status of the employee-beneficiary, and any other material changes in the information previously filed by the employee-beneficiary as part of an enrollment application. Each notice to the Fund shall be submitted through the employee-beneficiary's employer or, if none, shall be submitted directly to the Fund.

4.07 Verification of Eligibility

The board may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries enrolled by an employee-beneficiary in Fund benefit plans. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the employee-beneficiary or dependent-beneficiary's enrollment shall be cancelled as set forth in Rule 4.11(c).

4.08 Regular Open and Additional Limited Enrollment Periods

Except as otherwise provided by these rules, an employee-beneficiary may file an enrollment application during a regular open or additional limited enrollment period to make any one or a combination of enrollment changes that have been approved by the board for that regular open or additional limited enrollment period. The changes that the board may approve include, but are not limited to, changes from non-enrolled to enrolled status, changes between plans, changes in levels of coverage, and cancellations. All changes made shall become effective on the date approved by the board for the regular open or additional limited enrollment period.

4.09 Continuation of Coverage

Subject to applicable federal and state law, coverage under the benefit plans offered or sponsored by the Fund shall continue:

(a) Provided the employee-beneficiary meets the eligibility provisions of Rule 3.01 and pays the employee-beneficiary's premium contribution as provided by statute, the employer's administrative rules, or an applicable bargaining unit agreement;

(b) While the employee-beneficiary participates in an employee strike authorized by chapter 89, Hawaii Revised Statutes, provided that nothing in this rule shall limit the right or ability of the Fund to collect premium contributions from any public employer or employee-beneficiaries or the remedies available to the Fund to collect such premium contributions.

(c) When an employee terminates employment and is rehired by the same public employer within the same pay period or the next consecutive pay period, the employee shall be considered as having transferred employment, such as when the employee terminates employment with the state and is rehired with the state, or when the employee terminates employment with a county and is rehired by the same county. The employee shall be treated as if continuously enrolled in the Fund benefit plans in which the employee was enrolled at the time of termination and shall be required to pay the full cost of coverage to the extent that such is not paid by the employee's public employer. When an employee terminates employment and is rehired by a different public employer within the same pay period or the next consecutive pay period, such as when the employee terminates employment with the state and is hired by a county or terminates one county and is rehired by a different county, the employee shall be allowed to change between plans, including adding or dropping dependents and changing tiers. Notwithstanding the definitions of "employer" and "public employer" set forth and used in these rules, for purposes of this section only, the different public employers are: 1) State, including executive, legislative, and judicial branches, Department of Education, University of Hawaii, Hawaii Health Systems Corporation, Office of Hawaiian Affairs, and all Charter Schools; 2) City and County of Honolulu; 3) County of Hawaii; 4) County of Maui, and 5) County of Kauai. Changes shall become effective at the beginning of the next pay period in which the termination of employment occurred, without a break in coverage.

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4.10 Contribution Shortage

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly or monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the Fund. The notice shall be sent within thirty (30) days of the date on which the required semi-monthly or monthly contribution payment was due. Cancellation of the employee-beneficiary's enrollment due to any contribution shortage shall be as per Rule 4.11(b), and reinstatement of the employee-beneficiary's enrollment after any such cancellation shall be as per Rule 4.13(b).

4.10.5 Contribution Refund

The Fund may refund employee-beneficiaries or dependent-beneficiaries any amounts deemed owing, provided that at the time of the disbursement of such refunds, no refund need be made where the amount thereof is less than one dollar.

4.11 Cancellation of Enrollment; Effective Dates of Cancellation

(a) Cancellation Due to Ineligibility. The enrollment of any ineligible person who was enrolled in error or is ineligible to enroll in or be covered in a benefit plan offered or sponsored by the Fund shall be canceled:

(1) When the person is notified by the Fund of the error or ineligibility prior to the effective date of the enrollment, the person shall be treated as if the enrollment application was not submitted.

(2) When the person is notified by the Fund in writing after the effective date of the enrollment, but at least thirty (30) days in advance, the enrollment may be canceled retroactively (a rescission) to the date the person was ineligible if cancellation is due to Fraud or Intentional Misrepresentation of a material fact, as defined in Rule 1.02 or

(3) When the person is notified by the Fund in writing after the effective date of the enrollment, the enrollment will be cancelled prospectively effective the first day of the first pay period following the date that ineligibility is determined by the Fund. Employee-beneficiaries may be liable for the employer portion of

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premiums paid for any ineligible person and/or any benefits that were provided as per Rule 4.12(d).

(b) Cancellation Due to Failure to Pay Contribution Shortage. If an employee-beneficiary does not make full payment of all contributions due within thirty (30) days of the date of the notice of contribution shortage in Rule 4.10, the employee-beneficiary's enrollment in all health benefit plans, and all dependent-beneficiaries' health benefit plans under that enrollment shall be cancelled as of the first day following the last period for which full payment of the employee-beneficiary's required semi-monthly or monthly contributions were paid and transmitted to the Fund and the employee-beneficiary will be ineligible for fund health benefits. If an employee-beneficiary is currently on a leave of absence covered under the Family Medical Leave Act (FMLA), the employee-beneficiary and dependent beneficiary(s) enrollment in all health benefit plans shall be cancelled thirty (30) days from the date of the notice of contribution shortage. The employee-beneficiary may only apply for a new enrollment as per Rule 4.13(a). However, the enrollment and eligibility for benefits of the employee-beneficiary and his or her dependent-beneficiaries may be reinstated as provided in Rule 4.13(b). Cancellation of an employee-beneficiary's enrollment pursuant to this rule shall not affect the Fund's right to collect any and all contribution shortages from the employee-beneficiary.

