Department of Budget and Finance

RELEASE DATE: September 25, 2024

REQUEST FOR PROPOSALS
No. RFP 25-001

SEALED PROPOSALS
FOR
Actuarial Valuation Services for
Other Post-Employment Benefits
STATE OF HAWAII
DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS
TRUST FUND (EUTF)

WILL BE RECEIVED UP TO 12:00 P.M., HAWAII STANDARD TIME (HST) ON

FRIDAY, NOVEMBER 1, 2024

ELECTRONICALLY OR PHYSICALLY AT THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND, CITY FINANCIAL TOWER, 201 MERCHANT STREET, SUITE 1700, HONOLULU, HAWAII 96813. SUBMIT DIRECT QUESTIONS RELATING TO THIS SOLICITATION TO DEREK M. MIZUNO, VIA E-MAIL AT EUTF.RFP@HAWAII.GOV.

Derek M. Mizuno
Procurement Officer

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SECTION ONE
ADMINISTRATIVE OVERVIEW

1.1 BACKGROUND

This Request for Proposals (RFP) is issued by the Hawaii Employer-Union Health Benefits Trust Fund (EUTF), an agency of the State of Hawaii (State). The EUTF was established by Act 88, 2001 Session Laws of Hawaii (SLH). Act 88 was partially codified as Chapter 87A, Hawaii Revised Statutes (HRS). Under HRS Chapter 87A, the EUTF is authorized to design, provide, and administer health and other benefit plans for State and county employees, retirees, and their dependents (aka "employee-beneficiaries" and "dependent beneficiaries"). The benefit plans include medical, prescription drug, dental, vision, chiropractic, and life insurance. The EUTF currently provides benefit plans to over 117,000 subscribers which include employees and retirees. When dependents are included, the participant count is approximately 191,000. Health Benefit Reference Guides for Actives (July 1, 2024 through June 30, 2025) and Retirees (January 1, 2024 through December 31, 2024) are attached as Exhibit C.

Public employer contributions to pay for these plans, insofar as retirees are concerned, are set or limited by provisions of HRS Chapter 87A. A description of the EUTF's retiree plans are noted in Exhibit C. The EUTF also provides Medicare Part B reimbursements to retirees and spouses of retirees hired prior to July 1, 2023.

The EUTF is administered by a board of ten Trustees (Board), who are appointed by the Governor. Five Trustees represent the employee-beneficiaries, one of whom represents retirees. These five Trustees are selected by the Governor from a list of candidates provided by exclusive employee representative organizations. The remaining five Trustees represent the public employers. The Board's responsibilities include determining the nature and scope of benefit plans, negotiating and entering into contracts to provide such plans, establishing eligibility and management policies, and overseeing all EUTF activities. The Board has adopted rules to administer the EUTF. Additional information can be found at: http://eutf.hawaii.gov/rules-statutes.

The EUTF's day-to-day operations are administered by an administrator appointed by the Board (Administrator). The Administrator is assisted in managing the EUTF by an Assistant Administrator, an Investment Office, a Benefits Office, a Member Services Branch Manager, a Financial Management Officer, and an Information Systems Chief. The Investment Office is responsible for all investment-related activities of the EUTF. The Benefits Office is responsible for the benefit plan design, cost control through disease management and wellness programs, and auditing of claims. The day-to-day operations of the EUTF are organized under three branches: Member Services, Financial Services, and Information Systems. The Member Services Branch Manager oversees the Member Services Branch and is supported by employees assigned customer service duties such as answering phone calls and responding to emails from members and processing enrollment submissions for active employees and retirees. The Financial Management Officer is supported by accountants and account clerks who reconcile employee accounts, collect employer/employee contributions for health benefits, and process all payments. The Information Systems Chief is supported by information technology (IT) specialists who provide internal IT support services, including Health Insurance Portability and Accountability Act of 1996 (HIPAA) security responsibilities, and coordinate with the State Department of Accounting and General Services to provide additional support services.

OPEB Trust

The OPEB Trust was established on June 30, 2013 by Act 268, SLH 2013 as an irrevocable trust

for the dedicated purpose of pre-funding other post-employment (OPEB) benefits of participating State and county employers. Act 268 also established an Annual Required Contribution (ARC) for participating employers that amortizes the unfunded actuarial accrued liability over a period of 30 years and an accompanying phase-in schedule that increases the annual contribution level through fiscal year 2019. The Board has shortened the amortization period for any new unfunded actuarial accrued liability layers to 20 years. Employers are projected to be fully funded by June 30, 2044.

At inception of the OPEB Trust in 2013, investment assets were valued at $313 million. Over the past years the OPEB Trust has seen tremendous growth and as of June 30, 2024, the portfolio amounts to $7.9 billion.

1.2 PURPOSE

The EUTF is soliciting proposals from qualified firms to provide actuarial services to be used for planning, budgeting, accounting, and financial reporting purposes relative to Government Accounting Standards Board (GASB) Statement Nos. 74, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, and 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*. The actuarial service will include studies of the health care plans and other postemployment benefits (collectively called OPEB) provided by the State and the counties to public employees, retirees, and their dependents through the EUTF.

The purpose of this RFP is to obtain data in accordance with actuarial standards of practice regarding the EUTF's OPEB plans that will satisfy the requirements of GASB Statement No. 74 and No. 75.

1.3 TERMS AND ACRONYMS USED THROUGHOUT THE SOLICITATION

BAFO	=	Best and Final Offer
CPO	=	Chief Procurement Officer
EUTF	=	Hawaii Employer-Union Health Benefits Trust Fund
GC	=	General Conditions, issued by the Department of the Attorney General
GET	=	General Excise Tax
HAR	=	Hawaii Administrative Rules
HRS	=	Hawaii Revised Statutes
OFFEROR	=	Any individual, partnership, firm, corporation, joint venture, or representative or agent submitting an offer in response to this solicitation
PLO	=	Priority-Listed Offeror
Procurement Officer	=	The contracting officer for the State of Hawaii, EUTF
RFP	=	Request for Proposals
State	=	State of Hawaii, including its departments, agencies, and political subdivisions

1.4 CONTRACT PERIOD

The term of a contract resulting from this RFP, subject to approval by the State, shall be as follows:

1. First Contract Period – July 1, 2025 to March 31, 2027 (actuarial valuations July 1, 2025 and 2026)
2. Optional Second Contract Period – April 1, 2027 to March 31, 2029 (actuarial valuations July 1, 2027 and 2028)
3. Optional Third Contract Period – April 1, 2029 to March 31, 2031 (actuarial valuations July 1, 2029 and 2030).

The term of the contract may be extended by the Board, at its sole discretion, to facilitate the completion of any contracted services at the end of the existing term. Such extension shall be solely for the purpose of completing the contracted services and shall be at no cost to the EUTF.

1.5 AUTHORITY

This RFP is issued under the provision of Chapters 87A and 103D, HRS, and the implementing Administrative Rules. All prospective OFFERORS are charged with presumptive knowledge of all requirements of the cited authorities. Submission of a proposal by any prospective OFFEROR shall constitute a representation of such knowledge on the part of such prospective OFFEROR.

1.6 CONTRACT ADMINISTRATOR AND PROCUREMENT OFFICER

This RFP is issued by the EUTF. The individual listed below is the contract administrator and the Procurement Officer for this procurement.

Derek M. Mizuno
Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1700
Honolulu, HI 96813

1.7 RFP SCHEDULE AND SIGNIFICANT DATES

Proposals must be received by 12:00 PM, HST on Friday, November 1, 2024. Late proposals will be rejected and not considered. The table below represents the EUTF's best estimate of the schedule that will be followed. All times indicated are based on HST. These dates are estimates only and are subject to change at the EUTF's sole discretion. The EUTF reserves the right to change any date(s) as deemed necessary and in the best interest in the State. If a component of this schedule, such as "Proposal Due date/time" is delayed, the rest of the schedule will likely be shifted by the same number of days.

Release of RFP	**Wednesday, September 25, 2024**
Deadline to Submit Written Questions	**Friday, October 4, 2024**
EUTF's Response to Written Questions	**Wednesday, October 16, 2024**
Proposals Due	**Friday, November 1, 2024 12:00 PM HST**
Determination of Priority Listed OFFERORs (if necessary)	**Friday, December 20, 2024**
Discussion with Priority Listed OFFERORs (if necessary)	**Week of January 13-17, 2025**
Best and Final Offer Due (if necessary)	**Friday, January 24, 2025**
Notice of Award	**Wednesday, February 12, 2025**
Contract Start Date	**July 1, 2025**

1.8 COMMUNICATIONS WITH THE EUTF

OFFERORS and potential OFFERORS (including agents of OFFERORS and potential OFFERORS) shall not contact any member of the EUTF Board or any member of the EUTF staff except as specified in this RFP. An exception to this rule applies to companies who currently do business with the EUTF; provided that any contact made by any such company should be related to that business, and should not relate to this RFP.

All questions regarding the RFP document shall be submitted in writing to the authorized contact person noted in Section 1.9, *Issuing Office and Contact Person*. To facilitate a meaningful response, written questions shall reference the page, paragraph, and line or sentence to which the question relates. Such inquires must contain identification of the OFFEROR, its email address, telephone and fax numbers, and the RFP number. Questions will be accepted until the due date to submit questions specified in Section 1.7 *RFP Schedule and Significant Dates*. No telephone calls will be accepted.

The State will respond to questions through addenda/amendments by the date specified in Section 1.7 *RFP Schedule and Significant Dates*; responses to all questions will be available on the State Procurement Office's (SPO) website (http://www.spo.hawaii.gov) and the EUTF website (https://eutf.hawaii.gov/about-eutf/procurement/). The EUTF is not responsible for delays or non-receipt of such responses or any communications by the OFFERORS.

1.9 ISSUING OFFICE AND CONTACT PERSON

This RFP is issued by the EUTF. The individual listed below is the sole point of contact from the date of the RFP is released until the award to the successful OFFEROR. Questions will be accepted only if submitted in writing and received on or before the day and time specified in Section 1.7, *RFP Schedule and Significant Dates.*

Mr. Derek M. Mizuno
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant St., Suite 1700
Honolulu, HI 96813
Email: eutf.rfp@hawaii.gov

A copy of this RFP can also be obtained from the EUTF website (https://eutf.hawaii.gov/about-eutf/procurement)

1.10 SUBMISSION OF PROPOSALS

OFFERORS must carefully examine this RFP, all amendments issued via addendum, all required contract forms, and other documents, laws and rules, as necessary, before submitting a proposal. The submission of a proposal shall be considered a warranty and representation that the OFFEROR has made a careful examination and understands the work and the requirements of this RFP.

OFFERORS have the option to submit their proposals under one of the two options below:

1. **Hard copies**:
   - One signed master proposal. The master proposal must be single-sided, unbound, and clearly marked, "Master."
   - Six hard copies of the proposal. Each copy shall be marked, "Copy __ of 6." Copies may be bound and double-sided.
   - Two electronic copies (on two CDs or USB flash drives) of the master proposal and a redacted version of the proposal in PDF format. The redacted version of the proposal shall redact any proprietary and confidential, trade secret information in the form of marked-out (blacked out) pages of the master proposal for submission to the public under any request compliant with the public information disclosure laws of the State.
2. **Emailed and File-Sharing Electronic copies**:
   - Complete electronic versions of the master and redacted proposals, presented in logical sections (e.g., proposal, attachments, forms) shall be submitted in PDF format. The redacted version of the proposal shall redact any proprietary and confidential, trade secret information in the form of marked-out (blacked out) pages of the master proposal for submission to the public under any request compliant with the public information disclosure laws of the State.
   - The EUTF will accept emailed electronic files up to 35MB. If the OFFEROR's electronic files exceed 35MB, the EUTF will accept multiple emails and each email shall be numbered in the subject line or within the email message (e.g., "email #1" or "email 1 of __"). It is the OFFEROR's sole responsibility to ensure that a complete emailed proposal is electronically received by the EUTF at eutf.rfp@hawaii.gov no later than the closing date and time specified in Section 1.7, *RFP Schedule and Significant Dates*.
   - For files larger than 35MB that cannot be emailed, OFFERORS also have the option of emailing their own file-sharing link to eutf.rfp@hawaii.gov. It is the OFFEROR's sole responsibility to ensure that emailed links to file-sharing services are received by the EUTF no later than the closing date and time specified in Section 1.7, *RFP Schedule and Significant Dates*.

The OFFEROR's proposal, including the required submission types as noted above, must be received by the EUTF no later than the closing date and time specified for the receipt of proposals as specified in Section 1.7, *RFP Schedule and Significant Dates*. Any proposal received after the closing date and time as specified in Section 1.7, *RFP Schedule and Significant Dates* will be rejected. No faxed or emailed proposals will be considered or accepted. Handwritten proposals will be rejected.

If selecting the hard copy option:
OFFERORS are encouraged to confirm their delivery agent's requirements for Hawaii. Proposals must be physically received by the EUTF via mail or hand delivery by **Friday, November 1, 2024, 12:00 noon, HST** and addressed to:

Mr. Derek M. Mizuno
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813

If the proposal is to be hand-delivered via courier (e.g., FedEx, UPS), the outside envelope shall be marked, "RFP No. 25-001, hand delivered, proposal due Friday, November 1, 2024, 12:00 noon, HST."

The outside cover of the package containing the proposal shall be marked:

State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
Proposal submitted in response to:
RFP No. 25-001, Actuarial Valuation Services

1.11 RECEIPT, OPENING, AND RECORDING OF PROPOSALS

Proposals will be time stamped upon receipt and held in a secure place by the Procurement Officer until the established due date. Proposals will not be opened publicly, but in the presence of two State officials on or after the proposal submission deadline specified in Section 1.7, *RFP Schedule and Significant Dates*. Late proposals will not be accepted.

The register of proposals and the proposals of the OFFEROR(s) shall be open to public inspection upon posting of award pursuant to Section 103D-701, HRS.

1.12 MODIFICATION PRIOR TO DEADLINE OR WITHDRAWAL OF OFFERS

An OFFEROR may withdraw or modify a proposal prior to the final submission date. No withdrawals or re-submissions will be allowed after the final submission date. Proposals may be modified or withdrawn, prior to the deadline for submission of proposals, by the following:

- **Modifications** – The OFFEROR provides a written notice delivered by hand, mail, or fax that accompanies the actual modification received by the Procurement Officer; or the OFFEROR provides a written notice and the actual modification by email to eutf.rfp@hawaii.gov, provided that the OFFEROR submits the written notice accompanying the actual modification by hand delivery, mail, or fax within two working days of the Procurement Officer's receipt of the electronic notification.
- **Withdrawal** – The OFFEROR provides a written notice delivered by hand, mail or fax received by the Procurement Officer or a notice by email to eutf.rfp@hawaii.gov.

1.13 DISCUSSION AND PRESENTATIONS

Discussions may be conducted with PRIORITY-LISTED OFFERORS (PLOs) (i.e., OFFERORS who submit proposals determined to be reasonably susceptible of being selected for award). Such OFFERORS may be invited to make presentations to the Evaluation Committee to clarify their proposals; to promote understanding of the EUTF's requirements

and the OFFEROR's proposal; and to facilitate arriving at a contract that will provide the best value to the State. Whether such discussions and presentations will be held will be at the discretion of the Evaluation Committee. The OFFEROR shall bear all responsibility for any and all costs related to making the presentations. The EUTF reserves the right to conduct the presentation in person in Honolulu, via teleconference call and/or via conference call.

1.14 BEST AND FINAL OFFER

If the EUTF determines a Best and Final Offer (BAFO) is necessary, it shall request one from the PLOs. BAFOs must be received by the EUTF no later than the date and time specified in Section 1.7, *RFP Schedule and Significant Dates,* or as may be amended by RFP addendum. If a BAFO is not requested by the EUTF, or if requested and not submitted by a PLO, the previous submittal will be construed as its BAFO. After BAFOs are received, final evaluations will be conducted for an award. All proposals become the property of the EUTF. The EUTF may destroy or return copies of proposals to non-winning OFFERORS.

1.15 PREPARATION OF PROPOSAL AND COSTS

The proposal shall be formatted in accordance with the requirements specified in this RFP.

Expenses for the development and submission of proposals and other responses to the RFP are the sole responsibility of the OFFEROR submitting the proposal or other response regardless of whether any award results from this RFP. Travel and expenses are also the sole responsibility of the OFFEROR submitting a proposal or otherwise responding to this RFP.

1.16 DISQUALIFICATION OF PROPOSALS

The EUTF reserves the right to consider as acceptable only those proposals submitted in compliance with all requirements set forth or referenced in this RFP and which demonstrate an understanding of the scope of work. Any proposal offering any other set of terms and conditions or terms and conditions contradictory to those included in this RFP may be disqualified without further notice. All proposals must meet the minimum qualifications as established in this RFP for consideration.

Grounds for disqualification include:

- Proof of collusion among OFFERORS, in which case all proposals and OFFERORS involved in the collusive action will be rejected and any participant to such collusion will be barred from future bidding until reinstated as a qualified OFFEROR.
- The OFFEROR's lack of responsibility and cooperation as shown by past work or services rendered.
- The OFFEROR's being in arrears on existing contracts with the State or having defaulted on previous contract(s).
- Delivery of the proposal after the time specified in Section 1.7, *RFP Schedule and Significant Dates.*
- The OFFEROR's failure to pay, or satisfactorily settle, all bills overdue for labor and materials on former contracts with the State at the time of issuance of the RFP.
- The proposal does not comply with applicable laws or contains provisions contrary to applicable law.
- The proposal is conditional, incomplete, or irregular in such a way as to make the proposal ambiguous as to its meaning.

- The proposal has provisions reserving the right to accept or reject the award, or to enter into a contract pursuant to an award, or provisions contrary to those required in the RFP.
- The OFFEROR's lack of sufficient experience to perform the work contemplated.
- The OFFEROR's conflicts of interest or lack of independence in judgment.
    - Handwritten proposals will be rejected.

1.17 RFP AMENDMENTS AND ADDENDUM

The EUTF reserves the right to amend this RFP at any time prior to the closing date for BAFOs. All amendments will be issued by written addendum and will be posted on the following websites:

- SPO Hawaii Awards and Notices Data System (HANDS) (https://hands.ehawaii.gov/welcome)
- EUTF (https://eutf.hawaii.gov/about-eutf-procurement)

1.18 CANCELLATION OF RFP / REJECTIONS OF PROPOSALS

This RFP may be cancelled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State or for any other reason permitted by Chapter 103D, HRS, and its implementing Administrative Rules.

1.19 UNCERTAINTIES BEYOND THE CONTROL OF THE EUTF

The EUTF recognizes that circumstances beyond the control of the EUTF may arise that may significantly affect the ability of the Contractor to provide the services described in this RFP or as proposed by the Contractor. Accordingly, the EUTF reserves the right to modify the contract resulting from this RFP to address such circumstances within the scope of the RFP.

1.20 PROPOSAL, PERFORMANCE AND/OR PAYMENT BONDs

No proposal bond is required to be submitted with the proposal and no performance or payment bond will be required for the contract awarded pursuant to this RFP.

1.21 EVALUATION OF PROPOSALS

An Evaluation Committee of at least three qualified State employees selected by the Procurement Officer shall evaluate proposals. The evaluation will be based solely on the evaluation criteria set out in Section IV of this RFP.

Prior to holding any discussions with PLOs, a priority list shall be generated consisting of OFFERORS who are determined to be acceptable or potentially acceptable. However, proposals may be accepted without such discussions.

If numerous acceptable and potentially acceptable proposals are submitted, the Evaluation Committee may limit the priority list to the highest ranked, responsive, and responsible OFFERORS. The PLOs may be afforded the opportunity to submit BAFOs. If a BAFO is requested, final evaluations will be conducted after BAFOs are received. If a BAFO is requested and is not submitted, the previous submittal will be construed as the BAFO.

1.22 AWARD OF CONTRACT

Award will be made to the responsible OFFEROR whose proposal is determined to be the most advantageous to the EUTF based on the evaluation criteria set forth in this RFP. If award is made, the successful OFFEROR will be required to enter into a formal written contract with the EUTF and shall be required to sign Exhibit B, *Business Associate Agreement* (BAA). The

RFP, the OFFEROR's accepted proposal, the BAFO, and the executed contract comprise the contract. A copy of the *Contract Form and General Conditions* can be found in Exhibit A. The RFP and the successful proposal will be incorporated in the resulting contract by reference; to the extent that the RFP and successful proposal and BAFO conflict, the terms of the RFP shall govern, unless otherwise agreed upon by the EUTF in the contract.

1.23 CONTRACT EXECUTION

The successful OFFEROR shall enter into a formal written contract in the form of Exhibit A, *Contract Form and General Conditions*. In submitting the proposal, the OFFEROR will be deemed to have agreed to each provision set forth in Exhibit A, *Contract Form and General Conditions* unless the OFFEROR specifically identifies the provision to which objection is made and submits alternative language as part of Attachment 4, *Exceptions*. The EUTF shall have no obligation to accept terms and conditions that vary from those set forth in Exhibit A, *Contract Form and General Conditions*, the contract awarded pursuant to this RFP, and any amendments thereto. Exceptions to Attachment 5, *Performance Guarantees*, will not be accepted by the EUTF.