(c) Cancellation Due to Failure to Comply with Rules. If an employee-beneficiary materially fails to comply with any of the Fund's rules, the employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be canceled after thirty (30) days advance written notice of such has been provided to the employee-beneficiary. The board may set standards and procedures for providing notice to employee-beneficiaries under this rule. The notice shall at a minimum specify how the employee-beneficiary has failed to comply with the Fund's rules, and a date by which the employee-beneficiary must comply with the Fund's rules in order to avoid cancellation. The effective date of the cancellation shall be the date set forth in the notice as to when the employee-beneficiary must comply with the Fund's rules in order to avoid cancellation.

(d) Cancellation Due to Acquiring Coverage From a Non-Fund Plan. An employee-beneficiary or dependent-beneficiary may cancel enrollment in

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a Fund benefit plan upon acquiring coverage from a non-Fund plan or when moving to a country in which they are eligible for publicly provided healthcare or similar, by filing an enrollment application to the employee-beneficiary's employer or, if none, directly with the Fund requesting cancellation. The enrollment application must be filed with the employee-beneficiary's employer, or, if none, directly to the Fund within forty five (45) days of acquiring coverage from the non-Fund plan or moving to another country as noted above. The effective date of cancellation shall be the end of the pay period in which the employee-beneficiary or dependent-beneficiary moves to another country as noted above or acquires coverage from the non-Fund plan, except when the employee-beneficiary or dependent-beneficiary acquires coverage from the non-Fund plan on the first or the sixteenth of the month, in which case coverage ends at the end of the prior pay period.

The Fund shall determine the required proof documents.

(e) Cancellation When Beginning a Leave of Absence Without Pay. An employee-beneficiary may voluntarily cancel enrollment in all Fund benefit plans when beginning a leave of absence without pay that is expected to last more than one month. An enrollment application must be filed with the employee-beneficiary's employer requesting cancellation of all plans within forty five (45) days of the beginning of the leave of absence without pay. The effective date of the cancellation shall be the end of the pay period during which the leave of absence without pay begins. Employee-beneficiaries who cancel coverage in accordance with this section may re-enroll in the same benefit plans upon return from the leave of absence without pay by completing an enrollment application and submitting it to the employee-beneficiary's employer within forty five (45) days of returning from the leave of absence.

4.12 Termination of Enrollment; Effective Dates of Termination

(a) Termination Due to Change in Employment Status. An employee-beneficiary's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the employee-beneficiary's loss of eligibility to participate in such plans due to a change in employment status. The effective date of the termination shall be the first day of the pay period following the effective date of the change in employment status, provided the termination is not retroactive. If, by virtue of an administrative error,

coverage continues to be provided by the Fund, and paid for by the employee-beneficiary, the effective date of cancellation shall be the last day of the pay period following the date of issuance of a thirty (30) days written notice. Employers shall submit to the Fund the enrollment application within thirty (30) days of the change in employment status causing termination of enrollment. Employers submitting enrollment applications after thirty (30) days of the change in employment status may be responsible for 100% of the premiums, both employer and employee contributions, until such termination.

(b) Termination Due to Filing of Fraudulent Claims. An employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be terminated upon thirty (30) days advance written notice if the employee-beneficiary files fraudulent claims for benefit. A dependent-beneficiary's coverage in all of the benefit plans offered or sponsored by the Fund may be terminated if the dependent-beneficiary files fraudulent claims for coverage and/or benefits. The effective date of the termination shall be the date that the Fund determines that the employee-beneficiary or dependent-beneficiary, as applicable, has filed fraudulent claims.

(c) Notice to the Fund. If an event occurs that makes a person ineligible for continued enrollment or coverage in the benefit plans offered or sponsored by the Fund, that person or employee-beneficiary shall notify the Fund of the event within forty five (45) days. All such notices shall be in writing and shall be sent to the Fund.

(d) Recovery of Benefits. In all situations in which an ineligible person receives benefits under the Fund, or the employee-beneficiary or dependent-beneficiary files fraudulent claims for benefits per Rule 4.12(b), the Fund shall be entitled to seek recovery of any benefits that were provided to any person or seek recovery of the employer contributions paid for any ineligible person after an event that terminated the person's enrollment or that otherwise made that person ineligible for continued enrollment in or coverage by the benefit plans offered or sponsored by the Fund. In seeking to recover benefits under this rule and in situations in which the Fund overpays amounts to an employee-beneficiary or dependent-beneficiary, the Fund shall have the rights of offset and set-off, including without limitation, the right to recover amounts from and out of any and all future payments to the person whose

enrollment was terminated, who otherwise ceased to be eligible for continued enrollment or coverage in the Fund's benefit plans or who was overpaid.

4.13 Reinstatement of Enrollment

(a) General Rule. Unless another rule of the Fund expressly applies, an employee-beneficiary whose enrollment in any of the Fund's benefit plans has been cancelled or terminated may not apply for reinstatement in those benefit plans. The employee-beneficiary may only apply for a new enrollment during the Fund's open enrollment period or upon experiencing a mid-year qualifying event in any plan year following the cancellation. Any such new enrollment may be conditioned upon the employee-beneficiary meeting all the Fund's rules for eligibility and enrollment, curing any past deficiencies or failures that led to the employee-beneficiary's cancellation or termination, and providing adequate assurance that the employee-beneficiary will not further engage in the conduct that previously led to the employee-beneficiary's cancellation or termination. Nothing in this rule shall be deemed to require the Fund to re-enroll any employee-beneficiary whose enrollment has been previously cancelled or terminated.

(b) Contribution Shortage Cancellation. If an employee-beneficiary's enrollment in the Fund's benefit plan or plans has been cancelled under Rule 4.11(b), the employee-beneficiary's enrollment in such benefit plan or plans may be reinstated if the employee-beneficiary makes full payment of all contributions due from the employee-beneficiary within sixty (60) days from the date of the notice of cancellation in accordance with cancellation of enrollment under Rule 4.11(b) and whose enrollment has not been cancelled under Rule 4.11(b) within twelve (12) months of the date of the notice of cancellation. The reinstatement shall be made so that the employee-beneficiary and his or her dependent-beneficiaries shall suffer no break in coverage. Employee-beneficiaries who are currently on leave of absence covered under the FMLA or Uniform Services Employment and Reemployment Rights Act (USERRA) shall be allowed to re-enroll in coverage as per Rule 5.06(c).

(c) Reinstatement Upon Return From Lawful Strike. If an employee-beneficiary's enrollment is cancelled for non-payment during a lawful strike, the employee-beneficiary may re-enroll upon return from the lawful

strike without the requirement to pay back premiums and without coverage during the non-payment period under the following conditions:

(1) The employee-beneficiary files an enrollment application within forty five (45) days of returning from the lawful strike, and
(2) The employee-beneficiary and any covered dependent-beneficiaries had no covered services during the non-payment period.
(3) The employee-beneficiary enrolls in the same plans and at the same tier the employee-beneficiary was enrolled in prior to the lawful strike.

The effective date of coverage shall be the date the employee-beneficiary returns from the lawful strike.

4.14 Mandatory Enrollment in Recurring Electronic Premium Deductions

(a) Employee-beneficiaries who retire or become a surviving-beneficiary on or after September 15, 2020 and who are required to pay all or a portion of their premiums shall have their share of premiums electronically deducted and transmitted to the Fund monthly by the Employees' Retirement System of the State of Hawaii or the employee-beneficiary's financial institution. Premium payments shall be made electronically unless waived by the Fund and another method is determined to be more appropriate.

(b) New Enrollment in Recurring Electronic Premium Deductions. Employee-beneficiaries who are required to pay a portion of their retiree premiums shall submit an Electronic Deduction Authorization Form within sixty (60) days of the effective date of the event that results in the required premium. Failure to submit an Electronic Deduction Authorization Form within sixty (60) days shall result in either the rejection of the employee-beneficiary's enrollment application or termination of health benefit plans as of the first day following the last period for which full payment was received by the Fund.

If the Electronic Deduction Authorization Form is submitted after rejection of an enrollment application or termination of health benefit plans, the changes requested in the enrollment application or reinstatement of terminated health benefit plans, respectively, shall be effective retroactively to the effective date of enrollment application changes or the termination date, respectively.

(c) Returned Recurring Electronic Premium Deduction. If an employee-beneficiary's recurring electronic deduction is returned by the Employees' Retirement System of the State of Hawaii or financial institution, a notice from the Fund will be sent to the employee-beneficiary. The employee-beneficiary has thirty (30) days from the date of the notice to submit a valid Electronic Deduction Authorization Form. Failure to provide a valid Electronic Deduction Authorization Form within thirty (30) days of the date of the notice will result in termination of health benefit plans as of the first day following the last period for which full payment was made. Health benefit plan(s) may be reinstated if their enrollment has not been terminated within twelve (12) months of the date of the notice of cancellation and the employee-beneficiary submits a valid Electronic Deduction Authorization Form within sixty (60) days from the date of the notice of cancellation. The reinstatement shall be made so that the employee beneficiary and dependent-beneficiaries suffer no break in coverage.

4.15 Overpayments

If an employee-beneficiary is overpaid for a reimbursement, refund, or any other reason, the Fund may automatically withdraw the over-paid amount from the financial account on record for the employee-beneficiary.

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5.00 HEALTH AND OTHER BENEFIT PLANS

5.01 Enrollment; Effective Dates of Coverage
5.02 Changes in Enrollment; Effective Dates of Coverage
5.03 Mandatory Enrollment in Medicare Part B and Medicare Part D for Retired Employees and Cancellation Due to Failure to Enroll
5.04 Cancellation Due to Failure to Enroll or Failure to Maintain Enrollment in Medicare; Effective Date of Cancellation
5.05 Termination of Enrollment; Effective Dates of Termination
5.06 Reinstatement of Enrollment; Effective Dates of Reinstatement
5.07 Reimbursement of Retired Employee-Beneficiaries and Their Dependent-Beneficiaries Who Relocate Outside of the State of Hawaii

5.01 Enrollment; Effective Dates of Coverage

(a) New Employee. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when the employee-beneficiary is first eligible as an employee as defined in 87A-1, Hawaii Revised Statutes. At the option of the employee-beneficiary, the effective date of coverage shall be one of the following dates: (1) the date the employee beneficiary is first eligible; or (2) the first day of the first pay period following the date the employee-beneficiary is first eligible; or (3) the first day of the second pay period following the date the employee-beneficiary is first eligible. The employee-beneficiary shall select the effective date of coverage in an enrollment application that must be filed within forty five (45) days of the date that the employee-beneficiary is first eligible. If the employee-beneficiary fails to make an effective date of coverage selection, the effective date of coverage shall be the date the employee-beneficiary is first eligible.