Upon selection and award of the contract(s), the EUTF will send the formal contract(s) and BAA to the successful OFFEROR for signature. The contract and BAA shall be signed by the successful OFFEROR and returned with any required documents, within seven calendar days after receipt by the OFFEROR or within such time as the EUTF may allow. Failure to keep this deadline may result in a cancellation of the award and contract. The EUTF reserves the right to cancel any contract, and request new proposals or negotiate with remaining OFFERORS, if the EUTF is not satisfied with the awarded Contractor's performance.

No work is to be undertaken by the Contractor prior to the effective date of contract. The State is not liable for any work, contract costs, expenses, loss of profits, or any damages whatsoever incurred by the Contractor prior to the official effective date of the contract. No contract shall be considered binding upon the EUTF until the contract has been fully and properly executed by all parties thereto.

If an option to extend the contract is exercised at the Board's discretion, the Contractor shall be required to execute a supplement to the contract for the additional extension period.

1.24 REQUIREMENTS FOR DOING BUSINESS IN THE STATE OF HAWAII

OFFERORS are advised that in order to be awarded a contract under this solicitation, the OFFEROR will be required to be compliant with the following chapters of the HRS pursuant to HRS §103D-310(c) upon execution of a contract:

1. Chapter 237, General Excise Tax Law;
2. Chapter 383, Hawaii Employment Security Law;
3. Chapter 386, Worker's Compensation Law;
4. Chapter 392, Temporary Disability Insurance;
5. Chapter 393, Prepaid Health Care Act; and
6. §103D-310(c), Certificate of Good Standing (COGS) for entities doing business in the State.

If the OFFEROR is not compliant with the above HRS chapters at the time of contract execution, the OFFEROR may not receive the award. To demonstrate compliance, OFFERORS are encouraged to subscribe to Hawaii Compliance Express (HCE). OFFERORS who do not participate in HCE may submit paper compliance certificates to the EUTF.

The HCE is an electronic system that allows vendors/contractors/service providers doing business with the State to quickly and easily demonstrate compliance with applicable laws. It is an online system that replaces the necessity of obtaining paper compliance certificates from the State Department of Taxation, the Federal Internal Revenue Service, the State Department of Labor and Industrial Relations, and the State Department of Commerce and Consumer Affairs.

OFFERORS who are interested in registering in HCE should do so prior to submitting a proposal at https://vendors.ehawaii.gov. The annual registration fee is currently $12.00, and the 'Certificate of Vendor Compliance' is accepted for both contract execution and final payment.

1.25 PUBLIC EXAMINATION OF PROPOSALS

Except for confidential portions, the proposals shall be made available for public inspection upon posting of award pursuant to Section 103D-701, HRS.

If a person is denied access to a State procurement record, the person may appeal the denial to the State Office of Information Practices in accordance with Section 92F-42(12), HRS.

1.26 DEBRIEFING

Pursuant to Section 3-122-60, HAR, a non-selected OFFEROR may request a debriefing to understand the basis for award.

A written request for debriefing shall be made within three working days after the posting of the award of the contract. The Procurement Officer or designee shall hold the debriefing within seven working days or to the extent practicable from the receipt date of the written request.

Any protest by the requestor following a debriefing shall be filed within five working days after the date that the debriefing is completed, as specified in Section 103D-303(h), HRS.

1.27 PROTEST PROCEDURES

Pursuant to Section 103D-70, HRS and Section 3-126-3 HAR, an actual or prospective OFFEROR who is aggrieved in connection with the solicitation or award of a contract may submit a protest. Any protest shall be submitted in writing to the Procurement Officer at:

Mr. Derek M. Mizuno
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813

A protest shall be submitted in writing within five working days after the aggrieved person knows or should have known of the facts giving rise thereto; provided that a protest based upon the content of the solicitation shall be submitted in writing prior to the date set for receipt of offers. Further provided that a protest of an award or proposed award shall be submitted within five working days after the posting of award or, if requested, within five working days after the Procurement Officer's debriefing is completed.

The notice of award, if any, resulting from this solicitation shall be posted SPO HANDS website (https://hands.ehawaii.gov/hands/welcome).

1.28 SPECIAL CONDITIONS

The following Special Conditions will supplement Exhibit A, *Contract Form and General Conditions*:

1. Certificate of Authority/License. Prior to the effective date of the contract and during the entire term of the contract, the Contractor shall obtain and maintain all certificates of authority, licenses, and other approvals necessary to lawfully provide all services required under the contract. By accepting award of the contract, the Contractor certifies that it has all certificates, licenses, and approvals necessary to lawfully provide all services required under the contract.

2. Compliance with EUTF Laws and Rules. The Contractor shall comply with: Chapter 87A, HRS, as amended from time to time; all rules, including, but not limited to, EUTF Administrative Rules, policies, standards, procedures, and directives adopted by the Board; and all policies, standards, procedures, and directives of the Administrator. The Contractor shall be bound by the Board's interpretation of Chapter 87A, HRS, and the EUTF's rules, policies, standards, procedures, and directives.

3. Liquidated Damages. In the event of any breach of the contract by the Contractor, liquidated damages shall be assessed against the Contractor in the sum of $5,000.00 per calendar day until the breach is remedied by the Contractor.

4. Insurance. Prior to the contract start date, the Contractor shall procure, at its sole expense, and maintain insurance coverage acceptable to the State in full force and effect throughout the term of the contract. The Contractor shall provide proof of insurance for the following minimum insurance coverage(s) and limit(s) in order to be awarded a contract. The type of insurance is listed as follows:

    a. A fidelity bond, commercial crime policy, or other equivalent insurance that provides insurance coverage or similar protection to the EUTF against forgery, theft, robbery, fraud, dishonest and criminal acts committed by any of the Contractor's employees that causes the EUTF to sustain monetary loss. The limits of such bond or policy shall be $5,000,000 per occurrence and in the aggregate.

    b. Commercial general liability insurance coverage against claims for bodily injury and property damage arising out of all operations, activities or contractual liability by the Contractor, its employees and subcontractors during the term of the Contract. This insurance shall include the following coverage and limits specified or required by any applicable law: bodily injury and property damage coverage with a minimum of $1,000,000 per occurrence; personal and advertising injury of $1,000,000 per occurrence; and with an aggregated limit of $2,000,000. The commercial general liability policy shall be written on an occurrence basis and the policy shall provide legal defense costs and expenses in addition to the limits of liability stated above. The Contractor shall be responsible for payment of any deductible applicable to this policy.

    c. Automobile liability insurance covering owned, non-owned, leased, and hired vehicles with a minimum of $1,000,000 for bodily injury for each person, $1,000,000 for bodily injury for each accident, and $1,000,000 for property damage for each accident or $3,000,000 combined single limit.

    d. Appropriate levels of per occurrence insurance coverage for workers' compensation and any other insurance coverage required by Federal or State law.

e. Professional liability insurance covering all activities under the contract with a minimum of $10,000,000 per claim and with an aggregate limit of $10,000,000.

f. Cyber liability insurance with limits not less than $25,000,000 per occurrence/claim, $25,000,000 aggregate. Coverage shall be sufficiently broad in response to the duties and obligations as is undertaken by the scope of work within this contract and shall include, but not be limited to, claims involving infringement of intellectual property, including but not limited to, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall also provide coverage for breach response costs and regulatory fines and penalties and credit monitoring expenses.

g. Any and all other insurance that is required by applicable law and that is reasonably necessary in order for the Contractor to perform the work and services required under the contract. The insurance policies shall have limits of liability, per occurrence and in the aggregate, in amounts that are reasonably satisfactory to the Board, as measured by what a reasonably prudent trustee would require of a Contractor in similar circumstances.

If the Contractor maintains broader coverage and/or higher limits than the minimums shown above, the State requires and shall be entitled to the broader coverage and/or higher limits maintained by the Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the State.

The adequacy of the coverage afforded by the Contractor's insurance shall be subject to review by the Board, from time to time, and if it appears that a reasonably prudent trustee, operating a trust fund similar to that operated by the Board, would require an increase in the limits of liability of such insurance, the Contractor shall, to that extent, take all necessary actions to increase such limits.

All the required insurance shall be carried with insurance carriers that have a general policyholder's rating of not less than A and a financial rating of no less than VII in the most current A.M. Best's Insurance Reports. If the A.M. Best's ratings are changed or discontinued, the parties shall agree to an equivalent method of rating insurance companies.

Throughout the entire term of the contract, the EUTF, the Board and its trustees shall be named as additional insureds on all the required insurance policies except for professional liability/errors and omissions and workers' compensation policies. Prior to the commencement of the contract, the Contractor shall provide the EUTF with certificates of insurance showing that it is carrying all the insurance required hereunder. At or prior to the expiration of all insurance policies required hereunder, the Contractor shall provide the EUTF with certificates of insurance showing the renewal or replacement of such insurance policies. All policies of insurance shall provide that the Board will be given 30 days' notice in writing in advance of any cancellation, lapse, or reduction in the amount of insurance.

Each insurance policy required by this contract, including a subcontractor's policy, shall contain the following clauses:

(1) "This insurance shall not be canceled, limited in scope of coverage or non-renewed until after 30 days' written notice has been given to the Hawaii Employer-Union Health Benefits Trust Fund, 201 Merchant Street, Suite 1700, Honolulu, Hawaii 96813."

(2) "The State of Hawaii, the Hawaii Employer-Union Health Benefits Trust Fund (EUTF), the EUTF Board of Trustees, and individual trustees of the EUTF Board are

added as additional insureds with respect to operations performed for the State of Hawaii and the EUTF."

(3) "It is agreed that any insurance maintained by the State of Hawaii and/or the EUTF will apply in excess of, and not contribute with, insurance provided by this policy."

The minimum insurance required shall be in full compliance with the Hawaii Insurance Code throughout the entire term of the contract, including supplemental agreements.

Upon the Contractor's execution of the contract, the Contractor agrees to deposit with the EUTF, certificate(s) of insurance necessary to satisfy the EUTF that the insurance provisions of this contract have been complied with and to keep such insurance in effect and the certificate(s) therefore on deposit with the EUTF during the entire term of this contract, including those of its subcontractor(s), where appropriate.

Upon request by the State, the Contractor shall be responsible for furnishing a copy of the policy or policies.

Failure of the Contractor to provide and keep in force such insurance shall be regarded as material default under this contract, entitling the EUTF to exercise any or all of the remedies provided in this contract for a default of the Contractor.

The procuring of such required insurance shall not be construed to limit the Contractor's liability hereunder nor to fulfill the indemnification provisions and requirements of this contract. Notwithstanding said policy or policies of insurance, the Contractor shall be obliged for the full and total amount of any damage, injury, or loss caused by negligence or neglect connected with this contract.

5. Transition Procedures. At no cost to the EUTF, the Contractor shall comply with the following provisions upon receipt of a notice of termination or upon the expiration of the contract:

   a. The Contractor shall transfer title and deliver to the EUTF or its designee, any and all completed or partially completed goods, materials, reports, information, data or other work product of the Contractor that were made under the contract or as part of the Contractor's performance of the contract.
   b. As directed by the EUTF, the Contractor shall destroy and/or deliver to the EUTF or its designee, all confidential or proprietary documents, information, and data that Contractor has received under the contract and all copies thereof.

1.29 PAYMENT TO CONTRACTOR

Contractor shall be paid upon delivery of draft actuarial valuation report (60%) and final actuarial valuation report (40%). Contractor shall submit invoices and payment will be made according to general terms and conditions.

1.30 CONTRACTOR INVALIDATION

If any provision of this contract is found to be invalid, such invalidation will not be construed to invalidate the entire contract.

1.31 FUNDING

Execution of any contract between the EUTF and the successful OFFEROR is contingent upon the availability of funds. In addition, any contract resulting from this RFP shall be enforceable only to the extent of the availability of funds. No damages or interest shall accrue against the State or the EUTF as a result of the non-availability of funds.

SECTION TWO

SCOPE OF WORK

2.1 PROJECT OVERVIEW AND HISTORY

GASB has issued Statement Nos. 74 and 75. These accounting and financial reporting standards require the State to obtain actuarial valuations for employee-beneficiaries that are participating in the OPEB plans offered by the State and the counties through the EUTF. The EUTF hires an investment consultant to advise the trustees on the investment of these funds.

Moreover, the State and counties will be required to report in their annual financial reports certain additional data pertaining to OPEB plans. As of June 30, 2024, the following are the market values of each of the employers for OPEB:

Employer	Market Value
State of Hawaii	$5,142,578,397
City & County of Honolulu	1,397,212,727
County of Maui	535,013,015
County of Hawaii	371,959,429
County of Kauai	235,469,567
Honolulu Board of Water Supply	133,495,414
Hawaii Dept. of Water Supply	31,071,747
Kauai Dept. of Water Supply	17,052,945
Honolulu Authority for Rapid Transit	6,011,177
Total	$7,869,864,418

Additionally, Act 268 SLH 2013 (Exhibit G) requires public employers full funding of the ARC from fiscal year July 1, 2018 – June 30, 2019 and Acts 040 and 041, SLH 2023 (Exhibit I) eliminated Medicare Part B premium reimbursements for spouses and reimbursements of the income related monthly adjustment amounts (IRMAA), respectively, both for new hires after June 30, 2023.

The purpose of this procurement is to secure professional services to obtain data in accordance with actuarial standards of practice regarding the EUTF's OPEB plans that will satisfy the requirements of the GASB Statements Nos. 74 and 75**.** The GASB statements require actuarial valuations for active and retired State and county employees. The actuarial valuations as of July 1, 2023 (July 1, 2024 actuarial valuation is currently being prepared) is attached to this document as Exhibit F. Additionally, Act 093, SLH 2017 (Exhibit H) requires annual valuations.

2.2 SCOPE OF WORK

All services provided to the EUTF shall be in accordance with this RFP, including its attachments and any addenda.

The Contractor must perform an actuarial valuation in accordance with actuarial standards of practice for the State, and the counties' OPEB plans provided through the EUTF that will satisfy the requirements of GASB Statement Nos. 74 and 75.

The valuation date will be as of July 1, 2025 and annually thereafter.

A. Actuarial valuation. The Contractor shall prepare an actuarial valuation of the OPEB plan classified as an agent multiple employer to include:

1. One combined and nine separate employer actuarial valuations of the EUTF OPEB Plan as of July 1, 2025 for each public employer participating in the EUTF, i.e., the State of Hawaii, City and County of Honolulu, the County of Hawaii, the County of Maui, the County of Kauai, the Board of Water Supply of Honolulu, the Hawaii Department of Water Supply, the Kauai Department of Water Supply, and Honolulu Authority for Rapid Transportation (HART). With respect to each actuarial evaluation, Contractor shall prepare and deliver to the EUTF and employers any and all statements, reports, and documents that an actuary would reasonably be expected to prepare and deliver in connection with an actuarial valuation conducted in accordance with actuarial standards of practice. Medicare Part B premiums for the State and counties shall also be included in the actuarial valuation.
2. The actuarial present value of total projected benefits.
3. The ARC of the State and county public employers.
4. Actuarial valuation reports. A written report on each actuarial valuation conducted is required for the combined and nine separate employer reports. Reports must be in the form and covering the subjects as specified by the EUTF. The actuarial valuation reports shall be completed three weeks prior to and presented at the EUTF Board's first meeting of the calendar year which is the first or second Monday of January (e.g., the July 1, 2024 actuarial valuation will be presented at the January 6, 2025 Board meeting). All actuarial valuation reports shall contain the following information:
    a. An executive summary for formal presentation to the EUTF Board, the State's executive branch and the Legislature as well as the other employers and the legislative bodies.
    b. All data necessary for the EUTF Plan and the employers to comply with the requirements of Act 268, SLH 2013 including, without limitation:
        i. Actuarial accrued liability
        ii. Actuarial value of accrued assets
        iii. Unfunded actuarial liability (UAAL) – funded percent of UAAL
        iv. Normal cost
        v. ARC per Act 268, SLH2013, as a dollar amount and percentage of covered payroll
    c. A description of:
        i. EUTF OPEB plan provisions, including group(s) covered and benefits valued
        ii. Actuarial methods including:
            1. Actuarial funding method
            2. UAAL amortization policy
            3. All actuarial assumptions
        iii. Data used in the valuation, including age/service distribution table(s)
        iv. Perform an annual gain/loss analysis to determine reasons for changes in the UAAL, if and when prior actuarial valuations is available as support
        v. Assess the data for inconsistencies and make recommendations for enhancing data quality
5. For each employer, a valuation forecast of 30 years of UAAL, ARC, pay-as-you-go, funded percentage prospected asset balance gain as required by the stated funding policy of the State noted in Act 268, SLH 2013.

6. With respect to each actuarial valuation, the contractor shall attend and make presentations at six meetings on the island of Oahu for the EUTF Board, the Legislature (2), employee organizations, employers and the State Department Budget and Finance. The EUTF will attempt to schedule the five meetings during the week of the January EUTF Board meeting. Additional meetings may also be required on an as-needed basis. The cost for each additional meeting shall be noted on Attachment 2, Offer Form OF-2.

   Alternative Funding Period: Prepare a Projection of Funding Progress (page 19 of the 7/1/23 Actuarial Valuation Report) in aggregate (all employers combined) and for the State as of each actuarial valuation date utilizing the same assumptions but with shorter amortization periods – through June 30, 2044 (5-years earlier) for the initial liability base and 15-years (5-years shorter) for any new liability bases.

   Alternative Strategies. The Contractor shall provide recommendations on managing the OPEB obligation.

B. Assumptions. The Contractor shall validate assumptions prior to making calculations based on the following:
   1. EUTF Plan, classified as an agent multiple employer plan.
   2. Investment rate of return: A percentage rate to be mutually agreed upon by the EUTF and the Contractor.
   3. Value of the plan assets: As determined by the EUTF
   4. Amortization period: 20 years
   5. Amortization method: In accordance with Act 268, SLH 2013

C. GASB 75 Valuation Reports. The Contractor shall also provide additional accounting valuation reports for each of the nine employers, as required by GASB Statement No. 75. GASB 75 will require (1) separate reports for funding and accounting purposes and (2) annual accounting reports. Pursuant to GASB 75, the Contractor shall prepare the following: (a) a detailed, annual reconciliation of liabilities and assets; (b) an asset depletion test for determining the appropriate discount rate and development of liabilities based on GASB's prescribed discount rate methodology; (c) four sensitivity scenarios based on a +/-1% change to the discount rate and a +/-1% change to the health care trend assumption; (d) an expense calculation that separately tracks gains and losses due to demographic experience, asset experience, assumption changes, and plan changes; and (e) annual accounting reports required by GASB 75's requirement for an annual update to unfunded liability. The Contractor must also provide an annual letter in response to the State Department of Accounting and General Services request for information to support the census data and assumptions and provide assistance for any other requests from the employers' and EUTF's auditors.

D. Additional Services (Included in Base Services). The Contractor shall build into its fixed rate, 30 hours for the base contract period plus 30 hours for the first extension and 30 hours for the second extension to be used by the EUTF for actuarial studies such as, but not be limited to, 1) evaluation of the impact on the actuarial accrued liability and ARC for plan design changes; 2) evaluation of the impact on future liabilities and ARCs of legislation to modify the employer contributions for future employees; 3) evaluation of the impact on the actuarial accrued liability and ARCs for additional employer contributions; or 4) development and authorization to use a tool that allows employers to model various additional contribution amounts. If the hours are not used during the base contract or first extension periods, they will carry forward, at no limit, to the next period.

E. Additional Services (NOT Included in Base Services). In addition, the EUTF may, at any time, with written notice to the Contractor, request the Contractor to perform other actuarial services in addition to those included as part of the base services on behalf of the EUTF including, but not limited to, actuarial services for technical assistance. The Contractor shall provide a separate listing of hourly rates for each employment type (i.e., Senior Actuarial Analyst, Support Services, etc.) that may be required to provide optional technical assistance and analysis. If the Contractor intends to bill for any advice or service requested by the EUTF, the Contractor shall so notify the EUTF prior to providing such advice or service. No additional services shall be performed unless requested by the EUTF and agreed to by the Contractor.

SECTION THREE

PROPOSAL FORMAT AND CONTENT

3.1 PROPOSAL OBJECTIVES

One of the objectives of this RFP is to make proposal preparation easy and efficient, while giving OFFERORS ample opportunity to highlight their proposals. Proposals shall be prepared in a straightforward and concise manner, in a format that is reasonably consistent and appropriate for the purpose. Emphasis will be on completeness and clarity of content.

When an OFFEROR submits a proposal, it shall be considered a complete plan for accomplishing the tasks described in this RFP and any supplemental tasks the OFFEROR has identified as necessary to successfully complete the obligations outlined in this RFP.

The proposal shall describe in detail the OFFEROR's ability and availability of services to meet the goals and objectives of this RFP as stated in Section 2.2, *Scope of Work*. The OFFEROR shall submit a proposal that includes an overall strategy, timeline and plan for the work proposed as well as expected results and possible shortfalls.

3.2 PROPOSAL CONTENTS

The OFFEROR shall adhere to all instructions listed in Section 1.10, *Submission of Proposals*, and prepare a written proposal that will fully describe the qualifications and availability of the OFFEROR to provide the services requested and the compensation the OFFEROR proposes in response to this RFP. To be considered responsive, the OFFEROR's proposal shall respond to, and include all items specified in this RFP and any subsequent addendum. Any proposal offering any other set of terms and conditions that conflict with the terms and conditions provided in the RFP or in any subsequent addendum may be rejected without further consideration.
The proposal shall include, without limitation, the following:

- Cover letter
- Offer Form, OF-1 (Attachment 1)
- Offer Form, OF-2 (Attachment 2)
- Confidential Information (Attachment 3)
- Exceptions (Attachment 4)
- OFFEROR Information Sheet (Section 5)
- Completed Questionnaire (Section 6)
- Sample Reports (Actuarial Valuation and GASB 75)
- Financial Statements

All proposals become the property of the EUTF. The EUTF may return or destroy copies of proposals of non-winning OFFERORS.

3.3 COVER LETTER

The RFP response must include a cover letter addressed to the Administrator. The letter, which will be considered an integral part of the proposal, must contain the following:

- Contact Information – The cover letter shall include the OFFEROR's name, address, telephone/fax numbers, and e-mail address.

- Terms and Conditions of RFP – A statement that the OFFEROR fully understands and will comply with all terms and conditions contained in the RFP. The OFFEROR must include written acknowledgment of receipt of any and all amendments or addenda made to this RFP.
- Legal Entity – A statement indicating that the OFFEROR is an individual, a partnership, a limited liability company, a corporation or other legal entity (as identified) and the jurisdiction where the OFFEROR is organized.
- Authorized Signature – The cover letter must be signed by an individual or individuals authorized to legally bind the OFFEROR. If the OFFEROR is a corporation, evidence in the form of a certified copy of a corporate resolution or certified copy of articles of incorporation or bylaws shall be submitted showing the individual's authority to bind the corporation. If the OFFEROR is a partnership, the proposal must be signed by all the partners, or evidence in the form of a certified copy of the partnership agreement shall be submitted showing the individuals' authority to bind the partnership. Similar evidence must be submitted for an individual signing the proposal letter on behalf of any kind of entity.
- Current Licenses and Registration – A statement that the OFFEROR maintains the current licenses necessary to provide the services required. In addition, an OFFEROR must provide evidence that the OFFEROR is registered to do business in the State prior to commencement of the work. True and accurate copies of the OFFEROR's license(s) and certificates must be provided. See Section 1.24, *Requirements for Doing Business in the State of Hawaii*.
- Subcontracting of Services – A statement by the OFFEROR indicating that the work described in the RFP will not be subcontracted. If subcontractors will be used, append a statement to the cover letter from each subcontractor, signed by an individual authorized to legally bind the subcontractor stating: 1) the general scope of work to be performed by the subcontractor and 2) the subcontractor's willingness to perform the indicated tasks. The extent to which the work will be subcontracted and the qualifications of any subcontractor will be considered in evaluating the OFFEROR's ability to perform the service referred to in the RFP.
- Non-Discrimination – A statement that the OFFEROR does not discriminate in employment or business practices with regard to race, color, religion, age (except as provided by law), sex, sexual orientation, marital status, political affiliation, national origin, disability, or any other characteristic protected by federal, state or local laws.
- EUTF Rights Regarding Contractor's Recommendations – A statement that the OFFEROR understands that the EUTF reserves the right to disapprove the Contractor's recommendations without penalty when they conflict with the policy or fiscal interests of the EUTF, as determined by the Board.
- Terms and Conditions of Contract – Affirm that the provisions of the sample contract in Exhibit A, *Contract Form and General Conditions* are acceptable or state any proposed modifications in Attachment 4, *Exceptions*. The EUTF reserves the right to decline or classify as "unresponsive" any substantive changes, modifications, or revisions to the provisions of the sample contract. Exceptions to Attachment 5, *Performance Guarantees*, will not be accepted by the EUTF.

3.4 OFFER FORM, OF-1

Offer Form, OF-1 is required to be completed using the OFFEROR's exact legal name as registered with the State Department of Commerce and Consumer Affairs, if applicable, in the appropriate space on Offer Form, OF-1 (Attachment 1). Failure to do so may delay proper execution of the Contract.

The OFFEROR's authorized signature on the Offer Form, OF-1 shall be an original signature, which shall be required before an award, if any, can be made. The submission of the proposal shall indicate OFFEROR's intent to be bound.

3.5 OFFER FORM, OF-2

Pricing shall be submitted on Offer Form OF-2 (Attachment 2). The price shall be the all-inclusive cost, including the GET, to the State. No other costs will be honored. Any unit prices shall be inclusive.

3.6 CONFIDENTIAL INFORMATION

The OFFEROR shall list in Attachment 3, *Confidential Information*, those portions of the proposal that contain trade secrets or other proprietary data/information that the OFFEROR wishes to remain confidential. The OFFEROR shall follow the instructions under Section 1.10, *Submission of Proposals*, for submitting a redacted copy of its proposal. The OFFEROR must also include on Attachment 3, a detailed explanation as to why this information is considered confidential, with respect to the requirements of Chapter 92F, HRS. Any request for public inspection is subject to the requirements of Chapter 92F, HRS. The entire proposal CANNOT be considered confidential. The fee proposal CANNOT be considered confidential. With the indication of sections that are deemed proprietary and confidential, the OFFEROR must include a written explanation of the nature and rationale for considering the information as confidential.

3.7 EXCEPTIONS

Any exceptions to terms, conditions, or other requirements in any part of these specifications must be listed in Attachment 4, *Exceptions*. The OFFEROR shall reference the RFP section where the exception is taken, a description of the exception taken, and the proposed alternative, if any. Otherwise, it will be considered that all items offered are in strict compliance with the specifications. Amendments or clarifications shall not affect the remainder of the proposal, but only the portion so amended or clarified. In instances where there is a difference between a proposal including the BAFO and this RFP, the RFP terms will be binding unless specifically accepted as an exception stipulated in the contract. The EUTF reserves the right to accept or reject any request for exceptions. Exceptions to Attachment 5, *Performance Guarantees*, will not be accepted by the EUTF.

3.8 OFFEROR INFORMATION SHEET

The Offeror Information sheet (Section 5) shall be completed and submitted with the proposal.

3.9 QUESTIONNAIRE

Clear and concise answers in response to Section 6 are required to facilitate the evaluation of a proposal; responses must also be returned in the Word format provided. Any additional information shall be provided as an appendix to the proposal.

3.10 SAMPLE REPORTS AND FINANCIAL STATEMENTS

Sample reports should be attached as Exhibit A. The OFFEROR's most recent audited financial statements should be attached as Exhibit B. If the OFFEROR is not able to submit audited financial statements with the proposal, the OFFEROR must agree to submit audited financial statements if selected as a PLO.

SECTION FOUR

EVALUATION CRITERIA

4.1 INTRODUCTION

The EUTF seeks the highest quality organization to provide actuarial valuation services. Throughout the selection process, the EUTF reserves the right, in its sole discretion:

a. To not award the contract to the lowest cost OFFEROR.
b. To not award the contract at all.

4.2 EVALUATION PROCESS

An Evaluation Committee selected by the Procurement Officer will review and evaluate all proposals submitted by the deadline specified in this RFP. The evaluation process will be conducted in up to six phases:

Phase 1 – Evaluation of Mandatory Requirements
Phase 2 – Establishment of PRIORITY-LISTED OFFERORS (PLOs) (optional)
Phase 3 – Discussions with PLOs (optional)
Phase 4 – Best and Final Offers (optional)
Phase 5 – Final Evaluation of Proposals
Phase 6 – Award

Phase 1 – Evaluation of Mandatory Requirements

The evaluation of the mandatory requirements shall be on a "pass/no pass" basis. The purpose of this phase is to determine whether an OFFEROR's proposal is sufficiently responsive to the RFP to permit a complete evaluation. Each proposal will be reviewed for responsiveness. Failure to meet the mandatory requirements ("no pass") will be grounds for deeming the proposal non-responsive to the RFP and rejection of the proposal. Only those proposals meeting the following requirements ("pass") of Phase 1 will be considered in Phase 2.

- Adhere to all proposal submission guidelines.
- Follow proposal submission timeline.
- The proposal must include proposed rates for the initial contract period, all extension contract periods and additional services.
- All proposed rates must be guaranteed for the term of the contract, including the proposed extensions and additional services. There shall be no contingencies on the proposed rates.
- There shall be no time limitations on the validity of the proposal.
- Submission of evidence of financial stability. If OFFEROR is not able to submit evidence with the proposal, the OFFEROR must agree to submit evidence if selected as a PLO.
- The OFFEROR must agree to be bound, in order of precedence, by 1) the contract between the State and the Contractor, 2) the RFP including all attachments and addenda, and 3) the Contractor's proposal and BAFO.

Phase 2 – Establishment of PLOs (optional)

All OFFERORS who pass Phase 1, Evaluation of Mandatory Requirements, shall be classified as "acceptable" or "potentially acceptable." The Evaluation Committee will evaluate all proposals

and establish a priority list of OFFERORS who received the best preliminary evaluations. The order, priority and points to be applied to each evaluation criteria are as listed above. This phase is optional and may not be included in the evaluation.

Phase 3 – **Discussions with PLOs (optional)**

In this phase, the Evaluation Committee may conduct interviews with the PLOs as listed in the timeline provided in Section 1.7, *RFP Schedule and Significant Dates*. This phase is optional and may not be included in the evaluation.

Phase 4 –Best and Final Offers (optional)

In this phase, the PLOs may be asked to submit a BAFO for the services that are being proposed. This phase is optional and may not be included in the evaluation.

Phase 5 – Final Evaluation of Proposal

In this phase, the Evaluation Committee will conduct final evaluations of the PLOs' BAFOs in accordance with the criteria listed below. This phase is optional and may not be included in the evaluation.

Phase 6 – Award

The EUTF Board will make the final selection.

4.3 EVALUATION CRITERIA AND POINTS

The evaluation criteria listed below will be used to evaluate and rank OFFERORS' proposals.

Criteria	Points
Fees	50
Agreement to perform services requested in RFP	25
Experience offering services and references including prior engagements with the EUTF and the State	25
Total	100

Description of Evaluation Criteria:

Fees: For fee evaluation, the OFFEROR proposing the lowest total fee will receive the maximum points of 50. The total fee includes all proposal periods including extensions but excludes costs for additional services and meetings. Other OFFERORS will be awarded points based on the following formula:

Lowest fee proposed / Fee proposed by OFFEROR X Maximum points = Points awarded to OFFEROR

Agreement to perform services requested in RFP: This category will be evaluated based upon the responses contained in the proposal with respect to the OFFEROR's agreement to perform all of the services required in a manner and to the specifications outlined in this RFP. The OFFEROR's thorough explanation of how it will complete the required tasks outlined in the RFP will be

evaluated based upon its understanding of the tasks, the demonstrated ability to perform the tasks and agreement to dedicate the necessary resources to perform the tasks.

Experience offering services and references including prior engagements with the EUTF and the State: This criteria includes, but is not limited to: the organization's and the proposed consultants' general experience in actuarial services; the organization's and the proposed consultants' experience in providing actuarial services to entities similar to the EUTF; the stability of the organization and the proposed consultants and servicing team; the nature of any proposed subcontracting; the nature of any regulatory problems (past or current) involving the organization and/or the proposed consultants and servicing team; and the client reference checks.

SECTION FIVE

OFFEROR INFORMATION SHEET

OFFEROR INFORMATION SHEET	
Organization Name	_____
Contact Person's Name	_____
Title	_____
Address	_____
Phone Number	_____
E-mail Address	_____
Fax Number	_____

SECTION SIX

QUESTIONAIRE

Questionnaire Instructions to OFFERORS:

*****DO NOT ALTER THE QUESTIONS OR QUESTION NUMBERING*****

Please complete all appropriate sections of the questionnaire.

Provide answers to the questionnaires in Word format provided.

Provide an answer to each question even if the answer is "not applicable" or "unknown."

Answer the question as directly as possible.

- If the question asks "How many…" provide a number
- If the question asks, "Do you…" indicate Yes or No followed by any additional brief narrative explanation to clarify.

IMPORTANT: Be concise in your response. Use bullet points as appropriate. Reconsider how to word any response that exceeds 200 words in length so that the response contains the **most important points** you want displayed. Referring the reader to an attachment for further information should be avoided or used on a limited basis. Any response that does not directly address the question, but only contains marketing information will be considered non-responsive.

The OFFEROR will be held accountable for accuracy/validity of all answers.

RFP responses will become part of the contract between the winning OFFEROR and the EUTF.

The submission of your proposal will be deemed a certification that you will comply with all requirements set forth in this RFP.

NOTE: Answers to the questions must be provided in hard copy and WORD format on CDs or USB flash drives

DO NOT PDF or otherwise protect the CDs or USB flash drives

The following questions are designed to provide information to evaluate the OFFEROR's capabilities since the decision to award a contract will not be based solely on cost. OFFERORS should be concise with their responses, which should begin with the most important points the OFFEROR wants the Evaluation Committee to read.

GENERAL INFORMATION

1. Do you agree that if this proposal results in your company being awarded a contract and if there are inconsistencies between what was requested in the RFP and what is contained in the proposal and BAFO response that any controversy arising over such discrepancy will be resolved in favor of the language contained in the RFP, unless specifically modified by the contract? (Yes or No)

2. Do you agree to perform all of the services contained in this RFP? (Yes or No) If there are any exceptions to these requirements, please specify in Attachment 4, *Exceptions* as a separate section to your proposal. Failure to indicate that you will perform the services required in this RFP may result in your proposal being deemed incomplete. If NO, please list all exceptions in Attachment 4, *Exceptions*.

   Do you agree to all the terms and conditions in Section I of this RFP? (Yes or No) IF NO, LIST ALL EXCEPTIONS TO THIS RFP in Attachment 4, *Exceptions*.

PERFORMANCE OF SERVICES REQUESTED IN THIS RFP

1. Provide an overview of the project with the objective of demonstrating the OFFEROR's understanding of the RFP requirements. The section should contain a description of how the project will be carried out and why this approach was selected. Include anticipated problem areas, if any.

2. Provide point by point written confirmation for each of the tasks and deliverables listed in Section Two, Background and Scope of Work, as to how the OFFEROR's proposal meets the requirement.

3. Describe how the OFFEROR will perform the calculation of the actuarial present value of total projected benefits, ARC per Act 268, SLH 2013 as a dollar amount and percentage of covered payroll and funding impacts for the healthcare plan. For each step in the process, describe in detail any expected tasks to be performed by the EUTF and any documentation expected to be provided by the EUTF, in addition to the tasks and data currently described in this RFP.

4. Describe how the OFFEROR will perform the requirements of the GASB 75 valuation reports.

5. Provide a work plan and schedule that includes a detailed task-by-task work plan for the entire project. Ample time should be allotted for approval of each deliverable.

   a. Provide a chart developing the project schedule and milestones
   b. Provide provisions for handling potential or actual problems
   c. Include assumptions or constraints identified by the OFFEROR
   d. Include details and method to be used in managing, controlling, and reporting project activities

6. Include a description of the proposed work product resulting from completion of this study and submit a sample funding actuarial study and GASB 75 report as Exhibit A. This sample may be a copy of the OFFEROR's previous work product done for another client or it may be the OFFEROR's conceptual sample study.

EXPERIENCE OFFERING SERVICES AND REFERENCES INCLUDING PRIOR ENGAGEMENTS WITH THE EUTF AND THE STATE

1. Describe the OFFEROR's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the name, mailing address, and telephone number of the person the EUTF should contact regarding the proposal.

2. Provide a statement of whether there are any plans or there have been any mergers, acquisitions, or sales of the OFFEROR company within the last 10 years, and if so, an explanation providing relevant details.

3. Provide a statement of whether there is any pending litigation or anticipated litigation against the OFFEROR and, if such litigation exists, an attached opinion of counsel as to whether the pending or anticipated litigation will impair the OFFEROR's performance in a contract under this RFP.

4. Provide a statement of whether, in the last 10 years, the OFFEROR has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors and, if so, an explanation providing relevant details.

5. Provide a statement of whether there are any pending Securities Exchange Commission investigations involving the OFFEROR, and if such are pending or in progress, an explanation providing relevant details and an attached opinion of counsel as to whether the pending investigation(s) will impair the OFFEROR's performance in a contract under this RFP.

6. Provide a brief, descriptive statement indicating the OFFEROR's credentials to deliver the services sought under this RFP.

7. Briefly describe how long the OFFEROR has been performing the services required by this RFP and include the number of years in business.

8. Describe the OFFEROR organization's number of employees, client base, and location of offices.

9. Provide the proposed project team, its members, and organizational structure.

10. Provide a personnel roster and resumes of key people who shall be assigned by the OFFEROR to perform duties or services under the contract (the roster shall include the estimated number of hours to be worked on the contract for each person. The resumes shall detail each individual's title, education, current position with the OFFEROR, and employment history as well as an organizational chart highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrating the lines of authority and designate the individual responsible for the completion of each service component and deliverable of the RFP.

    Provide a summary presenting the number of years of experience the key people who shall be assigned have had in providing actuarial services concerning the funding of retirement benefits, the design and funding of health insurance benefits and/or the application of accounting standards to retirement or insurance plans each with at least 5,000 employee participants.

11. Provide a statement of whether the OFFEROR intends to use subcontractors and, if so, the names and mailing address of the subcontractors and a description of the scope and portions of the work the subcontractors will perform.

12. Provide 1) a list of current clients and 2) a list of three customer references. The three customer references must meet the following criteria:

    - Must have a minimum of 5,000 employees;
    - Must maintain an array of employee and retiree benefits (e.g., health insurance benefit options, term life insurance, other optional coverage); and
    - Services provided to the customer must be similar to the services required under this RFP.

    The reference list shall include:

    a. Fund Name;
    b. Contact Name(s);
    c. Address;
    d. Telephone Number(s); and
    e. Email Address(es)

13. Provide a list of former clients, including contact information, of those that did not renew contracts with the OFFEROR within the past five years. List must include reason for non-renewal.

14. Provide a copy of the most recently audited/reviewed financial statements. If financial statements are not audited/reviewed provide your most recent financial statements along with certification from the Chief Financial Officer or similar position of the completeness and accuracy of the financial statements.

PRICING

The OFFEROR shall propose a total price for the entire project. The price will include all costs associated with the project including all applicable taxes. See Attachment 2, Offer Form OF-2.

SECTION SEVEN

ATTACHMENTS AND EXHIBITS

- Attachment 1: OFFER FORM, OF-1
- Attachment 2: OFFER FORM, OF-2
- Attachment 3: CONFIDENTIAL INFORMATION
- Attachment 4: EXCEPTIONS
- Attachment 5: PERFORMANCE GUARANTEES

- Exhibit A: CONTRACT FORM AND GENERAL CONDITIONS
- Exhibit B: BUSINESS ASSOCIATE AGREEMENT
- Exhibit C: ACTIVE AND RETIREE HEALTH BENEFIT REFERENCE GUIDES
- Exhibit D: CHAPTER 87A, HRS
- Exhibit E: EUTF ADMINISTRATIVE RULES
- Exhibit F: EUTF OPEB ACTUARIAL VALUATION STUDIES JULY 1, 2023
- Exhibit G: ACT 268, SLH 2013
- Exhibit H: ACT 093, SLH 2017
- Exhibit I: ACTS 040 and 041, SLN 2023

ATTACHMENT 1 - OFFER FORM

OF-1

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

Procurement Officer
Department of Budget and Finance/EUTF
State of Hawaii
Honolulu, Hawaii 96813

Dear Procurement Officer:

The undersigned has carefully read and understands the terms and conditions specified in the Specifications and Special Provisions attached hereto, and in the General Conditions, by reference made a part hereof and available upon request; and hereby submits the following offer to perform the work specified herein, all in accordance with the true intent and meaning thereof. The undersigned further understands and agrees that by submitting this offer, 1) he/she is declaring his/her offer is not in violation of Chapter 84, Hawaii Revised Statutes, concerning prohibited State contracts, and 2) he/she is certifying that the price(s) submitted was (were) independently arrived at without collusion.

OFFEROR is:

☐ Sole Proprietor ☐ Partnership ☐ *Corporation ☐ Joint Venture
☐ Other _____
*State of incorporation: _____

Hawaii General Excise Tax License I.D. No. _____

Federal I.D. No. _____

Payment address (other than street address below): _____
City, State, Zip Code: _____

Business address (street address): _____
City, State, Zip Code: _____

Respectfully submitted:

Date: _____ _____
Authorized (Original) Signature

Telephone No.: _____

_____
Name and Title (Please Type or Print)

Fax No.: _____

E-mail Address: _____

** _____
Exact Legal Name of Company (OFFEROR)

**If the OFFEROR is a "dba" or a "division" of a corporation, furnish the exact legal name of the corporation under which the awarded contract will be executed:

_____

ATTACHMENT 2 - OFFER FORM

OF-2

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

Total contract cost for accomplishing the development and delivery of the services.