(b) Loss of Coverage in a Benefit Plan Offered by the Fund. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for dependent-beneficiaries when the employee-beneficiary loses coverage under the benefit plans offered or sponsored by the Fund because the employee-beneficiary's covering

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enrollment was terminated or the employee-beneficiary ceased to be eligible as a dependent-beneficiary. The effective date of coverage shall be the date of the employee-beneficiary's loss of coverage if a properly completed enrollment application is filed within forty five (45) days of the loss of coverage. The employee-beneficiary may only enroll during the next open enrollment period when the enrollment application is received more than forty five (45) days after the loss of coverage.

(c) Loss of Coverage in a Non-Fund Health Benefit Plan. An employee-beneficiary who is eligible but not enrolled, may enroll in the health benefit plans offered or sponsored by the Fund, and obtain coverage for eligible dependent-beneficiaries, when the employee-beneficiary's coverage under non-Fund health benefit plans is terminated. The effective date of coverage shall be the date of the employee-beneficiary's loss of coverage if a properly completed enrollment application is filed within forty five (45) days of the loss of coverage. The employee-beneficiary may only enroll during the next open enrollment period when the enrollment application is received more than forty five (45) days after the loss of coverage. The Fund shall determine the required proof documents.

(d) Enrollment Due to Changes in Marital, Partnership or Family Status. An employee-beneficiary who has previously declined coverage in the health benefit plans offered or sponsored by the Fund may enroll in the Fund benefit plans when the employee-beneficiary gains a dependent through a change in marital, partnership or family status, e.g., marriage, entry into a domestic or civil union partnership, birth, adoption, guardianship, or issuance of a qualified medical child support order. At the option of the employee-beneficiary, the effective date of coverage shall be one of the following dates: (1) the date of the event; or (2) the first day of the first pay period following the date of the event; or (3) the first day of the second pay period following the event, except for a qualified medical child support order, which shall be limited to the date of the event. The date of the event shall be:

(1) For marriages the date on the marriage certificate;
(2) For civil unions the date on the civil union certificate;
(3) For domestic partnerships the date the notary notarizes the Declaration of Domestic Partnership;
(4) For births the date of birth;
(5) For adoptions the date of the adoption;

(6) For placement of adoption or guardianships the date of guardianship;

(7) For placement of a foster child the date indicated on the State of Hawaii Department of Human Services Form 1564, Admission to Foster Home; and

(8) For a qualified medical child support order, the date specified in the order, or if no date is specified, the date that the order is issued.

(9) For dependent-beneficiary joining the employee-beneficiary's household, the date the dependent-beneficiary joins the household.

The employee-beneficiary shall select the effective date of coverage in an enrollment application that must be filed within forty five (45) days of the date of the event, except for newborns which is within one hundred eighty (180) days of the birth. If the employee-beneficiary fails to make an effective date of coverage selection, the effective date of coverage shall be the date of the event. The Fund shall determine the required proof documents.

(e) Enrollment or Changes in Enrollment Upon Retirement. An employee-beneficiary may enroll or change coverages in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when that person becomes a retired member of the Employees' Retirement System as defined in 87A-1, Hawaii Revised Statutes. The effective date of the coverage shall be the first of the month on or after the employee-beneficiary's date of retirement provided a completed enrollment application is received by the Fund within sixty (60) days of retirement.

For disability retirement, at the option of the employee-beneficiary, the effective date of coverage shall be the first of the month on or after the employee-beneficiary's date of retirement or the 1st of the month of the date of the Employees' Retirement System disability certification letter provided that a completed enrollment application is received by the Fund within 60 days of certification from the Employees' Retirement System of a disability retirement.

Retired employee beneficiaries shall be eligible to enroll in the Fund's health benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the date of retirement.

(f) Surviving Spouse, Partner, or Child of a Deceased Retiree Not Enrolled in the Fund or an Employee Who was Killed in the Performance of Duty Who Was Not Enrolled in the Fund. A surviving spouse, partner or unmarried child who is eligible as an employee-beneficiary under Rule 3.01(a) may enroll in the health benefit plans offered or sponsored by the Fund. The effective date of coverage shall be the date the retiree passed away or the date the employee was killed in the performance of duty, provided a completed enrollment application is received by the Fund within sixty (60) days of the retiree passing away or within sixty (60) days of the date the employee was killed in the performance of duty for dependents not enrolled at the time of death. Surviving spouses, partners, or unmarried children of a deceased retiree or an employee who was killed in the performance of duty shall be eligible to enroll in the Fund's health benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the passing away of the retiree or more than sixty (60) days after the date the employee was killed in the performance of duty.

(g) The public employer's premium contributions and employee-beneficiary's premium contributions, if any, shall begin as of the first day of the pay period during which the employee-beneficiary's effective date of coverage occurs. The contributions shall not be prorated based on when the employee-beneficiary's coverage begins during the pay period. For example, if an employee-beneficiary's effective date of coverage occurs on any date during the first pay period of a month (first half of a month), the public employer and employee-beneficiary shall make contributions as if the employee-beneficiary had been enrolled in the applicable health benefit plans as of the first day of that first pay period. Similarly, if there is a change in contributions due to an employee-beneficiary's change in enrollment or coverage, the change in contributions shall begin as of the first day of the pay period during which the change in enrollment or coverage occurs. For example, if an employee-beneficiary changes enrollment or coverage during any date during the second pay period of a month (second half of a month), the public employer and employee-beneficiary shall make contributions as if the change in enrollment or coverage had occurred as of the first day of that second pay period.

5.02 Changes in Enrollment; Effective Dates of Coverage

(a) Additions of Dependents Due to Changes in Marital, Partnership, Legal Guardianship, or Family Status. An employee-beneficiary may change his or her enrollment to add coverage for dependent-beneficiaries in the Fund health benefit plans in which the employee-beneficiary is currently enrolled upon the occurrence of any of the following events: marriage, entry into a partnership, birth of a child, adoption of a child, addition of a foster child, the issuance of a qualified medical support order, or when a dependent-beneficiary joins the employee-beneficiary's household. At the option of the employee-beneficiary, the effective date of the change in enrollment shall be one of the following dates: (1) the date of the event; or (2) the first day of the first pay period following the date of the event; or (3) the first day of the second pay period following the event, except for a qualified medical support child support order, which shall be limited to the date of the event, provided an enrollment application is filed with the employer for active employee-beneficiaries and to the Fund for retirees within forty five (45) days of the event, except in the event of a birth of a child in which case the enrollment application shall be filed with the employer or in the case of a retired employee-beneficiary with the Fund within one hundred eighty (180) days of the birth.

(1) With respect to the addition of a spouse or civil union partner, as well as dependent(s) of a new spouse or civil union partner, the event date shall be the date indicated on the marriage or civil union certificate.
(2) With respect to the addition of a domestic partner, as well as the dependent(s) of a domestic partner, the event date shall be the date the notary notarizes the Declaration of Domestic Partnership.
(3) With respect to the birth of a child, the event date shall be the birth date.
(4) With respect to the addition of a foster child, the event date shall be the date indicated on the State of Hawaii Department of Human Services Form 1564, Admission to Foster Home.
(5) With respect to the adoption of a child, the event date shall be the date of the adoption (which may occur up to 1 year after the child was initially placed for adoption). For placement of adoption or legal guardianship, the event date shall be the date of guardianship.
(6) With respect to a qualified medical child support order, the event date shall be the date specified in the order, or if no date is specified, the date that the order is issued.

(7) With respect to a dependent-beneficiary joining the employee-beneficiary's household; the event date shall be the date the dependent-beneficiary joined the employee-beneficiary's household if the dependent-beneficiary lived in a residence outside of the geographic areas covered by the employee-beneficiary's present benefit plan.

The Fund shall determine the required proof documents for each of the above events.

(b) Deletions of Dependents Due to Changes in Marital, Partnership or Family Status, or Legal Guardianship. An employee-beneficiary shall change his or her enrollment to terminate coverage of dependent-beneficiaries who cease to be eligible for continued enrollment in the Fund health benefit plans upon the occurrence of any of the following events: divorce or dissolution; annulment; legal separation; dissolution or other act ending a partnership; death of a spouse, partner or child; the end of any required coverage of a child under a qualified medical support order; a child ceases to be eligible for coverage under Rule 3.01 or a dependent covered due to legal guardianship turns the age of 18 (age of majority). The effective date of change in coverage shall be the first day of the first pay period following the occurrence of the event. Enrollment applications must be filed with the employer or in the cases of retirees to the Fund within forty-five (45) days of the event. Employee-beneficiaries may be responsible for paying all claims incurred, reimbursements received or employer contributions paid for any ineligible person after the event date for enrollment applications filed more than forty five (45) days after the event pursuant to Rule 4.12(c).

The Fund shall determine the required proof documents.

(c) Loss of Eligible Dependent's Coverage. An employee-beneficiary may change enrollment to add an eligible dependent-beneficiary in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when a dependent-beneficiary loses coverage in any health benefit plan. The effective date of the change in enrollment shall be the date that the dependent-beneficiary loses coverage in the health benefit plan, provided an enrollment application is received by the employer or in the case of a retiree by the Fund within forty five (45) days of the loss of coverage. Coverage for a dependent-beneficiary may be added at the next

open enrollment period when enrollment applications are received after forty five (45) days of the loss of coverage.

The Fund shall determine the required proof documents.

(d) Last Child Becomes Ineligible. An employee-beneficiary may change his or her enrollment in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when the last of the employee-beneficiary's children becomes ineligible for coverage as a dependent-beneficiary under the health benefit plans offered or sponsored by the Fund, e.g., when the child reaches the limiting age, as defined in Section 1.02 (unless the child is an adult disabled child under Section 3.01). An enrollment application shall be filed with the employer or in the case of a retiree with the Fund within forty five (45) days of the loss of eligibility. The effective date of the change in enrollment shall be the first day of the first pay period following the loss of eligibility.

(e) Changes Between Plans. An employee-beneficiary may change between health benefit plans offered or sponsored by the Fund when:

(1) The employee-beneficiary or dependent-beneficiary moves to a residence outside of the geographic areas covered by the employee-beneficiary's present benefit plan. The effective date of the change shall be the first day of the pay period following the employee-beneficiary or dependent-beneficiary's relocation except for retired employee-beneficiaries and dependent-beneficiaries enrolled in a Medicare medical and/or prescription drug plan.

For retired employee-beneficiaries and dependent-beneficiaries enrolled in a Medicare medical and/or prescription drug plan, the effective date of the change shall be made prospectively at the end of the month of the relocation or the end of the month in which the EUTF is notified, whichever is later.

(2) The employee-beneficiary is enrolled in a supplemental health benefits plan offered or sponsored by the Fund and loses primary coverage in a Non-Fund health benefits plan. The effective date of the change shall be the date that the employee-beneficiary loses coverage in the Non-Fund health benefits plan. The requirements of Rule 5.01(c) apply, except for the cancellation of the supplemental health benefits plan which will be cancelled upon

notification of the loss of the primary coverage in the Non-Fund health benefits plan.

(3) The employee-beneficiary is enrolled in a health benefits plan sponsored by the Fund and gains coverage under a Non-Fund health benefits plan. The employee-beneficiary may enroll in a supplemental health benefit plan offered or sponsored by the Fund. The effective date of the change shall be the first day of the pay period following the cancellation of the health benefits plan sponsored by the Fund.