July 1, 2025 Report	$_____
July 1, 2026 Report	$_____
Total cost	$_____

Optional extension 1	
July 1, 2027 Report	$_____
July 1, 2028 Report	$_____
Optional extension 2	
July 1, 2029 Report	$_____
July 1, 2030 Report	$_____
Total cost	$_____

Hourly fee for providing "Additional Services" described in Section 2.2 E.

Contract ending March 31, 2027 $_____ per hour

Optional extensions:

Contract ending March 31, 2029 $_____ per hour
Contract ending March 31, 2031 $_____ per hour

Cost of additional meetings described in Section 2.2 A6. Include all expenses such as travel, hotel, etc.

Additional meeting (including expenses)$_____ per day

Travel Credit

If the OFFEROR is not required to present the results of the actuarial valuation in-person as described in Section 2.2 A6, OFFEROR will reduce their annual fee noted above in the amount of $_____ for that year. Presentations may still be required to be made virtually.

Note: **Pricing shall include labor, materials, supplies, all applicable taxes, and any other costs incurred to provide the specified services**.

OFFEROR _____
Name of Company

ATTACHMENT 3 – CONFIDENTIAL INFORMATION

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

List all information believed to be confidential and not to be disclosed to the public along with the basis for your belief. Identify the page numbers and sections in the proposal where the information is located.

Include one signed hard unbound copy which redacts any proprietary, confidential, and trade secret information in the form of marked out pages (blanked out) of the master proposal for submission to the public under any request compliant with the public information laws of the State.

ATTACHMENT 4 - EXCEPTIONS

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

Should the OFFEROR take any exception to the terms, conditions, specifications, or other requirements listed in the RFP, the OFFEROR shall list such exceptions in the space below. The OFFEROR shall reference the RFP section where exception is taken, a description of the exception taken, and the proposed alternative, if any. The State reserves the right to accept or reject any request for exceptions.

ATTACHMENT 5 – PERFORMANCE GUARANTEES

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

Performance Guarantees are not negotiable. Payments are calculated and paid yearly. Performance Guarantees are subject to audit by the EUTF.

Guarantee	**Penalty Dollars at Risk**	**Frequency**
Achieve a level 4 or higher (on a scale of 1 to 5) on Contractor service levels to the EUTF staff as rated by the EUTF staff selected by the Administrator on an annual basis. The EUTF to determine the evaluation criteria	$5,000 per year	Annual
Provide the actuarial valuation report and GASB 75 report within time periods determined by EUTF staff	$10,000 per year	Annual

EXHIBIT A

CONTRACT FORM AND GENERAL CONDITIONS

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)

STATE OF HAWAII
CONTRACT FOR GOODS AND SERVICES
BASED UPON
COMPETITIVE SEALED PROPOSALS

This Contract, executed on the respective dates indicated below, is effective as of _____, _____, between Hawaii Employer-Union Health Benefits Trust Fund, *(Insert name of state department, agency, board or commission)* State of Hawaii ("STATE"), by its Administrator, *(Insert title of person signing for State)* (hereafter also referred to as the HEAD OF THE PURCHASING AGENCY or designee ("HOPA")), whose address is 201 Merchant Street, Suite 1700, Honolulu, Hawaii 96813 _____ and _____ ("CONTRACTOR"), a _____ *(Insert corporation, partnership, joint venture, sole proprietorship. or other legal form of the Contractor)* under the laws of the State of _____, whose business address and federal taxpayer identification numbers are as follows: _____

RECITALS

A. The STATE desires to retain and engage the CONTRACTOR to provide the Goods or services, or both, described in this Contract and its attachments, and the CONTRACTOR is Agreeable to providing said goods or services or both.

B. The STATE has issued a request for competitive sealed proposals, and has received and reviewed proposals submitted in response to the request.

C. The solicitation for proposals and selection of the CONTRACTOR were made in accordance with section 103D-303, Hawaii Revised Statutes ("HRS"), Hawaii Administrative Rules, Title 3, Department of Accounting and General Services, Subtitle 11 ("HAR"), Chapter 122, Subchapter 6, and applicable procedures established by the applicable Chief Procurement Officer ("CPO").

D. The CONTRACTOR has been identified as the responsible and responsive offeror whose proposal is the most advantageous for the STATE, taking into consideration price and the evaluation factors set forth in the request.

E. Pursuant to Section 87A-24(7), HRS, the STATE *(Legal authority to enter into this Contract)* is authorized to enter into this Contract.

F. Money is available to fund this Contract pursuant to:

(1) Section 87A-24(7), HRS *(Identify state sources)*

or (2) ---- *(Identify federal sources)*

or both, in the following amounts: State $ _____

Federal $ ----

NOW, THEREFORE, in consideration of the promises contained in this Contract, the STATE and the CONTRACTOR agree as follows:

1. Scope of Services. The CONTRACTOR shall, in a proper and satisfactory manner as determined by the STATE, provide all the goods or services, or both, set forth in the request for competitive sealed proposals number RFP No._____ ("RFP") and the CONTRACTOR's accepted proposal ("Proposal"), both of which, even if not physically attached to this Contract, are made a part of this Contract..

2. Compensation. The CONTRACTOR shall be compensated for goods supplied or services performed, or both, under this Contract in a total amount not to exceed

_____ ($ _____), including approved costs incurred and taxes, at the time and in the manner set forth in the RFP and CONTRACTOR's Proposal.

3. Time of Performance. The services or goods required of the CONTRACTOR under this Contract shall be performed and completed in accordance with the Time of Performance set forth in Attachment-S3, which is made a part of this Contract.

4. Bonds. The CONTRACTOR ☐ is required to provide or ☒ is not required to provide: ☐ a performance bond, ☐ a payment bond, ☐ a performance and payment bond in the amount of N/A DOLLARS ($ _____).

5. Standards of Conduct Declaration. The Standards of Conduct Declaration of the CONTRACTOR is attached to and made a part of this Contract.

6. Other Terms and Conditions. The General Conditions and any Special Conditions are attached to and made a part of this Contract. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control. In the event of a conflict among the documents, the order of precedence shall be as follows: (1) this Contract, including all attachments and addenda; (2) the RFP, including all attachments and addenda; and (3) the Proposal.

7. Liquidated Damages. Liquidated damages shall be assessed in the amount of _____ DOLLARS ($ _____) per day, in accordance with the terms of paragraph 9 of the General Conditions.

8. Notices. Any written notice required to be given by any party to this Contract shall be (a) delivered personally, or (b) sent by United States first class mail, postage prepaid. Notice to the STATE shall be sent to the HOPA's address indicated in the Contract. Notice to the CONTRACTOR shall be sent to the CONTRACTOR's address indicated in the Contract. A notice shall be deemed to have been received three (3) days after mailing or at the time of actual receipt, whichever is earlier. The CONTRACTOR is responsible for notifying the STATE in writing of any change of address.

IN VIEW OF THE ABOVE, the parties execute this Contract by their signatures, on the dates below, to be effective as of the date first above written.

STATE

_____
(Signature)

Derek M. Mizuno
(Print Name)

Administrator
(Print Title)

_____
(Date)

CONTRACTOR

CORPORATE SEAL
(If available)

_____
(Name of Contractor)

_____
(Signature)

_____
(Print Name)

_____ *
(Print Title)

_____
(Date)

APPROVED AS TO FORM:

_____
Deputy Attorney General

*Evidence of authority of the CONTRACTOR'S representative to sign this Contract for the CONTRACTOR must be attached.

STATE OF HAWAII

CONTRACTOR'S STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

"Agency" means and includes the State, the legislature and its committees, all executive departments, boards, commissions, committees, bureaus, offices; and all independent commissions and other establishments of the state government but excluding the courts.

"Controlling interest" means an interest in a business or other undertaking which is sufficient in fact to control, whether the interest is greater or less than fifty per cent (50%).

"Employee" means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and employees under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and judges. (Section 84-3, HRS).

On behalf of _____, CONTRACTOR, the undersigned does declare as follows:

1. CONTRACTOR ☐ is* ☒ is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).
2. CONTRACTOR has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).
3. CONTRACTOR has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).
4. CONTRACTOR has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

CONTRACTOR understands that the Contract to which this document is attached is voidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawaii Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the declarations above. Additionally, any fee, compensation, gift, or profit received by any person as a result of a violation of the Code of Ethics may be recovered by the STATE.

CONTRACTOR

By _____
(Signature)

Print Name _____

Print Title _____

Name of Contractor _____

Date _____

* Reminder to Agency: If the "is" block is checked and if the Contract involves goods or services of a value in excess of $10,000, the Contract must be awarded by competitive sealed bidding under section 103D-302, HRS, or a competitive sealed proposal under section 103D-303, HRS. Otherwise, the Agency may not award the Contract unless it posts a notice of its intent to award it and files a copy of the notice with the State Ethics Commission. (Section 84-15(a), HRS).

Attachment - S1

STATE OF HAWAII

SCOPE OF SERVICES

Attachment - S2

STATE OF HAWAII

COMPENSATION AND PAYMENT SCHEDULE

Attachment – S3

STATE OF HAWAII

TIME OF PERFORMANCE

STATE OF HAWAII

CERTIFICATE OF EXEMPTION FROM CIVIL SERVICE

1. By Heads of Departments Delegated by the Director of the Department of Human Resources Development ("DHRD").*

Pursuant to a delegation of the authority by the Director of DHRD, I certify that the services to be provided under this Contract, and the person(s) providing the services under this Contract are exempt from the civil service, pursuant to § 76-16, Hawaii Revised Statutes (HRS).

(Signature) (Date)

Derek M. Mizuno
(Print Name)

Administrator
(Print Title)

* This part of the form may be used by all department heads and the heads of attached agencies to whom the Director of DHRD expressly has delegated authority to certify § 76-16, HRS, civil service exemptions. The specific paragraph(s) of § 76-16, HRS, upon which an exemption is based should be noted in the contract file. If an exemption is based on § 76-16(b)(15), the contract must meet the following conditions:

(1) It involves the delivery of completed work or product by or during a specific time;
(2) There is no employee-employer relationship; and
(3) The authorized funding for the service is from other than the "A" or personal services cost element.

NOTE: Not all attached agencies have received a delegation under § 76-16(b)(15). If in doubt, attached agencies should check with the Director of DHRD prior to certifying an exemption under § 76-16(b)(15). Authority to certify exemptions under §§76-16(b)(2), and 76-16(b)(12), HRS, has not been delegated; only the Director of DHRD may certify §§ 76-16(b)(2),and 76-16(b)(12) exemptions.

2. By the Director of DHRD, State of Hawaii.

I certify that the services to be provided under this Contract, and the person(s) providing the services under this Contract are exempt from the civil service, pursuant to §76-16, HRS.

(Signature) (Date)

(Print Name)

(Print Title, if designee of the Director of DHRD)

STATE OF HAWAII

SPECIAL CONDITIONS

GENERAL CONDITIONS

Table of Contents

GENERAL CONDITIONS

1. Coordination of Services by the STATE. The head of the purchasing agency ("HOPA") (which term includes the designee of the HOPA) shall coordinate the services to be provided by the CONTRACTOR in order to complete the performance required in the Contract. The CONTRACTOR shall maintain communications with HOPA at all stages of the CONTRACTOR'S work, and submit to HOPA for resolution any questions which may arise as to the performance of this Contract. "Purchasing agency" as used in these General Conditions means and includes any governmental body which is authorized under chapter 103D, HRS, or its implementing rules and procedures, or by way of delegation, to enter into contracts for the procurement of goods or services or both.

2. Relationship of Parties: Independent Contractor Status and Responsibilities, Including Tax Responsibilities.

   a. In the performance of services required under this Contract, the CONTRACTOR is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE'S opinion, the services are being performed by the CONTRACTOR in compliance with this Contract. Unless otherwise provided by special condition, it is understood that the STATE does not agree to use the CONTRACTOR exclusively, and that the CONTRACTOR is free to contract to provide services to other individuals or entities while under contract with the STATE.

   b. The CONTRACTOR and the CONTRACTOR'S employees and agents are not by reason of this Contract, agents or employees of the State for any purpose, and the CONTRACTOR and the CONTRACTOR'S employees and agents shall not be entitled to claim or receive from the State any vacation, sick leave, retirement, workers' compensation, unemployment insurance, or other benefits provided to state employees.

   c. The CONTRACTOR shall be responsible for the accuracy, completeness, and adequacy of the CONTRACTOR'S performance under this Contract. Furthermore, the CONTRACTOR intentionally, voluntarily, and knowingly assumes the sole and entire liability to the CONTRACTOR'S employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the CONTRACTOR, or the CONTRACTOR'S employees or agents in the course of their employment.

   d. The CONTRACTOR shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the CONTRACTOR by reason of this Contract, including but not limited to (i) income taxes, (ii) employment related fees, assessments, and taxes, and (iii) general excise taxes. The CONTRACTOR also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.

   e. The CONTRACTOR shall obtain a general excise tax license from the Department of Taxation, State of Hawaii, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The CONTRACTOR shall obtain a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of the Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The CONTRACTOR shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under sections 103-53 and 103D-328, HRS, and paragraph 17 of these General Conditions.

   f. The CONTRACTOR is responsible for securing all employee-related insurance coverage for the CONTRACTOR and the CONTRACTOR'S employees and agents that is or may be required by law, and for payment of all premiums, costs, and other liabilities associated with securing the insurance coverage.

g. The CONTRACTOR shall obtain a certificate of compliance issued by the Department of Labor and Industrial Relations, State of Hawaii, in accordance with section103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

h. The CONTRACTOR shall obtain a certificate of good standing issued by the Department of Commerce and Consumer Affairs, State of Hawaii, in accordance with section 103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

i. In lieu of the above certificates from the Department of Taxation, Labor and Industrial Relations, and Commerce and Consumer Affairs, the CONTRACTOR may submit proof of compliance through the State Procurement Office's designated certification process.

3. Personnel Requirements.

a. The CONTRACTOR shall secure, at the CONTRACTOR'S own expense, all personnel required to perform this Contract.

b. The CONTRACTOR shall ensure that the CONTRACTOR'S employees or agents are experienced and fully qualified to engage in the activities and perform the services required under this Contract, and that all applicable licensing and operating requirements imposed or required under federal, state, or county law, and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

4. Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the CONTRACTOR, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

5. Conflicts of Interest. The CONTRACTOR represents that neither the CONTRACTOR, nor any employee or agent of the CONTRACTOR, presently has any interest, and promises that no such interest, direct or indirect, shall be acquired, that would or might conflict in any manner or degree with the CONTRACTOR'S performance under this Contract.

6. Subcontracts and Assignments. The CONTRACTOR shall not assign or subcontract any of the CONTRACTOR'S duties, obligations, or interests under this Contract and no such assignment or subcontract shall be effective unless (i) the CONTRACTOR obtains the prior written consent of the STATE, and (ii) the CONTRACTOR'S assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR'S assignee or subcontractor have been paid. Additionally, no assignment by the CONTRACTOR of the CONTRACTOR'S right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in section 40-58, HRS.

a. Recognition of a successor in interest. When in the best interest of the State, a successor in interest may be recognized in an assignment contract in which the STATE, the CONTRACTOR and the assignee or transferee (hereinafter referred to as the "Assignee") agree that:

(1) The Assignee assumes all of the CONTRACTOR'S obligations;

(2) The CONTRACTOR remains liable for all obligations under this Contract but waives all rights under this Contract as against the STATE; and

(3) The CONTRACTOR shall continue to furnish, and the Assignee shall also furnish, all required bonds.

b. Change of name. When the CONTRACTOR asks to change the name in which it holds this Contract with the STATE, the procurement officer of the purchasing agency (hereinafter referred to as the "Agency procurement officer") shall, upon receipt of a document acceptable or satisfactory to the

Agency procurement officer indicating such change of name (for example, an amendment to the CONTRACTOR'S articles of incorporation), enter into an amendment to this Contract with the CONTRACTOR to effect such a change of name. The amendment to this Contract changing the CONTRACTOR'S name shall specifically indicate that no other terms and conditions of this Contract are thereby changed.

c. Reports. All assignment contracts and amendments to this Contract effecting changes of the CONTRACTOR'S name or novations hereunder shall be reported to the chief procurement officer (CPO) as defined in section 103D-203(a), HRS, within thirty days of the date that the assignment contract or amendment becomes effective.

d. Actions affecting more than one purchasing agency. Notwithstanding the provisions of subparagraphs 6a through 6c herein, when the CONTRACTOR holds contracts with more than one purchasing agency of the State, the assignment contracts and the novation and change of name amendments herein authorized shall be processed only through the CPO's office.

7. Indemnification and Defense. The CONTRACTOR shall defend, indemnify, and hold harmless the State of Hawaii, the contracting agency, and their officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys' fees, and all claims, suits, and demands therefore, arising out of or resulting from the acts or omissions of the CONTRACTOR or the CONTRACTOR'S employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.

8. Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the CONTRACTOR in connection with this Contract, the CONTRACTOR shall pay all costs and expenses incurred by or imposed on the STATE, including attorneys' fees.

9. Liquidated Damages. When the CONTRACTOR is given notice of delay or nonperformance as specified in paragraph 13 (Termination for Default) and fails to cure in the time specified, it is agreed the CONTRACTOR shall pay to the STATE the amount, if any, set forth in this Contract per calendar day from the date set for cure until either (i) the STATE reasonably obtains similar goods or services, or both, if the CONTRACTOR is terminated for default, or (ii) until the CONTRACTOR provides the goods or services, or both, if the CONTRACTOR is not terminated for default. To the extent that the CONTRACTOR'S delay or nonperformance is excused under paragraph 13d (Excuse for Nonperformance or Delay Performance), liquidated damages shall not be assessable against the CONTRACTOR. The CONTRACTOR remains liable for damages caused other than by delay.

10. STATE'S Right of Offset. The STATE may offset against any monies or other obligations the STATE owes to the CONTRACTOR under this Contract, any amounts owed to the State of Hawaii by the CONTRACTOR under this Contract or any other contracts, or pursuant to any law or other obligation owed to the State of Hawaii by the CONTRACTOR, including, without limitation, the payment of any taxes or levies of any kind or nature. The STATE will notify the CONTRACTOR in writing of any offset and the nature of such offset. For purposes of this paragraph, amounts owed to the State of Hawaii shall not include debts or obligations which have been liquidated, agreed to by the CONTRACTOR, and are covered by an installment payment or other settlement plan approved by the State of Hawaii, provided, however, that the CONTRACTOR shall be entitled to such exclusion only to the extent that the CONTRACTOR is current with, and not delinquent on, any payments or obligations owed to the State of Hawaii under such payment or other settlement plan.

11. Disputes. Disputes shall be resolved in accordance with section 103D-703, HRS, and chapter 3-126, Hawaii Administrative Rules ("HAR"), as the same may be amended from time to time.

12. Suspension of Contract. The STATE reserves the right at any time and for any reason to suspend this Contract for any reasonable period, upon written notice to the CONTRACTOR in accordance with the provisions herein.

a. Order to stop performance. The Agency procurement officer may, by written order to the CONTRACTOR, at any time, and without notice to any surety, require the CONTRACTOR to stop all or any part of the performance called for by this Contract. This order shall be for a specified

period not exceeding sixty (60) days after the order is delivered to the CONTRACTOR, unless the parties agree to any further period. Any such order shall be identified specifically as a stop performance order issued pursuant to this section. Stop performance orders shall include, as appropriate: (1) A clear description of the work to be suspended; (2) Instructions as to the issuance of further orders by the CONTRACTOR for material or services; (3) Guidance as to action to be taken on subcontracts; and (4) Other instructions and suggestions to the CONTRACTOR for minimizing costs. Upon receipt of such an order, the CONTRACTOR shall forthwith comply with its terms and suspend all performance under this Contract at the time stated, provided, however, the CONTRACTOR shall take all reasonable steps to minimize the occurrence of costs allocable to the performance covered by the order during the period of performance stoppage. Before the stop performance order expires, or within any further period to which the parties shall have agreed, the Agency procurement officer shall either:

(1) Cancel the stop performance order; or

(2) Terminate the performance covered by such order as provided in the termination for default provision or the termination for convenience provision of this Contract.

b. Cancellation or expiration of the order. If a stop performance order issued under this section is cancelled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the CONTRACTOR shall have the right to resume performance. An appropriate adjustment shall be made in the delivery schedule or contract price, or both, and the Contract shall be modified in writing accordingly, if:

(1) The stop performance order results in an increase in the time required for, or in the CONTRACTOR'S cost properly allocable to, the performance of any part of this Contract; and

(2) The CONTRACTOR asserts a claim for such an adjustment within thirty (30) days after the end of the period of performance stoppage; provided that, if the Agency procurement officer decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.

c. Termination of stopped performance. If a stop performance order is not cancelled and the performance covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop performance order shall be allowable by adjustment or otherwise.

d. Adjustment of price. Any adjustment in contract price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

13. Termination for Default.

a. Default. If the CONTRACTOR refuses or fails to perform any of the provisions of this Contract with such diligence as will ensure its completion within the time specified in this Contract, or any extension thereof, otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of this Contract, the Agency procurement officer may notify the CONTRACTOR in writing of the delay or non-performance and if not cured in ten (10) days or any longer time specified in writing by the Agency procurement officer, such officer may terminate the CONTRACTOR'S right to proceed with the Contract or such part of the Contract as to which there has been delay or a failure to properly perform. In the event of termination in whole or in part, the Agency procurement officer may procure similar goods or services in a manner and upon the terms deemed appropriate by the Agency procurement officer. The CONTRACTOR shall continue performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

b. CONTRACTOR'S duties. Notwithstanding termination of the Contract and subject to any directions from the Agency procurement officer, the CONTRACTOR shall take timely, reasonable, and

necessary action to protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest.

c. Compensation. Payment for completed goods and services delivered and accepted by the STATE shall be at the price set forth in the Contract. Payment for the protection and preservation of property shall be in an amount agreed upon by the CONTRACTOR and the Agency procurement officer. If the parties fail to agree, the Agency procurement officer shall set an amount subject to the CONTRACTOR'S rights under chapter 3-126, HAR. The STATE may withhold from amounts due the CONTRACTOR such sums as the Agency procurement officer deems to be necessary to protect the STATE against loss because of outstanding liens or claims and to reimburse the STATE for the excess costs expected to be incurred by the STATE in procuring similar goods and services.

d. Excuse for nonperformance or delayed performance. The CONTRACTOR shall not be in default by reason of any failure in performance of this Contract in accordance with its terms, including any failure by the CONTRACTOR to make progress in the prosecution of the performance hereunder which endangers such performance, if the CONTRACTOR has notified the Agency procurement officer within fifteen (15) days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of a public enemy; acts of the State and any other governmental body in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, the CONTRACTOR shall not be deemed to be in default, unless the goods and services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the CONTRACTOR to meet the requirements of the Contract. Upon request of the CONTRACTOR, the Agency procurement officer shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the CONTRACTOR'S progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the STATE under this Contract. As used in this paragraph, the term "subcontractor" means subcontractor at any tier.

e. Erroneous termination for default. If, after notice of termination of the CONTRACTOR'S right to proceed under this paragraph, it is determined for any reason that the CONTRACTOR was not in default under this paragraph, or that the delay was excusable under the provisions of subparagraph 13d, "Excuse for nonperformance or delayed performance," the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to paragraph 14.

f. Additional rights and remedies. The rights and remedies provided in this paragraph are in addition to any other rights and remedies provided by law or under this Contract.