(4) With respect to a qualified medical child support order, if an employee-beneficiary is enrolled in a plan whose services are limited to the State of Hawaii and whose dependent subject to the qualified medical child support order lives outside the State of Hawaii, the employee-beneficiary shall be allowed to change their plan selection to one whose services are available to the dependent.

(5) The retired employee-beneficiary enrolls in Medicare Part B. An enrollment application shall be filed within sixty (60) days of the retired employee-beneficiary's Medicare Part B effective date. The effective date of the change shall be the effective date of the retired employee-beneficiary's Medicare Part B or the first of the month following the Fund's receipt of the enrollment application, whichever is later. The retired employee-beneficiary and dependent-beneficiaries will remain in the previous medical and/or prescription drug plan(s) until the effective date of the new medical and/or prescription drug plan(s).

(f) Dependent Not Enrolled in a Fund Medical and/or Prescription Drug Plan Enrolls in Medicare Part B. A retired employee-beneficiary may add coverage for dependent-beneficiaries in the Fund medical and/or prescription drug plan(s), in which the retired employee-beneficiary is already enrolled when the dependent-beneficiary enrolls in Medicare Part B. An enrollment application shall be filed within sixty (60) days of the dependent-beneficiary's Medicare Part B effective date. The effective date of the addition shall be the effective date of the dependent-beneficiary's Medicare Part B, except when a health insurance carrier only offers a Medicare-only medical plan, in which case the effective date of the addition shall be the dependent-beneficiary's Medicare Part B effective date or the first of the month following the Fund's receipt of the enrollment application, whichever is later. If the health insurance carrier offers a non-Medicare medical and/or prescription drug plan, the dependent-beneficiary will be enrolled in the non-Medicare medical

and/or prescription drug plan until the effective date of the Medicare medical and/or prescription drug plan.

The Fund shall determine the required proof documents.

(g) Any change in the public employer's premium contributions and the employee-beneficiary's premium contributions, if any resulting from a change in enrollment or coverage shall begin as of the first day of the pay period in which the effective date of the employee-beneficiary's change in enrollment or coverage occurs. As in Rule 5.01(g), contributions shall not be prorated based on when the employee-beneficiary's change in enrollment or coverage occurs during the pay period.

5.03 Mandatory Enrollment in Medicare Part B and Medicare Part D for Retired Employees and Cancellation Due to Failure to Enroll

(a) Retired employee-beneficiaries or dependent-beneficiaries of retirees shall submit proof of enrollment in the federal Medicare Part B medical insurance plan when the employee-beneficiary or dependent-beneficiary becomes eligible to enroll in the federal Medicare Part B medical insurance plan if enrolled in a medical and/or prescription drug plan.

Failure to provide proof of enrollment in Medicare Part B within sixty (60) days of eligibility shall result in loss of medical and/or prescription drug coverage retroactive to the date of Medicare Part B medical insurance plan eligibility.

(b) Employee-beneficiaries who retire and are eligible for Medicare Part B at the time of retirement and their dependent beneficiaries who are eligible for Medicare Part B at the time of the employee-beneficiary's retirement shall provide proof of enrollment in Medicare Part B at the time of retirement or within sixty (60) days of retirement. Failure to provide proof of enrollment in Medicare Part B within sixty (60) days of retirement shall result in loss of medical and/or prescription drug coverage retroactive to the date of retirement.

(c) Retired employee-beneficiaries and their spouses/partners shall be reimbursed quarterly the cost of their Medicare Part B premiums, including Income Related Monthly Adjustment Amount (IRMAA) Medicare Part B premiums, less penalties. Reimbursements shall be made

using direct deposit unless the method of payment is waived by the Fund and another method is determined to be more appropriate.

(1) Medicare Part B premium reimbursements shall be effective the date the Medicare Part B is effective or the first day of the month that the fund receives appropriate proof of enrollment in Medicare Part B and a valid direct deposit agreement, whichever is later. In addition, proof of payment to the Social Security Administration or Centers for Medicare & Medicaid Services is required to begin Medicare Part B reimbursements.

(2) If a retired employee-beneficiary's direct deposit is returned by the financial institution or check is returned as undeliverable, a notice from the Fund will be sent to the retired employee-beneficiary. The retired employee-beneficiary has sixty (60) days from the date of the notice to submit a valid direct deposit agreement or a retiree address change form (returned check) to avoid a break in their reimbursement. Failure to provide a valid direct deposit agreement or a retiree address change form (returned check) within sixty (60) days of the date of the notice will result in cancellation of Medicare Part B premium reimbursements retroactive to the first day of the month of the quarter that the direct deposit was returned or when the check was returned undeliverable. If the reimbursement is cancelled, the retired employee-beneficiary's Medicare Part B premium reimbursements can be reinstated when a valid direct deposit agreement or a retiree address change form (returned check) is received with an effective date of the first day of the month that the valid direct deposit agreement or the retiree address change form (returned check) is received.

(3) Retired employee-beneficiaries and/or their spouses/partners shall provide the Fund appropriate proof of an IRMAA added to their Medicare Part B premium. If proof is submitted to the fund more than two years after the effective date of the IRMAA premium, the fund shall only reimburse for a two year retroactive period, subject to 5.03(c)(1).

(4) Each public employer shall pay to the Fund a contribution equal to the amount paid by the Fund to the retired employee-beneficiaries and their spouses/ partners.

Payment of these reimbursements shall be made only for retired employee-beneficiaries and/or their spouses/partners who are enrolled in the Medicare Part B medical insurance plan and pay their Medicare Part B medical insurance premiums to the Social Security Administration or Centers for Medicare & Medicaid Services.