14. Termination for Convenience.

a. Termination. The Agency procurement officer may, when the interests of the STATE so require, terminate this Contract in whole or in part, for the convenience of the STATE. The Agency procurement officer shall give written notice of the termination to the CONTRACTOR specifying the part of the Contract terminated and when termination becomes effective.

b. CONTRACTOR'S obligations. The CONTRACTOR shall incur no further obligations in connection with the terminated performance and on the date(s) set in the notice of termination the CONTRACTOR will stop performance to the extent specified. The CONTRACTOR shall also terminate outstanding orders and subcontracts as they relate to the terminated performance. The CONTRACTOR shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated performance subject to the STATE'S approval. The Agency procurement officer may direct the CONTRACTOR to assign the CONTRACTOR'S right, title, and interest under terminated orders or subcontracts to the STATE. The CONTRACTOR must still complete the performance not terminated by the notice of termination and may incur obligations as necessary to do so.

c. Right to goods and work product. The Agency procurement officer may require the CONTRACTOR to transfer title and deliver to the STATE in the manner and to the extent directed by the Agency procurement officer:

(1) Any completed goods or work product; and

(2) The partially completed goods and materials, parts, tools, dies, jigs, fixtures, plans, drawings, information, and contract rights (hereinafter called "manufacturing material") as the CONTRACTOR has specifically produced or specially acquired for the performance of the terminated part of this Contract.

The CONTRACTOR shall, upon direction of the Agency procurement officer, protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest. If the Agency procurement officer does not exercise this right, the CONTRACTOR shall use best efforts to sell such goods and manufacturing materials. Use of this paragraph in no way implies that the STATE has breached the Contract by exercise of the termination for convenience provision.

d. Compensation.

(1) The CONTRACTOR shall submit a termination claim specifying the amounts due because of the termination for convenience together with the cost or pricing data, submitted to the extent required by chapter 3-122, HAR, bearing on such claim. If the CONTRACTOR fails to file a termination claim within one year from the effective date of termination, the Agency procurement officer may pay the CONTRACTOR, if at all, an amount set in accordance with subparagraph 14d(3) below.

(2) The Agency procurement officer and the CONTRACTOR may agree to a settlement provided the CONTRACTOR has filed a termination claim supported by cost or pricing data submitted as required and that the settlement does not exceed the total Contract price plus settlement costs reduced by payments previously made by the STATE, the proceeds of any sales of goods and manufacturing materials under subparagraph 14c, and the Contract price of the performance not terminated.

(3) Absent complete agreement under subparagraph 14d(2) the Agency procurement officer shall pay the CONTRACTOR the following amounts, provided payments agreed to under subparagraph 14d(2) shall not duplicate payments under this subparagraph for the following:

(A) Contract prices for goods or services accepted under the Contract;

(B) Costs incurred in preparing to perform and performing the terminated portion of the performance plus a fair and reasonable profit on such portion of the performance, such profit shall not include anticipatory profit or consequential damages, less amounts paid or to be paid for accepted goods or services; provided, however, that if it appears that the CONTRACTOR would have sustained a loss if the entire Contract would have been completed, no profit shall be allowed or included and the amount of compensation shall be reduced to reflect the anticipated rate of loss;

(C) Costs of settling and paying claims arising out of the termination of subcontracts or orders pursuant to subparagraph 14b. These costs must not include costs paid in accordance with subparagraph 14d(3)(B);

(D) The reasonable settlement costs of the CONTRACTOR, including accounting, legal, clerical, and other expenses reasonably necessary for the preparation of settlement claims and supporting data with respect to the terminated portion of the Contract and for the termination of subcontracts thereunder, together with reasonable storage, transportation, and other costs incurred in connection with the protection or disposition of property allocable to the terminated portion of this Contract. The total sum to be paid the CONTRACTOR under this subparagraph shall not exceed the

total Contract price plus the reasonable settlement costs of the CONTRACTOR reduced by the amount of payments otherwise made, the proceeds of any sales of supplies and manufacturing materials under subparagraph 14d(2), and the contract price of performance not terminated.

(4) Costs claimed, agreed to, or established under subparagraphs 14d(2) and 14d(3) shall be in accordance with Chapter 3-123 (Cost Principles) of the Procurement Rules.

15. Claims Based on the Agency Procurement Officer's Actions or Omissions.

a. Changes in scope. If any action or omission on the part of the Agency procurement officer (which term includes the designee of such officer for purposes of this paragraph 15) requiring performance changes within the scope of the Contract constitutes the basis for a claim by the CONTRACTOR for additional compensation, damages, or an extension of time for completion, the CONTRACTOR shall continue with performance of the Contract in compliance with the directions or orders of such officials, but by so doing, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, damages, or an extension of time for completion; provided:

(1) Written notice required. The CONTRACTOR shall give written notice to the Agency procurement officer:

(A) Prior to the commencement of the performance involved, if at that time the CONTRACTOR knows of the occurrence of such action or omission;

(B) Within thirty (30) days after the CONTRACTOR knows of the occurrence of such action or omission, if the CONTRACTOR did not have such knowledge prior to the commencement of the performance; or

(C) Within such further time as may be allowed by the Agency procurement officer in writing.

(2) Notice content. This notice shall state that the CONTRACTOR regards the act or omission as a reason which may entitle the CONTRACTOR to additional compensation, damages, or an extension of time. The Agency procurement officer, upon receipt of such notice, may rescind such action, remedy such omission, or take such other steps as may be deemed advisable in the discretion of the Agency procurement officer;

(3) Basis must be explained. The notice required by subparagraph 15a(1) describes as clearly as practicable at the time the reasons why the CONTRACTOR believes that additional compensation, damages, or an extension of time may be remedies to which the CONTRACTOR is entitled; and

(4) Claim must be justified. The CONTRACTOR must maintain and, upon request, make available to the Agency procurement officer within a reasonable time, detailed records to the extent practicable, and other documentation and evidence satisfactory to the STATE, justifying the claimed additional costs or an extension of time in connection with such changes.

b. CONTRACTOR not excused. Nothing herein contained, however, shall excuse the CONTRACTOR from compliance with any rules or laws precluding any state officers and CONTRACTOR from acting in collusion or bad faith in issuing or performing change orders which are clearly not within the scope of the Contract.

c. Price adjustment. Any adjustment in the price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

16. Costs and Expenses. Any reimbursement due the CONTRACTOR for per diem and transportation expenses under this Contract shall be subject to chapter 3-123 (Cost Principles), HAR, and the following guidelines:

a. Reimbursement for air transportation shall be for actual cost or coach class air fare, whichever is less.

b. Reimbursement for ground transportation costs shall not exceed the actual cost of renting an intermediate-sized vehicle.

c. Unless prior written approval of the HOPA is obtained, reimbursement for subsistence allowance (i.e., hotel and meals, etc.) shall not exceed the applicable daily authorized rates for inter-island or out-of-state travel that are set forth in the current Governor's Executive Order authorizing adjustments in salaries and benefits for state officers and employees in the executive branch who are excluded from collective bargaining coverage.

17. Payment Procedures; Final Payment; Tax Clearance.

a. Original invoices required. All payments under this Contract shall be made only upon submission by the CONTRACTOR of original invoices specifying the amount due and certifying that services requested under the Contract have been performed by the CONTRACTOR according to the Contract.

b. Subject to available funds. Such payments are subject to availability of funds and allotment by the Director of Finance in accordance with chapter 37, HRS. Further, all payments shall be made in accordance with and subject to chapter 40, HRS.

c. Prompt payment.

(1) Any money, other than retainage, paid to the CONTRACTOR shall be disbursed to subcontractors within ten (10) days after receipt of the money in accordance with the terms of the subcontract; provided that the subcontractor has met all the terms and conditions of the subcontract and there are no bona fide disputes; and

(2) Upon final payment to the CONTRACTOR, full payment to the subcontractor, including retainage, shall be made within ten (10) days after receipt of the money; provided that there are no bona fide disputes over the subcontractor's performance under the subcontract.

d. Final payment. Final payment under this Contract shall be subject to sections 103-53 and 103D-328, HRS, which require a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid. Further, in accordance with section 3-122-112, HAR, CONTRACTOR shall provide a certificate affirming that the CONTRACTOR has remained in compliance with all applicable laws as required by this section.

18. Federal Funds. If this Contract is payable in whole or in part from federal funds, CONTRACTOR agrees that, as to the portion of the compensation under this Contract to be payable from federal funds, the CONTRACTOR shall be paid only from such funds received from the federal government, and shall not be paid from any other funds. Failure of the STATE to receive anticipated federal funds shall not be considered a breach by the STATE or an excuse for nonperformance by the CONTRACTOR.

19. Modifications of Contract.

a. In writing. Any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract permitted by this Contract shall be made by written amendment to this Contract, signed by the CONTRACTOR and the STATE, provided that change orders shall be made in accordance with paragraph 20 herein.

b. No oral modification. No oral modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract shall be permitted.

c. Agency procurement officer. By written order, at any time, and without notice to any surety, the Agency procurement officer may unilaterally order of the CONTRACTOR:

(A) Changes in the work within the scope of the Contract; and

(B) Changes in the time of performance of the Contract that do not alter the scope of the Contract work.

d. Adjustments of price or time for performance. If any modification increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, an adjustment shall be made and this Contract modified in writing accordingly. Any adjustment in contract price made pursuant to this clause shall be determined, where applicable, in accordance with the price adjustment clause of this Contract or as negotiated.

e. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if written modification of the Contract is not made prior to final payment under this Contract.

f. Claims not barred. In the absence of a written contract modification, nothing in this clause shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under this Contract or for a breach of contract.

g. Head of the purchasing agency approval. If this is a professional services contract awarded pursuant to section 103D-303 or 103D-304, HRS, any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract which increases the amount payable to the CONTRACTOR by at least $25,000.00 and ten per cent (10%) or more of the initial contract price, must receive the prior approval of the head of the purchasing agency.

h. Tax clearance. The STATE may, at its discretion, require the CONTRACTOR to submit to the STATE, prior to the STATE'S approval of any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract, a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid.

i. Sole source contracts. Amendments to sole source contracts that would change the original scope of the Contract may only be made with the approval of the CPO. Annual renewal of a sole source contract for services should not be submitted as an amendment.

20. Change Order. The Agency procurement officer may, by a written order signed only by the STATE, at any time, and without notice to any surety, and subject to all appropriate adjustments, make changes within the general scope of this Contract in any one or more of the following:

(1) Drawings, designs, or specifications, if the goods or services to be furnished are to be specially provided to the STATE in accordance therewith;

(2) Method of delivery; or

(3) Place of delivery.

a. Adjustments of price or time for performance. If any change order increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, whether or not changed by the order, an adjustment shall be made and the Contract modified in writing accordingly. Any adjustment in the Contract price made pursuant to this provision shall be determined in accordance with the price adjustment provision of this Contract. Failure of the parties to agree to an adjustment shall not excuse the CONTRACTOR from proceeding with the Contract as changed, provided that the Agency procurement officer promptly and duly makes the provisional adjustments in payment or time for performance as may be reasonable. By

proceeding with the work, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, or any extension of time for completion.

b. Time period for claim. Within ten (10) days after receipt of a written change order under subparagraph 20a, unless the period is extended by the Agency procurement officer in writing, the CONTRACTOR shall respond with a claim for an adjustment. The requirement for a timely written response by CONTRACTOR cannot be waived and shall be a condition precedent to the assertion of a claim.

c. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if a written response is not given prior to final payment under this Contract.

d. Other claims not barred. In the absence of a change order, nothing in this paragraph 20 shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under the Contract or for breach of contract.

21. Price Adjustment.

a. Price adjustment. Any adjustment in the contract price pursuant to a provision in this Contract shall be made in one or more of the following ways:

(1) By agreement on a fixed price adjustment before commencement of the pertinent performance or as soon thereafter as practicable;

(2) By unit prices specified in the Contract or subsequently agreed upon;

(3) By the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as specified in the Contract or subsequently agreed upon;

(4) In such other manner as the parties may mutually agree; or

(5) In the absence of agreement between the parties, by a unilateral determination by the Agency procurement officer of the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as computed by the Agency procurement officer in accordance with generally accepted accounting principles and applicable sections of chapters 3-123 and 3-126, HAR.

b. Submission of cost or pricing data. The CONTRACTOR shall provide cost or pricing data for any price adjustments subject to the provisions of chapter 3-122, HAR.

22. Variation in Quantity for Definite Quantity Contracts. Upon the agreement of the STATE and the CONTRACTOR, the quantity of goods or services, or both, if a definite quantity is specified in this Contract, may be increased by a maximum of ten per cent (10%); provided the unit prices will remain the same except for any price adjustments otherwise applicable; and the Agency procurement officer makes a written determination that such an increase will either be more economical than awarding another contract or that it would not be practical to award another contract.

23. Changes in Cost-Reimbursement Contract. If this Contract is a cost-reimbursement contract, the following provisions shall apply:

a. The Agency procurement officer may at any time by written order, and without notice to the sureties, if any, make changes within the general scope of the Contract in any one or more of the following:

(1) Description of performance (Attachment 1);

(2) Time of performance (i.e., hours of the day, days of the week, etc.);

(3) Place of performance of services;

(4) Drawings, designs, or specifications when the supplies to be furnished are to be specially manufactured for the STATE in accordance with the drawings, designs, or specifications;

(5) Method of shipment or packing of supplies; or

(6) Place of delivery.

b. If any change causes an increase or decrease in the estimated cost of, or the time required for performance of, any part of the performance under this Contract, whether or not changed by the order, or otherwise affects any other terms and conditions of this Contract, the Agency procurement officer shall make an equitable adjustment in the (1) estimated cost, delivery or completion schedule, or both; (2) amount of any fixed fee; and (3) other affected terms and shall modify the Contract accordingly.

c. The CONTRACTOR must assert the CONTRACTOR'S rights to an adjustment under this provision within thirty (30) days from the day of receipt of the written order. However, if the Agency procurement officer decides that the facts justify it, the Agency procurement officer may receive and act upon a proposal submitted before final payment under the Contract.

d. Failure to agree to any adjustment shall be a dispute under paragraph 11 of this Contract. However, nothing in this provision shall excuse the CONTRACTOR from proceeding with the Contract as changed.

e. Notwithstanding the terms and conditions of subparagraphs 23a and 23b, the estimated cost of this Contract and, if this Contract is incrementally funded, the funds allotted for the performance of this Contract, shall not be increased or considered to be increased except by specific written modification of the Contract indicating the new contract estimated cost and, if this contract is incrementally funded, the new amount allotted to the contract.

24. Confidentiality of Material.

a. All material given to or made available to the CONTRACTOR by virtue of this Contract, which is identified as proprietary or confidential information, will be safeguarded by the CONTRACTOR and shall not be disclosed to any individual or organization without the prior written approval of the STATE.

b. All information, data, or other material provided by the CONTRACTOR to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS.

25. Publicity. The CONTRACTOR shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, including the HOPA, the CPO, the Agency procurement officer, or to the services or goods, or both, provided under this Contract, in any of the CONTRACTOR'S brochures, advertisements, or other publicity of the CONTRACTOR. All media contacts with the CONTRACTOR about the subject matter of this Contract shall be referred to the Agency procurement officer.

26. Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished, which is developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract, and all such material shall be considered "works made for hire." All such material shall be delivered to the STATE upon expiration or termination of this Contract. The STATE, in its sole discretion, shall have the exclusive right to copyright any product, concept, or material developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract.

27. Liens and Warranties. Goods provided under this Contract shall be provided free of all liens and provided together with all applicable warranties, or with the warranties described in the Contract documents, whichever are greater.

28. Audit of Books and Records of the CONTRACTOR. The STATE may, at reasonable times and places, audit the books and records of the CONTRACTOR, prospective contractor, subcontractor, or prospective subcontractor which are related to:

    a. The cost or pricing data, and

    b. A state contract, including subcontracts, other than a firm fixed-price contract.

29. Cost or Pricing Data. Cost or pricing data must be submitted to the Agency procurement officer and timely certified as accurate for contracts over $100,000 unless the contract is for a multiple-term or as otherwise specified by the Agency procurement officer. Unless otherwise required by the Agency procurement officer, cost or pricing data submission is not required for contracts awarded pursuant to competitive sealed bid procedures.

    If certified cost or pricing data are subsequently found to have been inaccurate, incomplete, or noncurrent as of the date stated in the certificate, the STATE is entitled to an adjustment of the contract price, including profit or fee, to exclude any significant sum by which the price, including profit or fee, was increased because of the defective data. It is presumed that overstated cost or pricing data increased the contract price in the amount of the defect plus related overhead and profit or fee. Therefore, unless there is a clear indication that the defective data was not used or relied upon, the price will be reduced in such amount.

30. Audit of Cost or Pricing Data. When cost or pricing principles are applicable, the STATE may require an audit of cost or pricing data.

31. Records Retention.

    (1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

    (2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

32. Antitrust Claims. The STATE and the CONTRACTOR recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the CONTRACTOR hereby assigns to STATE any and all claims for overcharges as to goods and materials purchased in connection with this Contract, except as to overcharges which result from violations commencing after the price is established under this Contract and which are not passed on to the STATE under an escalation clause.

33. Patented Articles. The CONTRACTOR shall defend, indemnify, and hold harmless the STATE, and its officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys fees, and all claims, suits, and demands arising out of or resulting from any claims, demands, or actions by the patent holder for infringement or other improper or unauthorized use of any patented article, patented process, or patented appliance in connection with this Contract. The CONTRACTOR shall be solely responsible for correcting or curing to the satisfaction of the STATE any such infringement or improper or unauthorized use, including, without limitation: (a) furnishing at no cost to the STATE a substitute article, process, or appliance acceptable to the STATE, (b) paying royalties or other required payments to the patent holder, (c) obtaining proper authorizations or releases from the patent holder, and (d) furnishing such security to or making such arrangements with the patent holder as may be necessary to correct or cure any such infringement or improper or unauthorized use.

34. Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawaii. Any action at law or in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawaii.

35. Compliance with Laws. The CONTRACTOR shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the CONTRACTOR'S performance of this Contract.

36. Conflict Between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the procurement rules, the procurement rules in effect on the date this Contract became effective shall control and are hereby incorporated by reference.

37. Entire Contract. This Contract sets forth all of the agreements, conditions, understandings, promises, warranties, and representations between the STATE and the CONTRACTOR relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings, promises, warranties, and representations, which shall have no further force or effect. There are no agreements, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the CONTRACTOR other than as set forth or as referred to herein.

38. Severability. In the event that any provision of this Contract is declared invalid or unenforceable by a court, such invalidity or unenforceability shall not affect the validity or enforceability of the remaining terms of this Contract.