(d) Retired employee-beneficiaries and dependent-beneficiaries whose medical and/or prescription drug coverages were cancelled due to failure to show proof of enrollment in Medicare Part B may be reinstated in the same medical and/or prescription drug plans upon proof of enrollment in Medicare Part B. The effective date of coverage shall be the later of the effective date of the Medicare Part B coverage or the medical and/or prescription drug coverage enrollment date.

(e) Retired employee-beneficiaries and their dependent-beneficiaries eligible for Medicare shall be enrolled in a Fund Medicare prescription drug plan if they wish to enroll in a Fund retiree prescription drug plan. Exceptions to this Rule include employee-beneficiaries and/or dependent-beneficiaries who reside outside of the Fund's Medicare prescription plan service area.

5.04 Cancellation Due to Failure to Enroll or Failure to Maintain Enrollment in Medicare; Effective Date of Cancellation

(a) If a retired employee-beneficiary's federal Medicare Part B medical insurance plan is not in effect when he/she is eligible to enroll, the retired employee-beneficiary's enrollment in the medical and/or prescription drug plans offered or sponsored by the Fund and the medical and/or prescription drug plan coverages for dependent-beneficiaries under that enrollment shall be cancelled.

(b) If a retired employee-beneficiary's dependent-beneficiary's federal Medicare Part B medical insurance plan is not in effect when he/she is eligible to enroll, the dependent-beneficiary's enrollment in the medical and/or prescription drug plans offered or sponsored by the Fund shall be cancelled.

(c) If a retired employee-beneficiary and/or dependent-beneficiary fails to enroll in the Fund's Medicare prescription drug plan their enrollment in the prescription drug plans offered or sponsored by the Fund shall be cancelled. Retired employee-beneficiaries and/or their dependent-

beneficiaries living outside of the Fund's Medicare prescription drug plan's service area are exempt from this Rule.

(d) The effective date of any cancellation under this rule shall be the date upon which the retired employee-beneficiary or their dependent-beneficiary, as applicable, first became eligible to enroll or ceased to be enrolled in the federal Medicare Part B medical insurance plan. The retired employee-beneficiary or their dependent-beneficiary shall be responsible for paying all claims incurred from the date the retired employee-beneficiary or their dependent-beneficiary became eligible to enroll, but did not enroll.

5.05 Termination of Enrollment; Effective Dates of Termination

(a) Termination Due to Surviving Spouse's or Partner's Remarriage or Entry into Another Partnership. A surviving spouse's or partner's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the surviving spouse's or partner's remarriage or entry into another partnership. The effective date of the termination shall be the first day of the pay period following the date of the surviving spouse's or partner's remarriage or entry into another partnership. The surviving spouse or partner shall be responsible for paying all claims incurred or for the employer contributions paid from the first day of the pay period following the date of the surviving spouse's or partner's remarriage or entry into a partnership for enrollment applications received more than forty five (45) days after the remarriage or entry into another partnership. Notwithstanding the foregoing, a child that is eligible to be an employee-beneficiary under Rules 3.01(a)(4) or Rule 3.01(a)(5) may continue his or her coverages by filing an enrollment application under Rule 5.01(f). The effective date of coverage shall be the date of termination of coverage due to the surviving spouse's or partner's remarriage or entry into a partnership.

(b) Termination Due to Child's Loss of Eligibility. A child's enrollment in all benefit plans offered or sponsored by the Fund shall be terminated upon the occurrence of any of the following events:

(1) The child reaches the limiting age, as defined in Section 1.02 and does not qualify as an adult disabled child under Section 3.01; or

(2) The employee-beneficiary fails to complete a legal adoption of the child within twelve (12) months of the date that the child is covered by the Fund's benefit plans; or

(3) The child no longer meets the requirements to be considered an adult disabled child as stated in Section 3.01.

With regards to subsection (1), a child that reaches the limiting age, as defined in Section 1.02. whose coverages were cancelled due to failure to show proof of student certification, may be reinstated with no break in coverage in the same benefit plans upon submission of proof documents within forty five (45) days of the birthdate.

Notwithstanding Rule 5.05 (b)(2), the enrollment of a child placed for adoption shall not be terminated if the employee-beneficiary has custody of and an obligation to support the child under a court order or agreement with a government agency or licensed child placing organization.

Unless provided otherwise by these rules or applicable federal or state law, the effective date of the termination shall be the first day of the pay period following the date of the event or, in an event under Rule 5.05 (b)(2), the date stated in a written notice to the employee-beneficiary.

5.06 Reinstatement of Enrollment; Effective Dates of Reinstatement

(a) Reinstatement in Employment. If as a result of an order or award from a court, arbitrator or other entity with proper jurisdiction over the matter, an employee-beneficiary is found to have been wrongfully terminated or suspended and is ordered to be reinstated in state or county employment, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which the employee-beneficiary's coverage was terminated. The effective date of the reinstatement shall be the date specified by the order or award. The employee-beneficiary shall pay the full cost of such coverage less any contribution paid by the employer on behalf of the employee-beneficiary as provided by statute, the employer's administrative rules, or an applicable bargaining unit agreement. If the full cost of such coverage is not paid, the employee-beneficiary shall have the option of having the reinstatement effective upon any of the following dates: (1) the employee-beneficiary's return to employment; or (2) the first day of the first pay period following the employee-beneficiary's return to employment; or (3) the first day of the second pay period following the employee-beneficiary's return to employment. The employee-beneficiary

shall select the effective date of coverage in an enrollment application filed within forty five (45) days of the date that the employee-beneficiary returns to active duty. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date the employee-beneficiary returns to active duty.

(b) Return From an Authorized Leave of Absence. If an employee-beneficiary returns from an authorized leave of absence ("LOA") during which coverage was not provided by a Fund benefit plan, the employee-beneficiary may be reinstated in the same Fund benefit plans from which coverage was cancelled if the employee-beneficiary files a properly completed enrollment application. At the option of the employee-beneficiary, the reinstatement shall be effective upon any of the following dates: (i) the employee-beneficiary's return from the LOA provided the employee-beneficiary files an enrollment application in accordance with Rule 4.05 within forty five (45) days of his or her return from the LOA, (ii) the first day of the first pay period following the employee-beneficiary's return from the LOA, subject to the same conditions set forth above, or (iii) the first day of the second pay period following the employee-beneficiary's return from the LOA, subject to the same conditions set forth above. If the employee-beneficiary fails to file an enrollment application within forty five (45) days of his or her return to work, the employee-beneficiary shall be eligible to reenroll during the next open enrollment period.

(c) Return From a Leave of Absence Covered by the Family Medical Leave Act (FMLA) Or Uniform Services Employment and Reemployment Rights Act (USERRA). If an employee-beneficiary returns from a leave of absence covered under the FMLA or USERRA and the employee-beneficiary's enrollment in the Fund benefit plans was canceled during that leave of absence, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which coverage was canceled. At the option of the employee-beneficiary, reinstatement shall be effective upon any of the following dates: (i) the date of the employee-beneficiary's return to work, (ii) the first day of the first pay period following the date of the employee-beneficiary's return to work, or (iii) the first day of the second pay period following the date of the employee-beneficiary's return to work. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within forty five (45) days of the date that the employee-beneficiary returns to work. If the employee-beneficiary fails to make a start date selection, the effective date of

coverage shall be the date of the employee-beneficiary's return to work. If the employee-beneficiary fails to file an enrollment application within forty five (45) days of his or her return to work, the reinstatement shall be effective on the first day of the first pay period following the employee-beneficiary's proper filing of the enrollment application.

(d) Enrollment in Medicare by a Retired Employee. If the enrollment of an employee-beneficiary or the coverage of a dependent-beneficiary was terminated due to the employee-beneficiary's or dependent-beneficiary's failure to enroll in the federal Medicare Part B medical insurance plan, upon the employee-beneficiary's or dependent-beneficiary's enrollment in such plan and submission of a proper and complete enrollment application to the Fund, the employee-beneficiary or dependent-beneficiary shall be enrolled in or covered by the Medicare supplemental plan offered by the Fund. The coverage shall be effective on the date specified in Rule 5.03.

(e) Enrollment in Medicare Advantage Plan by a Retired Employee. If the enrollment of a retired employee-beneficiary or their dependent-beneficiary was terminated due to failure to enroll in the Fund's Medicare Advantage plan, their coverage shall be reinstated effective the first of the month in which the Fund or their health insurance carrier receives a properly completed enrollment application.

(f) The public employer's premium contributions and the employee-beneficiary's premium contributions, if any, shall begin as of the first day of the pay period during which the employee-beneficiary's effective date of coverage occurs. Similarly, if there is a change in contributions due to an employee-beneficiary's change in enrollment or coverage, the change in contributions shall begin as of the first day of the pay period during which the change in enrollment or coverage occurs. As in Rule 5.01(g), contributions shall not be prorated based on when the employee-beneficiary's coverage begins during the pay period or on when an employee-beneficiary's change in enrollment or coverage occurs during the pay period.

5.07 Reimbursement of Retired Employee-Beneficiaries and Their Dependent-Beneficiaries Who Relocate Outside of the State of Hawaii

(a) Retired employee-beneficiaries and their dependent-beneficiaries of retirees who relocate outside of the State of Hawaii shall be eligible for reimbursement for premiums paid for personal medical and prescription drug plans issued by companies outside of the State of Hawaii who have also contracted with the Fund to provide medical and prescription drug plans that are only available to State of Hawaii residents.

(b) The reimbursement shall be the lesser of:

(1) The actual cost of the personal medical and prescription drug plan; or
(2) The amount of the state or county contribution for the most comparable medical and prescription drug plan offered by the Fund.

(c) Retired employee-beneficiaries or dependent-beneficiaries shall provide the Fund appropriate proof of premiums paid. Reimbursements are paid by the Fund in arrears on a quarterly basis upon receipt of documentation that the premiums for an individual health insurance policy has been paid by the retired employee-beneficiary. If proof is submitted more than two years after the premiums were paid, the Fund shall only reimburse for a two year retroactive period.

The Fund shall determine the required proof documents.

The Hawaii Employer-Union Health Benefits Trust Fund Board of Trustees Administrative Rules were adopted during a regular meeting of the Board of Trustees on February 19, 2003, which were amended and approved on May 19, 2004, August 25, 2004, September 28, 2005, March 22, 2006, September 26, 2007, August 20, 2008, August 26, 2009, August 4, 2014, December 9, 2015, June 30, 2016, July 25, 2017, June 26, 2018, August 27, 2019, and September 29, 2020. The rules shall take effect on the first day after filing with the Lieutenant Governor's Office.

Roderick Becker, Chairperson
Hawaii Employer-Union Health
Benefits Trust Fund

APPROVED

David Y. Ige
Governor
State of Hawaii

Date Filed, Office of the Lieutenant
Governor

LIEUTENANT GOVERNOR'S OFFICE
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APPROVED AS TO FORM:

Deputy Attorney General