39. Waiver. The failure of the STATE to insist upon the strict compliance with any term, provision, or condition of this Contract shall not constitute or be deemed to constitute a waiver or relinquishment of the STATE'S right to enforce the same in accordance with this Contract. The fact that the STATE specifically refers to one provision of the procurement rules or one section of the Hawaii Revised Statutes, and does not include other provisions or statutory sections in this Contract shall not constitute a waiver or relinquishment of the STATE'S rights or the CONTRACTOR'S obligations under the procurement rules or statutes.

40. Pollution Control. If during the performance of this Contract, the CONTRACTOR encounters a "release" or a "threatened release" of a reportable quantity of a "hazardous substance," "pollutant," or "contaminant" as those terms are defined in section 128D-1, HRS, the CONTRACTOR shall immediately notify the STATE and all other appropriate state, county, or federal agencies as required by law. The Contractor shall take all necessary actions, including stopping work, to avoid causing, contributing to, or making worse a release of a hazardous substance, pollutant, or contaminant, and shall promptly obey any orders the Environmental Protection Agency or the state Department of Health issues in response to the release. In the event there is an ensuing cease-work period, and the STATE determines that this Contract requires an adjustment of the time for performance, the Contract shall be modified in writing accordingly.

41. Campaign Contributions. The CONTRACTOR is hereby notified of the applicability of 11-355, HRS, which states that campaign contributions are prohibited from specified state or county government contractors during the terms of their contracts if the contractors are paid with funds appropriated by a legislative body.

42. Confidentiality of Personal Information.

a. Definitions.

"Personal information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either name or data elements are not encrypted:

(1) Social security number;

(2) Driver's license number or Hawaii identification card number; or

(3) Account number, credit or debit card number, access code, or password that would permit access to an individual's financial information.

Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

"Technological safeguards" means the technology and the policy and procedures for use of the technology to protect and control access to personal information.

b. Confidentiality of Material.

(1) All material given to or made available to the CONTRACTOR by the STATE by virtue of this Contract which is identified as personal information, shall be safeguarded by the CONTRACTOR and shall not be disclosed without the prior written approval of the STATE.

(2) CONTRACTOR agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.

(3) CONTRACTOR agrees to implement appropriate "technological safeguards" that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.

(4) CONTRACTOR shall report to the STATE in a prompt and complete manner any security breaches involving personal information.

(5) CONTRACTOR agrees to mitigate, to the extent practicable, any harmful effect that is known to CONTRACTOR because of a use or disclosure of personal information by CONTRACTOR in violation of the requirements of this paragraph.

(6) CONTRACTOR shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by CONTRACTOR on behalf of the STATE.

c. Security Awareness Training and Confidentiality Agreements.

(1) CONTRACTOR certifies that all of its employees who will have access to the personal information have completed training on security awareness topics relating to protecting personal information.

(2) CONTRACTOR certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:

(A) The personal information collected, used, or maintained by the CONTRACTOR will be treated as confidential;

(B) Access to the personal information will be allowed only as necessary to perform the Contract; and

(C) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

d. Termination for Cause. In addition to any other remedies provided for by this Contract, if the STATE learns of a material breach by CONTRACTOR of this paragraph by CONTRACTOR, the STATE may at its sole discretion:

(1) Provide an opportunity for the CONTRACTOR to cure the breach or end the violation; or

(2) Immediately terminate this Contract.

In either instance, the CONTRACTOR and the STATE shall follow chapter 487N, HRS, with respect to notification of a security breach of personal information.

e. Records Retention.

(1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

(2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (THE EUTF)

BUSINESS ASSOCIATE AGREEMENT

This Agreement is effective as of _____, between the Hawaii Employer-Union Health Benefits Trust Fund, State of Hawaii (hereinafter the "STATE"), by its Administrator, whose address is 201 Merchant Street, Suite 1700, Honolulu, Hawaii 96813, and _____ (hereinafter "BUSINESS ASSOCIATE"), a _____, whose business address is as follows: _____.

RECITALS

A. The STATE has entered into a contract with BUSINESS ASSOCIATE and/or procured the following goods and services from BUSINESS ASSOCIATE: _____.

B. BUSINESS ASSOCIATE's contract and/or provision of goods and performance of services may require that: (1) Protected Health Information (defined below) or Electronic Protected Health Information (defined below) be disclosed to or used by BUSINESS ASSOCIATE; (2) BUSINESS ASSOCIATE create, receive, maintain or transmit Protected Health Information or Electronic Protected Health Information on behalf of the STATE; and/or (3) BUSINESS ASSOCIATE be provided or have access to Personal Information (defined below).

C. Both parties are committed to complying with the Privacy and Security Laws (defined below) with respect to Protected Health Information, Electronic Protected Health Information, and Personal Information.

D. This Agreement sets forth the terms and conditions pursuant to which the following will be handled: (1) Protected Health Information and Electronic Protected Health Information that is disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; (2) Protected Health Information and Electronic Protected Health Information that is created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of the STATE; and (3) Personal Information provided to BUSINESS ASSOCIATE or to which BUSINESS ASSOCIATE will have access by virtue of a contract with the STATE.

TERMS AND CONDITIONS

1. Introduction: The STATE, as defined in this Agreement, has determined that it is a Covered Entity or a Health Care Component of a Covered Entity under HIPAA (defined below) and the Privacy and Security Rules (defined below). In addition, the STATE is subject to use and disclosure restrictions regarding Personal Information under Act 10 (defined below) and Chapters 487N and 487R, Hawaii Revised Statutes.

   The parties acknowledge that entry into this Agreement is necessary and desirable in order to: (a) protect the privacy and security of Protected Health Information and Electronic Protected Health Information in accordance with the Privacy and Security Laws and because BUSINESS ASSOCIATE is a "business associate" of the STATE

as that term is used in 45 Code of Federal Regulations ("C.F.R.") § 160.103; and (b) protect against the unauthorized use and disclosure of Personal Information that BUSINESS ASSOCIATE has been provided or to which BUSINESS ASSOCIATE has access by virtue of a contract with the STATE.

2. Definitions:

a. Except as otherwise defined herein, any and all capitalized terms in this Agreement shall have the definitions set forth in the Privacy and Security Laws.

b. Act 10. "Act 10" shall mean Act 10, 2008 Session Laws of Hawaii, Special Session.

c. Agreement. "Agreement" shall mean this agreement between STATE and BUSINESS ASSOCIATE and any and all attachments, exhibits and special conditions attached hereto.

d. ARRA. "ARRA" shall mean the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, and the rules and regulations promulgated under the ARRA.

e. Breach. "Breach" shall have the meaning set forth in the ARRA.

f. De-identified Information. "De-identified Information" shall have the meaning set forth in 45 C.F.R. §§ 164.514(a)-(b).

g. Electronic Protected Health Information. "Electronic Protected Health Information" shall have the meaning set forth in 45 C.F.R. § 160.103. For purposes of this Agreement, "Electronic Protected Health Information" is limited to Electronic Protected Health Information that is: (i) disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; and/or (ii) created, received, maintained, or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.

h. Electronic Transactions Rule. "Electronic Transactions Rule" shall mean the final rule set forth in 45 C.F.R. §§ 160 and 162.

i. HIPAA. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

j. Individual. "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative under 45 C.F.R. § 164.502(g).

k. Individually Identifiable Health Information. "Individually Identifiable Health Information" shall have the meaning set forth in 45 C.F.R. § 160.103.

l. Personal Information. "Personal Information" shall have the meaning set forth in Section 487N-1, Hawaii Revised Statutes. For purposes of this Agreement, "Personal Information" is limited to Personal Information provided to BUSINESS ASSOCIATE or to which BUSINESS ASSOCIATE has access by virtue of a contract with the STATE.

m. Ping. "Ping" shall mean a request-response utility or other method used to determine whether a specific Internet Protocol (IP) address or host exists or is accessible.

n. Port Scan. "Port Scan" shall mean a process that sends requests to a host to determine network services that are available on that host.

o. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as the same may be amended from time to time.

p. Privacy and Security Laws. "Privacy and Security Laws" shall include: (1) the provisions of HIPAA that relate to the privacy and security of Protected Health Information and Electronic Protected Health Information; (2) the Privacy and Security Rules; (3) the provisions of ARRA, including the rules and regulations promulgated under the ARRA, that relate to the privacy and security of Protected Health Information and Electronic Protected Health Information; (4) Act 10 and, to the extent applicable, Chapters 487N and 487R, Hawai‘i Revised Statutes; and (5) other Federal and State privacy or security statutes and regulations that apply to Protected Health Information, Electronic Protected Health Information, or Personal Information.

q. Protected Health Information. "Protected Health Information" shall have the meaning set forth in 45 C.F.R. § 160.103. For purposes of this Agreement, "Protected Health Information" is limited to Protected Health Information that is: (i) disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; and/or (ii) created, received, maintained, or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.

r. Secretary. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or designee.

s. Security Rule. "Security Rule" shall mean the Health Insurance Reform: Security Standards at 45 C.F.R. Part 160, Part 162, and Part 164, Subparts A and C, as the same may be amended from time to time.

t. Unsecured Protected Health Information. "Unsecured Protected Health Information" shall have the meaning set forth in the ARRA.

3. Obligations and Activities of BUSINESS ASSOCIATE

a. BUSINESS ASSOCIATE agrees to not use or disclose Protected Health Information, Electronic Protected Health Information, and Personal Information other than as permitted or required by this Agreement or as required by law.

b. BUSINESS ASSOCIATE agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information, Electronic Protected Health Information, and Personal Information other than as provided for by this Agreement.

c. BUSINESS ASSOCIATE agrees to implement administrative, physical, and technical safeguards (as those terms are defined in the Security Rule) that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the STATE. Without limiting the foregoing, BUSINESS ASSOCIATE agrees to implement administrative, physical, and technical safeguards to comply with 45 C.F.R. §§ 164.308, 164.310, and 164.312, as and to the extent that such is required of business associates under the Privacy and Security Laws (as amended by the ARRA).

(i) Required Safeguards. BUSINESS ASSOCIATE shall use all appropriate safeguards to prevent use or disclosure of Protected Health Information received from, or created or received on behalf of, STATE, other than as provided for in this Agreement or as required by law. These safeguards will include, but are not limited to:

(I) Training. Providing annual training to relevant employees, contractors, and subcontractors on how to prevent the improper use or disclosure of Protected Health Information; and updating and repeating training on a regular basis;

(II) Administrative Safeguards. Adopting policies and procedures regarding the safeguarding of Protected Health Information; and enforcing those policies and procedures, including sanctions for anyone not found in compliance;

(III) Technical and Physical Safeguards. Implementing appropriate technical safeguards to protect Protected Health Information, including access controls, authentication, and transmission security; and implementing appropriate physical safeguards to protect Protected Health Information, including workstation security and device and media controls.

d. In accordance with Part V of Act 10, BUSINESS ASSOCIATE agrees to implement: (i) technological safeguards to reduce exposure to unauthorized access to Personal Information, (ii) mandatory training on security awareness topics relating to Personal Information protection for BUSINESS ASSOCIATE's employees, and (iii) confidentiality agreements to be signed by BUSINESS ASSOCIATE's employees. BUSINESS ASSOCIATE further agrees to safeguard Protected Health Information, Electronic Protected Health Information, and Personal Information in accordance with any rules, policies, procedures and directions adopted or implemented by STATE to the extent that such are communicated to BUSINESS ASSOCIATE.

e. BUSINESS ASSOCIATE agrees to ensure that any agent (including a contractor or subcontractor) to whom it provides Protected Health Information, Electronic Protected Health Information, or Personal Information agrees to the same restrictions and conditions that apply to BUSINESS ASSOCIATE with respect to

such information under this Agreement and the Privacy and Security Laws. BUSINESS ASSOCIATE further agrees to ensure that any such agent shall safeguard such Protected Health Information, Electronic Protected Health Information, and Personal Information in accordance with any rules, policies, procedures and directions adopted or implemented by STATE to the extent that such are communicated to BUSINESS ASSOCIATE. BUSINESS ASSOCIATE agrees to ensure that any such agent shall implement reasonable and appropriate safeguards to protect Protected Health Information.

f. BUSINESS ASSOCIATE agrees to implement reasonable policies and procedures to comply with 45 C.F.R. § 164.316, as and to the extent that such is required of business associates under the Privacy and Security Laws (as amended by the ARRA).

g. BUSINESS ASSOCIATE agrees to provide access to Protected Health Information in the Designated Record Set to STATE or, as directed by STATE, to an Individual to the extent and in the manner required by 45 C.F.R. § 164.524.

h. BUSINESS ASSOCIATE agrees to make Protected Health Information available for amendment and to incorporate any amendments to Protected Health Information that the STATE directs or agrees to in accordance with the requirements of 45 C.F.R. § 164.526.

i. BUSINESS ASSOCIATE agrees to document disclosures of Protected Health Information, disclosures of Electronic Protected Health Information and information related to such disclosures as would be required for STATE to respond to a request by an Individual for an accounting of disclosures of: (1) Protected Health Information in accordance with 45 C.F.R. § 164.528; and (2) Electronic Protected Health Information in accordance Section 13405(c) of the ARRA. BUSINESS ASSOCIATE further agrees to collect and provide to STATE, any and all information that is reasonably necessary for STATE to timely respond to such requests by an Individual for an accounting of disclosures.

j. BUSINESS ASSOCIATE agrees to keep a log of Breaches of Unsecured Protected Health Information in such form and with such information as to enable the STATE to comply with Section 13402(e)(3) of the ARRA and the rules and regulations promulgated under ARRA.

k. BUSINESS ASSOCIATE agrees to keep a complete log of disclosures made of Personal Information in accordance with Section 8(b)(6) of Act 10.

l. BUSINESS ASSOCIATE agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information and Electronic Protected Health Information available to STATE and/or to the Secretary, at reasonable times and places or as designated by the STATE and/or the Secretary, for purposes of determining compliance with the Privacy and Security Laws. BUSINESS ASSOCIATE further agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Personal Information available to STATE, at reasonable times and places or as designated by the STATE, for purposes of determining compliance with this Agreement, Act 10,

and other Federal and State laws regarding the use and disclosure of Personal Information.

m. BUSINESS ASSOCIATE agrees to report to STATE any disclosure or use of Protected Health Information not provided for by this Agreement, of which BUSINESS ASSOCIATE becomes aware, but in no event later than five (5) business days of first learning of any such use or disclosure. BUSINESS ASSOCIATE further agrees to report to STATE any security incidents that are required to be reported by or to the STATE under 45 C.F.R. Part 164, particularly 45 C.F.R. § 164.314. BUSINESS ASSOCIATE agrees that if any of its employees, agents, subcontractors, and/or representatives use and/or disclose Protected Health Information received from, or created or received on behalf of, STATE, or any derivative De-identified Information in a manner not provided for in this Agreement, BUSINESS ASSOCIATE shall ensure that such employees, agents, subcontractors, and/or representatives shall receive training on BUSINESS ASSOCIATE's procedures for compliance with the Privacy Rule, or shall be sanctioned or prevented from accessing any Protected Health Information BUSINESS ASSOCIATE receives from, or creates or receives on behalf of, STATE. Continued use of Protected Health Information in a manner contrary to the terms of this Agreement shall constitute a material breach of this Agreement.

n. If there is a Breach of Unsecured Protected Health Information, BUSINESS ASSOCIATE shall: (i) notify the STATE in writing of the Breach no later than twenty (20) calendar days after BUSINESS ASSOCIATE's discovery of the Breach; (ii) investigate and report to STATE on the causes of the Breach including, without limitation, any steps that BUSINESS ASSOCIATE will take to mitigate the Breach and prevent the occurrence of future similar Breaches; (iii) in consultation with STATE, provide all notifications regarding the Breach that STATE and/or BUSINESS ASSOCIATE are required to make under ARRA including, without limitation, written notices to individuals, notices to the media, and notices to the Secretary or any other governmental entity, all such notices to be made in accordance with all ARRA requirements; (iv) unless the Breach is primarily caused by the negligence or other fault of the STATE, indemnify and hold STATE harmless from all claims, lawsuits, administrative proceedings, judgments, damages, liabilities, penalties, and costs arising from the Breach, including all costs of investigating the Breach, providing all required notices, and otherwise complying with all ARRA requirements; and (v) provide a log of all Breaches of Unsecured Protected Health Information to the STATE no later than twenty (20) calendar days after the end of each calendar year, which log shall include all information that STATE needs in order to comply with Section 13402(e)(3) of the ARRA.

o. If there is a "security breach" regarding Personal Information as that term is defined in Section 487N-1, Hawai'i Revised Statutes, BUSINESS ASSOCIATE shall: (i) notify the STATE in writing of the security breach no later than twenty (20) calendar days after BUSINESS ASSOCIATE's discovery of the security breach; (ii) investigate and report to STATE on the causes of the security breach including, without limitation, any steps that BUSINESS ASSOCIATE will take to mitigate the Breach and prevent the occurrence of future similar Breaches; (iii) in

consultation with STATE, provide all notifications regarding the security breach that STATE and/or BUSINESS ASSOCIATE are required to make under Chapter 487N and other applicable Hawai‘i Revised Statutes; (iv) unless the security breach is primarily caused by the negligence or other fault of the STATE, indemnify and hold STATE harmless from all claims, lawsuits, administrative proceedings, judgments, damages, liabilities, penalties, and costs arising from the security breach, including all costs of investigating the security breach, providing all required notices, and otherwise complying with Chapter 487N and other applicable Hawai‘i Revised Statutes; and (v) assist the State in providing any written report to the legislature or other government entities that is required by Chapter 478N and other applicable Hawai‘i Revised Statutes.

p. BUSINESS ASSOCIATE agrees to mitigate, to the extent practicable, any harmful effect that is known to BUSINESS ASSOCIATE of: (1) a security breach or disclosure or use of Protected Health Information, Electronic Protected Health Information, or Personal Information by BUSINESS ASSOCIATE in violation of the requirements of this Agreement; and/or (2) a Breach of Unsecured Protected Health Information by BUSINESS ASSOCIATE or any of its officers, employees, or agents (including contractors and subcontractors).

q. BUSINESS ASSOCIATE shall, upon notice from STATE, accommodate any restriction to the use or disclosure of Protected Health Information and any request for confidential communications to which STATE has agreed in accordance with the Privacy Rule.

r. BUSINESS ASSOCIATE shall comply with any other requirements of the Privacy Law, the Privacy Rule, the Security Law, and the Security Rule not expressly specified in this Agreement, as and to the extent that such requirements apply to business associates under the Privacy Law, the Privacy Rule, the Security Law, and the Security Rule, as they may be amended from time to time.

4. Permitted Uses and Disclosures by BUSINESS ASSOCIATE

a. General Use and Disclosure Provisions. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose or use Protected Health Information, Electronic Protected Health Information, and Personal Information to perform functions, activities, or services for, or on behalf of, STATE as specified in this Agreement, provided that such disclosure or use would not violate any Privacy and Security Laws if done by STATE.

b. Specific Use and Disclosure Provisions

(i) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use Protected Health Information and Personal Information for the proper management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE.

(ii) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose Protected Health Information for the proper management and administration of the BUSINESS ASSOCIATE, for disclosures that are

Required By Law, or where BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person and the person agrees to notify BUSINESS ASSOCIATE of any instances where the confidentiality of the information has been breached. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose Personal Information where such disclosure is permitted by applicable Federal or State laws.

(iii) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use Protected Health Information to provide Data Aggregation services to STATE as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

(iv) BUSINESS ASSOCIATE may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).

c. Further Uses Prohibited. Except as provided in sections 4.a and 4.b, above, BUSINESS ASSOCIATE is prohibited from further using or disclosing any information received from STATE, or from any other Business Associate of STATE, for any commercial purposes of BUSINESS ASSOCIATE including, for example, "data mining."

5. Minimum Necessary. BUSINESS ASSOCIATE shall only request, use, and disclose the minimum amount of Protected Health Information necessary to accomplish the purpose of the request, use, or disclosure.

6. Prohibited, Unlawful, or Unauthorized Use and Disclosure of Protected Health Information. BUSINESS ASSOCIATE shall not use or further disclose any Protected Health Information received from, or created or received on behalf of, STATE, in a manner that would violate the requirements of the Privacy Rule, if done by STATE.

7. Indemnity by BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall defend, indemnify and hold harmless STATE and STATE's officers, employees, and agents (including contractors and subcontractors) from and against any and all claims, demands, lawsuits, administrative or other proceedings, judgments, liabilities, damages, losses, fines, penalties, and costs, including reasonable attorneys' fees, that are caused by or arise out of a breach or failure to comply with any provision of this Agreement and/or by a violation of any provision of the Privacy and Security Laws, including the ARRA, by BUSINESS ASSOCIATE or any of BUSINESS ASSOCIATE's officers, employees, or agents (including contractors and subcontractors).

8. Permissible Requests by STATE. STATE shall not request BUSINESS ASSOCIATE to disclose or use Protected Health Information, Electronic Protected Health Information, or Personal Information in any manner that would not be permissible under the Privacy and Security Laws if done by STATE.

9. Standard Electronic Transactions. STATE and BUSINESS ASSOCIATE agree that BUSINESS ASSOCIATE shall, on behalf of STATE, transmit data for transactions that are required to be conducted in standardized format under the Electronic Transactions Rule. BUSINESS ASSOCIATE shall comply with the Electronic Transactions Rule for all transactions conducted on behalf of STATE that are required to be in standardized format. BUSINESS ASSOCIATE shall ensure that any of its subcontractors to whom it delegates any of its duties under its contract with STATE, agrees to conduct and agrees to require its agents or subcontractors to comply with the Electronic Transactions Rule for all transactions conducted on behalf of STATE that are required to be in standardized format.

10. Termination for Cause. In addition to any other remedies provided for by this Agreement, upon STATE's knowledge of a material breach or violation by BUSINESS ASSOCIATE of the terms of this Agreement, STATE may either:

    a. Provide an opportunity for BUSINESS ASSOCIATE to cure the breach or end the violation, and terminate this Agreement if BUSINESS ASSOCIATE does not cure the breach or end the violation within the time specified by the STATE; or

    b. Immediately terminate this Agreement if BUSINESS ASSOCIATE has breached or violated a material term of this Agreement and cure is not possible; and

    c. If neither termination nor cure is feasible, STATE shall report any violation of the federal Privacy and Security Rules to the Secretary.

11. Effect of Termination.

    a. Upon any termination of this Agreement, until notified otherwise by STATE, BUSINESS ASSOCIATE shall extend all protections, limitations, requirements, and other provisions of this Agreement to: (i) all Protected Health Information received from or on behalf of STATE or created or received by BUSINESS ASSOCIATE on behalf of STATE; (ii) all Electronic Protected Health Information created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of STATE; and (iii) all Personal Information.

    b. Upon any termination of this Agreement, STATE shall determine whether it is feasible for BUSINESS ASSOCIATE to return to STATE or destroy all or any part of: (i) all Protected Health Information received from or on behalf of STATE or created or received by BUSINESS ASSOCIATE on behalf of STATE that BUSINESS ASSOCIATE maintains in any form and shall retain no copies of such information; (ii) all Electronic Protected Health Information created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of STATE; and (iii) all Personal Information. In connection with the foregoing, upon any termination of the Agreement, BUSINESS ASSOCIATE shall notify the STATE in writing of any and all conditions that make return or destruction of such information not feasible and shall provide STATE with any requested information related to the STATE's determination as to whether the return or destruction of such information is feasible.

c. If STATE determines that return or destruction of all or any part of the Protected Health Information, Electronic Protected Health Information, and Personal Information is feasible, at STATE's option, BUSINESS ASSOCIATE shall return or destroy such information. If STATE directs that BUSINESS ASSOCIATE return or destroy all or any part of the Protected Health Information, Electronic Protected Health Information, and Personal Information, it is understood and agreed that BUSINESS ASSOCIATE shall retain no copies of such information. Destruction of Personal Information shall be performed in accordance with Chapter 487R, Hawaii Revised Statutes. Notwithstanding the foregoing, BUSINESS ASSOCIATE shall not destroy any Protected Health Information in less than six (6) years from the date that it is received by BUSINESS ASSOCIATE.

d. If STATE determines that return or destruction of all or any part of the Protected Health Information, Electronic Protected Health Information, and Personal Information is not feasible or opts not to require the return or destruction of such information, BUSINESS ASSOCIATE shall extend the protections, limitations, requirements, and other provisions of this Agreement to such information for so long as BUSINESS ASSOCIATE maintains such information. STATE understands that BUSINESS ASSOCIATE's need to maintain portions of the Protected Health Information in records of actuarial determinations and for other archival purposes related to memorializing advice provided, can render return or destruction infeasible.

e. The provisions of this Section 11 shall apply with respect to all terminations of this Agreement, for any reason whatsoever, and to any and all Protected Health Information, Electronic Protected Health Information, and Personal Information in the possession or control of any and all agents and subcontractors of BUSINESS ASSOCIATE.

12. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy and Security Laws means the section in effect or as amended.

b. Amendment. BUSINESS ASSOCIATE and STATE agree to take all actions necessary to amend this Agreement in order for STATE to comply with the requirements of the Privacy Rule, Security Rule, HIPAA, ARRA, and/or any other Federal or State law that is determined to apply to the Protected Health Information, Electronic Protected Health Information, or Personal Information covered by this Agreement. All amendments shall be in writing and executed by both parties.

c. Survival. The respective rights and obligations of STATE and BUSINESS ASSOCIATE under Sections 3, 6, 7, and 8 above, shall survive the termination of this Agreement.

d. Interpretation. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the Privacy and Security Laws, as amended, the Privacy and Security Laws shall control. Where provisions of this

Agreement are different than those mandated in the Privacy or Security Laws but are nonetheless permitted by the Privacy or Security Laws, the provisions of this Agreement shall control. Any ambiguity in this Agreement shall be resolved to permit STATE to comply with the Privacy and Security Laws.

e. Third Parties. This Agreement is solely between BUSINESS ASSOCIATE and the STATE and may be enforced only by BUSINESS ASSOCIATE or the STATE. This Agreement shall not be deemed to create any rights in any third parties or to create any obligations or liabilities of BUSINESS ASSOCIATE or the STATE to any third party.

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND ("STATE")

By _____
Its Administrator

Date: _____, 20____

[*name of business associate*]
("BUSINESS ASSOCIATE")

By _____

Its _____

Date: _____, 20____

APPROVED AS TO FORM:

_____
Deputy Attorney General

EXHIBIT C

ACTIVE AND RETIREE HEALTH BENEFIT REFERENCE GUIDES

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (THE EUTF)

EXHIBIT C

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

Effective July 1, 2024 – June 30, 2025

EMPLOYEE HEALTH BENEFITS REFERENCE GUIDE

(EUTF and HSTA VB)

Revised 04.19.24

EXHIBIT C

April 2024

Aloha State and County Employees:

We are pleased to present the *EUTF Employee Health Benefits Reference Guide*. This guide provides you with important information on EUTF health benefit plans available to most active employees for plan year July 1, 2024, through June 30, 2025.

The open enrollment (OE) election period is April 1-30, 2024. The OE election period is an opportunity to make changes to your enrollment in EUTF health benefit plans. You can also make changes to your enrollment if you have a qualifying event during the plan year. Please note that any changes you make during the April OE election period will take effect July 1, 2024. If you don't make any changes during OE, your current plan enrollment will continue into the new plan year.

Health plan premium rate information can be found beginning on page 18.

We are pleased to introduce the EUTF Member self-service portal. You can access this new benefits portal at **eutfbenefits.hawaii.gov**. The EUTF Member self-service portal is your information hub for all things benefits-related, including enrollment materials, plan descriptions and comparisons, and more. See pages 4-7 for details.

Our goal is to provide you with high-quality, affordable health benefit plan options that help maintain and improve health. The information contained here is intended to help you make good use of your benefits and make choices that best address your needs.

This guide and other useful information are posted on the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** and the EUTF website at **eutf.hawaii.gov**. For specific information on health plan benefits, please contact the health plan carriers directly. Carrier contact information can be found in the back of this guide. You may also call the EUTF and speak with one of our helpful staff at **1-808-586-7390** or toll-free at **1-800-295-0089**.

Mahalo,

Jacqueline Ferguson-Miyamoto, Chair
EUTF Board of Trustees

Introducing the EUTF Member Self-Service Portal

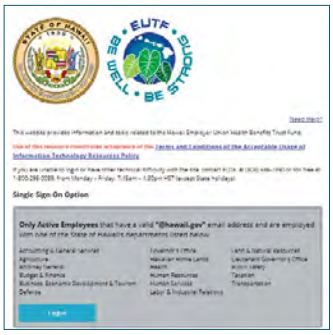
Access the new portal at eutfbenefits.hawaii.gov

The EUTF Member self-service portal is your one-stop resource for all benefits-related information. Go to eutfbenefits.hawaii.gov, where you can:

- Find benefit plan descriptions
- Review enrollment materials
- Update your dependent(s)
- Compare plan features and costs
- Enroll in or change your benefits

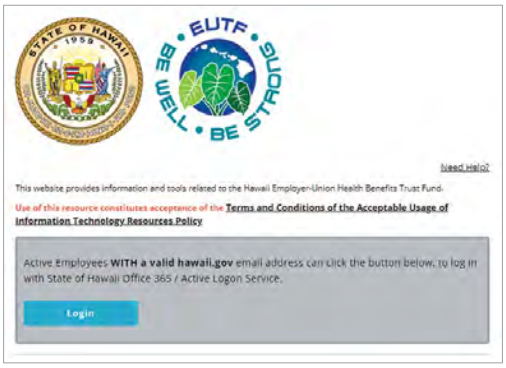
Register for the First Time

You only have to perform the registration process once. When you register, you'll be provided your login credentials that you'll need to access the portal in the future. Login credentials are your EUTF Health Benefits (HB) Number and Password. Active employees with a State of Hawaii Office 365 account can log in using Single-Sign-On (see page 6 for details).

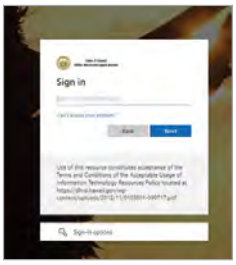


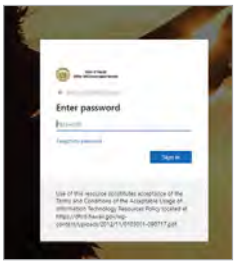
1. To start, click the **Register** link in the bottom right of the **EUTF Welcome screen**.
2. Answer the questions to continue: last four digits of your **Social Security number**, **date of birth**, and **mailing zip code**.
3. Click the **I'm not a robot** checkbox and, if required, complete the **picture recognition challenge**.
4. Click **Continue**.
5. Enter and confirm a **password** then click **Continue**.
6. If all steps are completed without error, your successful registration is confirmed.
7. Click **Show HB Number**. The **HB Number** will serve as your login name credential.
8. Click **Continue**.
9. Set up a Two-Step Verification for secure logins. Enter a personal email address in the empty field and click **Verify**.
10. An email will be sent to your personal email mailbox with a code. After code is entered, click **Verify**.
11. Once the Two-Step Verification Set Up is successful, you will see the green Verified button next your personal email. Next, click **Save**.
12. The Two-Step Verification Set Up is now in use. Click **Continue**.
13. Answer challenge questions then click **Continue**.
14. When you see a confirmation of the challenge questions, click **Continue**.
15. Disclaimer will appear for you to read. Click **I Accept** then **Continue**.
16. Disclaimer acceptance will appear. When you click **Continue**, you'll be taken to the Member Benefits Home Screen.

Single-Sign-On (SSO) capabilities for Active Employees with a State of Hawaii Microsoft Office 365 account



1. Click on the Single Sign On blue **Login** button in the gray box for State of Hawaii Active Employees.
2. Enter your State of Hawaii Employee **Email Address and Password (same as HiPay).** (If you are already logged in to your State of Hawaii Office 365 account then you may not be asked to re-enter your Email Address and Password.)
3. **If your criteria is accepted, your registration is confirmed.**
4. **Disclaimer** will appear. Click **I Accept** then **Continue**.
5. **Disclaimer acceptance** will appear. When you click **Continue**, you'll be taken to the **Member Benefits Home Screen**.





What Happens If You Forget Your Password

1. Click **Forgot Password** under the login window.
2. Answer three security challenge questions you selected during registration, or enter your email address and a link will be sent to change your password.
3. Reset your password.

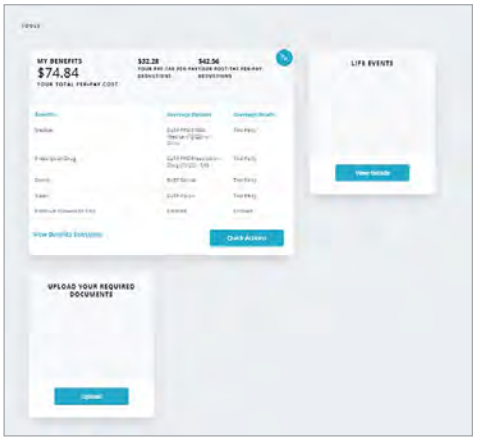
Active Employees with the State of Hawaii must contact their IT department's Office 365 administrator if they forget their SSO password.

Forget Password

Questions or Need Help?

Contact the EUTF at **1-808-586-7390**, or toll-free at **1-800-295-0089**, or visit the EUTF website at **eutf.hawaii.gov**.

Find Information about Your Current Benefits on the Member Benefits Home Screen

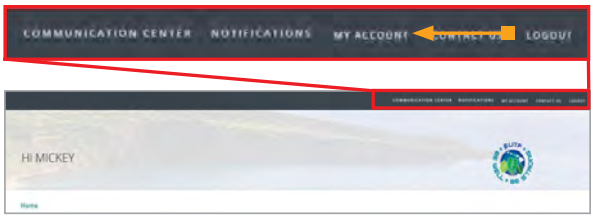


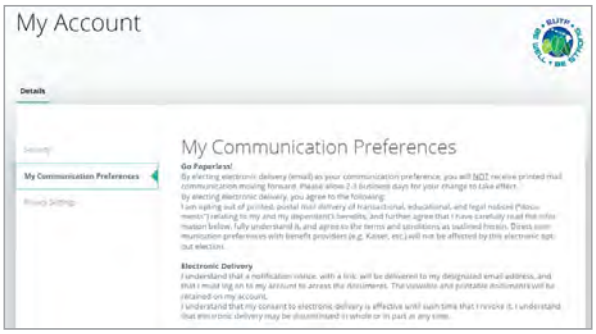
The **Home Screen** displays a collection called **Tools**, where you can access your current benefits. You can also view, print, and make changes during Open Enrollment or if you have a qualifying life event. This screenshot shows the following tools: **My Benefits**, **Life Events**, and **Upload Your Required Documents**.

1. Click the **double-arrow icon** on the top right of **My Benefits**. This will expand the **My Benefits Tool**.
2. You'll see your **Total Benefits Cost**, **Pre-Tax Deductions**, and **Post-Tax Deductions** per pay period.
3. Below the **Tools** section, you'll see a section called **Plan Details and Information**. This is where you can find benefits information, required plan notices, and other resources.

Set Your Communication Preference

1. Click **My Account** in the black bar at the top of the homepage.
2. Click **My Communication Preferences**.
3. Scroll down to view your **Communication Delivery** preference. All members are defaulted to Mail delivery. Select **Email** if you prefer to receive an email notification when a new notice is available to view in your account. Click **Save Changes** after making your selection.
4. Scroll down to view your **Email Collection**. Enter your personal email only. Set your preferred email option to **Personal**. Click **Save Changes** after entering your email.





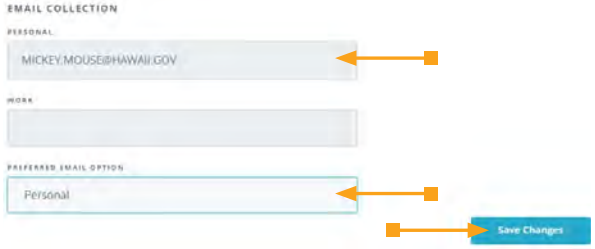


Table of Contents

Attention: Medicare-Eligible Members

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage through Medicare Part D. However, the EUTF active employee prescription drug plans offer benefits that are as good, or better, than the standard Medicare Part D plan coverage; therefore, you do not have to enroll in a Medicare Part D plan until you retire. For more information, a Notice of Creditable Coverage appears on page 68. The Notice of Creditable Coverage is also available on the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** and the EUTF website at **eutf.hawaii.gov**.

Introduction

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

The EUTF is a State agency administratively attached to the State Department of Budget and Finance and is governed by a 10-member, governor-appointed board of trustees.

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

If you have any questions regarding the information provided in this guide, please contact the EUTF Member Services Branch at **1-808-586-7390** or toll-free at **1-800-295-0089**, for clarification.

Disclaimer

This guide offers general information on your health and other benefit plans that are exclusively governed by the Hawaii Revised Statutes, the EUTF Administrative Rules as they are amended from time to time, and the carrier plan documents—all of which are available on the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** and on the EUTF website at **eutf.hawaii.gov**. Nothing in this guide is intended to amend, change, or contradict these documents. This guide is not a legal document or contract, and the information in this guide is not intended as legal advice or to create any legal or contractual liabilities.

Individuals With Special Needs

This guide can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990. Please contact the EUTF office at **1-808-586-7390** or toll-free at **1-800-295-0089**, for special needs.

EUTF's Mission

We care for the health and well-being of our beneficiaries by striving to provide quality benefit plans that are affordable, reliable, and meet their changing needs. We provide informed service that is excellent, courteous, and compassionate.

Wellness Programs

The EUTF cares for the health and well-being of our beneficiaries and strives to provide quality health benefits for you and your family. A vital part of EUTF health benefits is our wellness programs. In most cases, these programs are offered to members at no cost and provide tools to help members get healthy and stay healthy. By taking advantage of these benefits, members can experience improvement in wellness and in their overall quality of life. Please review the wellness programs in this section, and contact your insurance carrier for information on how you can participate. Members can also find additional EUTF Health and Wellness resources at **eutf.hawaii.gov/health-and-wellness**, or by sending an email to **eutfwellness@hawaii.gov**.

HMSA Members

What You Can Do to Stay Healthy

Staying healthy is the best way to keep your health care costs down. Ask your doctor about preventive care and screenings to take care of minor health problems before they get serious. Make an appointment for your Annual Preventive Health Evaluation at no cost, so your doctor can assess your overall health. For more information, visit **hmsa.com/eutf** and click **Member Resources**.

If you haven't seen your doctor in the past year, we encourage you to make an appointment for an annual visit. If you don't have a doctor, use the Find a Doctor tool at **hmsa.com/search/providers**. If you need help finding a doctor, call **1-808-948-6499** on Oahu or toll-free at **1-800-776-4672**, Monday through Friday, 7 a.m. to 7 p.m., and Saturday, 9 a.m. to 1 p.m.

Online Care

With HMSA's Online Care®, you can see a doctor or a behavioral health care provider on your smartphone or tablet without an appointment 24 hours a day, seven days a week. Online Care providers can diagnose conditions and prescribe medication as needed. There's no copayment for Online Care visits. Download Online Care from the App Store or Google Play and register or visit **hmsa.com/onlinecare**.

Health and Well-Being Support

We offer health and well-being support and resources at no cost to help you manage or prevent asthma, chronic obstructive pulmonary disease, coronary artery disease, heart failure, diabetes, chronic kidney disease, and/or behavioral health conditions. This program helps you and your doctor manage your care and make informed choices. For more information, call **1-855-329-5461** toll-free, Monday through Friday, 8 a.m. to 5 p.m., or visit **hmsa.com/well-being/health-well-being-support**.

Virta

If you or a family member has type 2 diabetes, the HMSA EUTF plan has a pilot program that can help. Virta helps patients reduce their need for diabetes medications, lower their blood sugar, and lose weight. You'll have access to your own health coach and physician-led team, all from a computer or smartphone. Virta is available at no cost for eligible HMSA EUTF members in Hawaii. You don't need a referral to receive care, go to **virtahealth.com/join/eutf** to join.

Diabetes Prevention Program (DPP)

HMSA Diabetes Prevention Program helps eligible members who are at risk for prediabetes prevent the onset of type 2 diabetes through lifestyle and diet changes, exercise, and group support. This program includes lessons, handouts, and resources from the Centers for Disease Control and Prevention to help you live a healthier lifestyle. To learn more, call **1-808-948-6499** or **1-800-776-4672**, Monday through Friday, 8 a.m. to 5 p.m. or visit **hmsa.com/well-being/diabetes-prevention**.

Health Coaching

Health coaching is available to you at no additional cost to help you reduce stress, manage your weight, develop a healthy eating plan, or manage chronic conditions. To talk with a health coach, call **1-855-329-5461**, Monday through Friday, 8 a.m. to 5 p.m.

Tobacco Cessation Support

This program is available to members who need help quitting tobacco use through online support, phone consultations, or both. Members can call the Hawai'i Tobacco Quitline toll-free at **1-800-QUIT-NOW** (**784-8669**).

Ornish Lifestyle Medicine™ (Dr. Ornish's Program for Reversing Heart Disease®)

If you have heart disease or an eligible cardiac condition or event, you may be eligible for the Ornish Lifestyle Medicine™ program. This program can help you improve your eating habits, manage stress, provide group support, and increase physical activity to lower your amount of medications and repeat procedures.

The program consists of 18 four-hour sessions over nine weeks. The plan's standard in-network coinsurance will apply (e.g., 10% of eligible charge under the 90/10 plan). Be advised that eligibility criteria aligns with that of the Centers for Medicare and Medicaid Services (CMS).

The program is available at four locations. To find the location nearest you, go to **hmsa.com/well-being/ornish**. To find out if you're eligible for this program, talk to your doctor or contact an Ornish program site:

- Hawaii Pacific Health, 1100 Ward Ave., Suite 715, Honolulu, HI 96814 or **1-808-522-4114**
- Island Heart Care, 75-1027 Henry St, Suite 110, Kailua-Kona, HI 96740 or **1-808-769-5225**
- Hilo Medical Center, 1190 Waianuenue Ave., Hilo, HI 96720 or **1-808-932-3455**
- Hui No ke Ola Pono Walter Cameron Center, 95 Mahalani St., Room 21, Wailuku, HI 96793 or **1-808-244-4647**

Mental Health Resources

Manage stress with access to behavioral health providers and services, programs to support mental health, and information on how to reduce anxiety. Visit **hmsa.com/EUTFMentalHealth** for more information.

Pregnancy Support

The HMSA Pregnancy and Postpartum Support Program pairs pregnant women with their own maternity nurse for personalized education and counseling over the phone. Nurse support provides additional services that complement the prenatal care members receive from their doctors. To get an enrollment form, call **1-808-948-6499** on Oahu or **1-800-776-4672** toll-free on the Neighbor Islands, or visit **hmsa.com/help-center/pregnancy-support**.

Plan for the Future

Advance Care Planning (ACP) helps patients plan for their medical treatment and care now instead of later when they're no longer able to make decisions. Approved ACP office visits are available at no cost when you see a participating provider. For more information, visit **hmsa.com/Media/Default/documents/eutf/EUTF_advance-care-planning.pdf**.

My Account

Go to **hmsa.com/eutf** and click **Member Login** for personalized information about your HMSA health plan. With My Account, you can:

- See a list of health care services you've received and your claims history.

- Access your well-being tools, such as ChooseHealthy® and Active&Fit Direct™.
- Access up-to-date information on your annual deductible and maximum out-of-pocket.
- Get a copy of your HMSA membership card, view your *Guide to Benefits*, and more.

HMSA365 Discounts*

Save money on a variety of health and fitness products and services, including:

- Discounted fitness classes and equipment along with access to more than 11,000 fitness centers nationwide with the Active&Fit Direct™ program.
- Discounts on vision, hearing products and services, transportation, and more.
- Up to 25% off specialty services such as acupuncture, chiropractic care, therapeutic massage, and more from a nationwide network of health care providers with the ChooseHealthy® program.
- Up to 57% off fitness and wellness products such as activity trackers, equipment, and more with the ChooseHealthy program. Get access to online health and wellness classes at no additional cost.

Learn more at **hmsa.com/hmsa365**.

HMSA's *Island Scene*

HMSA's *Island Scene* magazine offers health, fitness, and lifestyle tips with recipes, personal stories, community events, and health education workshops. You can also read the magazine and get new stories and videos at **islandscene.com**.

Kaiser Permanente Members

Preventive Services

Prevention makes good health possible!

Many preventive screening tests are covered at no additional cost to you when you use participating providers. Depending on your risk factors, such as age, gender, and family history, some screenings may not be necessary or may be required more frequently. Screenings may include: age-appropriate preventive medical examinations, preventive annual physical exam, blood pressure screening, colorectal cancer screening, cervical cancer screening, breast cancer screening, lipid evaluation, and much more. If you have questions about recommended screenings or what you are due for, please talk to your health care provider today.

Manage Your Care Online

Online tools to help you thrive.

kp.org is your online gateway to great health. When you register using your personal email address, you can securely access many time-saving tools for managing the care you get at our facilities. Visit **kp.org** anytime, from anywhere, to schedule and cancel routine appointments, view most lab results, refill most prescriptions, email your Kaiser Permanente doctor's office with nonurgent questions, print vaccination records, manage a family member's health, and so much more.

Online Wellness Programs

Jump start your health online.

The program gives you and your covered spouse/domestic partner enrolled in EUTF a chance to earn up to $100 each in gift card(s) annually for taking steps to improve health. Earn $25 each for completing a total health assessment to get an overall snapshot of your health, plus a recommended plan based on your answers. You can also each earn an additional $25 per online healthy lifestyle

* Amwell® is an independent company providing hosting and software services for HMSA's Online Care platform on behalf of HMSA. Active&Fit Direct and ChooseHealthy are trademarks of ASH. The ChooseHealthy program is provided by ChooseHealthy, Inc. The Active&Fit Direct program is provided by American Specialty Health Fitness Inc. (ASH Fitness). ChooseHealthy, Inc. and ASH Fitness are subsidiaries of American Specialty Health, Inc. (ASH).

The ChooseHealthy program is a discount program; it is not insurance. You can access services from any ChooseHealthy participating provider; referral from a primary care physician is not required. You're responsible for paying the discounted fee directly to the contracted provider.

program, up to three programs per year. Choose from a variety of programs to help in reducing stress, quitting smoking, losing weight, and more. You can participate in a program when it's convenient for you at your own pace. Current rewards run from July 1, 2024, until June 30, 2025.* Visit **kp.org/eutf**, and click on **Reap the rewards**.

Kaiser Permanente Fit Rewards

Earn a free gym membership!

With Fit Rewards, EUTF Kaiser Permanente members 16 years and older can pay the $200 annual membership fee to join or renew membership at fitness centers in the Standard or Premium Fitness Networks.* Or, download the ASHConnect™ mobile app for use at any qualifying non-participating fitness center. Just hit your gym 45 days for at least 30 minutes a visit by the end of the calendar year, and you can earn a reward of up to $200.**

If you prefer working out at home, pay just $10 per calendar year, and choose a home fitness kit, including the ability to choose a wearable fitness tracker at no additional cost. We're also offering new virtual offerings to help you move more and be healthier at home. Current Fit Rewards run from January 1 to December 31, 2024.*** Visit **kp.org/fitrewards**.

Wellness Coaching

Get a personal coach in your corner.

If you need a little extra support, we offer wellness coaching by phone at no cost. You'll work one-on-one with your personal wellness coach to make a plan to help you reach your goals. Take an active role in your health with our local health coaches. To schedule a convenient telephone session with your personal coach, call **1-808-432-2260** or **711** (TTY), Monday to Friday, 8 a.m. to 5 p.m.

Tobacco Cessation

Break the habit for good.

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

Health Classes

Take charge of your health and inspire others.

With all kinds of health classes and support groups offered right at our facilities, there's something for everyone. Classes vary at each location, and some may require a small fee. View our healthy living class catalogs at **kpinhawaii.org/our-services** to find a class near you.

* You are responsible for any taxes that may be due on the amounts received. Please talk to your personal tax advisor for specific tax information about this reward. Participation in the program MAY be shared with employers for tax purposes. The online wellness rewards program runs from July 1, 2024, to June 30, 2025, and is open to all EUTF subscribers and their enrolled spouses, 18 years old and older, excluding retirees and those enrolled in the HSTA VB Plan. You can take the total health assessment as often as you like and use as many healthy lifestyle programs as you like, but you can only earn up to $100 per contract period. You must complete the activities before June 30, 2025. Rewards will be issued four to six weeks after you complete your activity.

** The Premium Network adds new fitness center and studio choices at different price points.

*** Please consult with your own tax advisor about the taxability of the reimbursement. Participation in the program MAY be shared with employers for tax purposes. Kaiser Permanente Fit Rewards is available to all Kaiser Permanente Hawaii members, 16 years and older, excluding Medicare and Medicaid (QUEST Integration) members. Gym availability varies by island. Meet the 45-day, 30-minute-a-session activity requirement between January 1 and December 31, 2024, to qualify for reimbursement. Reimbursement is limited to your Active&Fit annual program fee each calendar year. Taxes and additional fees you pay your gym for classes, services, or amenities are not included in the Active&Fit program and are not eligible for reimbursement. Except for earning your annual program fee back by exercising 45 days a year, for at least 30 minutes a session, your Active&Fit annual program fee is not reimbursable and will not be prorated. The Active&Fit Home Fitness Program annual fee is nonrefundable and not eligible for reimbursement. Kaiser Permanente Fit Rewards is a value-added service and not part of your medical benefits. Your annual fee does not count toward your annual maximum out-of-pocket. Please see your Evidence of Coverage or **kp.org/fitrewards** for details, including conditions, limitations, and exclusions.

Member Discounts

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

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

You also have online exercise, nutrition, and healthy living resources to help assess and improve your health.

Visit **kp.org/choosehealthy**, or call **1-877-335-2746** weekdays, 3 a.m. to 4 p.m. HST.

CVS Caremark Members

Diabetes Products

Regular blood glucose testing is essential for people with diabetes. One of the best ways to manage diabetes is to check blood sugar every day with a blood glucose meter. The Diabetic Meter Program provides eligible members with a no-cost Accu-Chek or OneTouch blood glucose meter. To find out if you qualify for this benefit, call the CVS Caremark Member Services Diabetic Meter Team toll-free at **1-800-588-4456**, or request one at **caremark.com/managingdiabetes**. Continuous glucose monitoring systems (CGMS) are also available under the medical plans. For complete information, see your plan's Guide to Benefits, which can be found on **hmsa.com/eutf**.

Tobacco Cessation Products

Tobacco cessation products are provided as a plan benefit to support our members who are quitting smoking. CVS Caremark offers certain products at no or low cost to members, such as nicotine patches and other prescription medications. To learn more about this program and covered medications, call the CVS Caremark customer service center toll-free at **1-855-801-8263**.

Money Saving Tips

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

Choosing the Best Plan for Your Needs

Not all plans are created equal. Just because a plan has the highest monthly premium, does not mean it will be the most cost efficient. Be sure to factor in your cost share (deductibles, copayments, and coinsurance), monthly premiums, calendar-year maximum out-of-pocket, and your expected usage for the year before making any plan decisions. Every year open enrollment offers an opportunity to choose a plan that best suits your needs, which may change from year to year.

Pick the Right Facility

The ER should be reserved for serious emergency situations. If you have a nonemergency illness or injury, go to your regular doctor or an urgent care facility. Cost savings can be significant. For example, the total cost of a typical office visit is around $100, while an ER visit could cost $1,000 or more. Other options for care include Kaiser Permanente or HMSA's online or telephonic care and walk-in clinics such as urgent care or the CVS MinuteClinic.

HMSA members: Consider going to a Blue Distinction Center+ for surgery and/or specialty care. These are hospitals nationally recognized by Blue Cross Blue Shield for their expertise and efficiency in delivering specialty care. For more information, visit **bcbs.com/about-us/capabilities-initiatives/blue-distinction/blue-distinction-specialty-care**.

Kaiser Permanente members: For urgent care needs that aren't life threatening, visit **kp.org/getcare** for options to seek care. Available options include 24/7 nurse advice, 24/7 phone or video visits with a clinician, e-visits, and in-person urgent care appointments.

Participating Providers

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

Preventive Care

Preventing disease and detecting health issues at an early stage is key to living a healthy life. Getting regular preventive care may help you ward off serious health issues. It's much easier, and far less costly, to prevent an illness than it is to try to cure one. By following the guidelines for preventive care—and your doctor's advice—you're on your way to staying healthy. Most preventive services are completely free of charge for you and your dependents when you use participating providers (in-network providers). Examples include immunizations, annual exams, mammograms, and well-child care visits.

Prescription Drug Benefits

There are a number of ways to save money on your prescription drug costs. One of the most cost-effective ways is to ask your prescribing doctor if you can take a generic drug. Taking a brand-name drug over a generic can end up costing you three or four times more. For example, if you are on Zetia or Vytorin to lower cholesterol, ask your prescribing doctor if you can switch to ezetimibe/simvastatin or another generic. Doing so could save you at least $200 annually per prescription. Additionally, these changes could potentially save the EUTF hundreds of thousands of dollars annually, which helps to lower plan premiums.

Another great way to save money is by switching to mail order. In addition to saving money, mail

order offers the added convenience of receiving your prescriptions at your doorstep, saving you time and money by not having to make regular trips to the pharmacy.

HMSA/CVS members: Call CVS Customer Care toll-free at **1-855-801-8263**, visit **caremark.com**, or download CVS Caremark's mobile app at the **App Store** or **Google Play**. While online, or utilizing the app, you can download a digital prescription ID card and can also easily check the costs of your medications by using the "Check Your Drug Cost" tool by comparing your current prescription to other lower cost alternatives. Share this information with your physician to see if any of the lower cost alternatives are appropriate for you.

You can also save on certain non-covered drugs (e.g., over-the-counter medications) through the CVS RxSavingsPlus program, which is available to all employees regardless of whether you are enrolled in the CVS Caremark prescription drug plan (CVS plan). If enrolled in the CVS plan, discounts will automatically apply when your prescription is filled. If not enrolled in the CVS plan, you may register at **rxsavingsplus.com/eutf**.

Kaiser Permanente members: If you have not done so already, you'll need to register for a secure **kp.org** account in order to refill prescriptions online. You may also set up mail-order services when you visit Kaiser Permanente, or call the number on your prescription label.

What's New?

Effective July 1, 2024 (unless otherwise specified)

HMSA

1. Increased benefit maximum for orthodontic services for the treatment of orofacial anomalies from $5,500 to $6,900 under the EUTF and HSTA VB active plans.
2. Excluded out-of-network coverage of transplant evaluations and other organ transplants under the EUTF 80/20 active plan.
3. Changed coverage for Applied Behavior Analysis (ABA) services to 100% coverage under the EUTF HMO active plan.

CVS Caremark

4. Added a prior authorization requirement for anti-diabetic GLP-1 (e.g., Ozempic, Rybelsus, Trulicity, Victoza) and GIP/GLP-1 agonist agents (e.g., Mounjaro) effective July 1, 2023, to ensure appropriate prescribing for diabetes under the EUTF active plans.
5. Added quantity limits for anti-platelet products effective October 1, 2023, to the EUTF active plans. Existing members using anti-platelet products over the quantity limit will be grandfathered and will not be subject to these quantity limits.

Kaiser Permanente

6. Increased benefit maximum for orthodontic services for the treatment of orofacial anomalies from $5,500 to $6,898 under the EUTF and HSTA VB active plans.
7. Changed coverage for hearing aids to 80% coverage (one per hearing impaired ear every 36 months) based on the cost of the lowest priced model under the EUTF and HSTA VB active plans.

Premium Rate Changes

For information about the 2024-25 monthly premium rates that take effect July 1, 2024, see the 2024 Health Plan Premiums section, starting on page 18.

Your EUTF Benefits Coverage

Along with comprehensive medical and prescription drug coverage, EUTF offers dental, vision, and chiropractic benefits, and a 100% employer-paid life insurance policy for EUTF and HSTA VB active employees. For a snapshot of all your plan options:

- **EUTF employees:** See page 25.
- **HSTA VB employees:** See page 34.

2024 Health Plan Premiums

Effective July 1, 2024

ALL BUs AND EMPLOYEES EXCLUDED FROM ALL BARGAINING UNITS: ALL EMPLOYERS

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

BENEFIT PLAN	Type of Enrollment	Semi-monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
Medical Plans						
PPO – 90/10 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	$277.99	$555.98	$504.96	47.6%	$1,060.94
	Two-Party	$675.32	$1,350.64	$1,226.52	47.6%	$2,577.16
	Family	$861.13	$1,722.26	$1,563.62	47.6%	$3,285.88
PPO – 80/20 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	$168.33	$336.66	$504.96	60.0%	$841.62
	Two-Party	$408.84	$817.68	$1,226.52	60.0%	$2,044.20
	Family	$521.21	$1,042.42	$1,563.62	60.0%	$2,606.04
PPO – 75/25 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	$26.20	$52.40	$471.64	90.0%	$524.04
	Two-Party	$63.63	$127.26	$1,145.22	90.0%	$1,272.48
	Family	$81.10	$162.20	$1,459.74	90.0%	$1,621.94
HMO – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	$295.32	$590.64	$504.96	46.1%	$1,095.60
	Two-Party	$717.50	$1,435.00	$1,226.52	46.1%	$2,661.52
	Family	$914.98	$1,829.96	$1,563.62	46.1%	$3,393.58
HMO – Kaiser Permanente Comprehensive Medical, Prescription Drug, and Chiropractic	Self	$167.04	$334.08	$504.96	60.2%	$839.04
	Two-Party	$406.17	$812.34	$1,226.52	60.2%	$2,038.86
	Family	$518.70	$1,037.40	$1,563.62	60.1%	$2,601.02
HMO – Kaiser Permanente Standard Medical, Prescription Drug, and Chiropractic	Self	$26.03	$52.06	$468.50	90.0%	$520.56
	Two-Party	$63.25	$126.50	$1,138.44	90.0%	$1,264.94
	Family	$80.69	$161.38	$1,452.32	90.0%	$1,613.70
Supplemental Medical and Prescription Drug – Verdegard Administrators (formerly HMA)	Self	$6.94	$13.88	$20.80	60.0%	$34.68
	Two-Party	$12.37	$24.74	$37.08	60.0%	$61.82
	Family	$13.39	$26.78	$40.16	60.0%	$66.94
Dental Plan						
HDS Dental	Self	$7.38	$14.76	$22.12	60.0%	$36.88
	Two-Party	$14.76	$29.52	$44.26	60.0%	$73.78
	Family	$24.27	$48.54	$72.78	60.0%	$121.32
Vision Plan						
VSP Vision	Self	$0.84	$1.68	$2.52	60.0%	$4.20
	Two-Party	$1.57	$3.14	$4.68	59.8%	$7.82
	Family	$2.05	$4.10	$6.12	59.9%	$10.22
Life Insurance						
Securian Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

2024 Health Plan Premiums

Effective July 1, 2024

BU 05: ACTIVE EMPLOYEES FORMERLY UNDER THE HSTA VEBA

BENEFIT PLAN	Type of Enrollment	Semi-monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
Medical Plans						
HSTA VB – PPO – 90/10 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug, VSP Vision	Self	$216.95	$433.90	$458.98	51.4%	$892.88
	Two-Party	$525.91	$1,051.82	$1,112.26	51.4%	$2,164.08
	Family	$670.48	$1,340.96	$1,417.50	51.4%	$2,758.46
HSTA VB – PPO – 80/20 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug, VSP Vision	Self	$153.00	$306.00	$458.98	60.0%	$764.98
	Two-Party	$370.76	$741.52	$1,112.26	60.0%	$1,853.78
	Family	$472.50	$945.00	$1,417.50	60.0%	$2,362.50
HSTA VB – HMO – Kaiser Permanente Comprehensive Medical, Drug, Chiropractic, and VSP Vision	Self	$135.20	$270.40	$458.98	62.9%	$729.38
	Two-Party	$328.87	$657.74	$1,112.26	62.8%	$1,770.00
	Family	$420.38	$840.76	$1,417.50	62.8%	$2,258.26
Dental Plan						
HSTA VB – HDS Dental	Self	$8.09	$16.18	$24.28	60.0%	$40.46
	Two-Party	$16.19	$32.38	$48.54	60.0%	$80.92
	Family	$26.63	$53.26	$79.88	60.0%	$133.14
HSTA VB – HDS Supplemental Dental	Self	$3.78	$7.56	$11.32	60.0%	$18.88
	Two-Party	$7.55	$15.10	$22.66	60.0%	$37.76
	Family	$11.33	$22.66	$33.98	60.0%	$56.64
Vision Plan						
HSTA VB – VSP Vision	Self	$0.84	$1.68	$2.52	60.0%	$4.20
	Two-Party	$1.57	$3.14	$4.68	59.8%	$7.82
	Family	$2.05	$4.10	$6.12	59.9%	$10.22
Life Insurance						
HSTA VB – Securian Life Insurance	Employee	$0.00	$0.00	$4.12	100.0%	$4.12

General Health Plan Information

This section provides a general overview of how the different medical plan options work, including information about CVS Caremark prescription drug coverage for those enrolled in EUTF and HSTA VB medical plans through HMSA.

- **If you are eligible for and/or enrolled in an EUTF medical plan,** see pages 29-33 for summaries of your 2024–25 benefits coverage.
- **If you are eligible for and/or enrolled in an HSTA VB medical plan,** see pages 38-39 for a summary of your 2024–25 benefits coverage.

About the Medical Plans

EUTF and HSTA VB medical plans include prescription drug and chiropractic coverage. Employees are given a choice of medical plan options that vary in monthly premium cost and benefit plan design. Medical plan types include preferred provider organization (PPO) plans, health maintenance organization (HMO) plans, and a supplemental plan (for EUTF employees only).

Preferred Provider Organization (PPO) Plans

- EUTF HMSA 90/10, 80/20, and 75/25
- HSTA VB HMSA 90/10 and 80/20

A PPO plan is a medical plan that includes a network of preferred medical providers who have contracts with the insurance carrier. A PPO plan gives you the flexibility to visit the providers you choose—inside or outside the plan's network. Your out-of-pocket medical costs will be lower if you receive care from an in-network provider or facility. The plan title (e.g., 90/10) generally refers to the share of the cost by the health plan and member. For example, the 90/10 plan pays 90% of the eligible charges for most covered in-network services, and the member pays 10%.

Before making an appointment, ask if your medical provider is in your plan's network. If you use an out-of-network provider, your out-of-pocket costs may be higher. In addition to possible higher coinsurance, you will be responsible for the difference between the provider's billed charge and the plan's eligible charge (except for emergency services, air ambulance, and services from out-of-network providers received at an in-network facility). You will also often be responsible for submitting your own claims.

Health Maintenance Organization (HMO) Plans

- EUTF HMSA HMO
- EUTF Kaiser Permanente Comprehensive and Standard HMO
- HSTA VB Kaiser Permanente Comprehensive HMO

An HMO plan is a medical plan that uses a network of health care professionals and facilities associated with that HMO. Except in emergencies or in cases where you obtain a referral from your primary care physician (PCP), an HMO plan does not cover the cost of services you receive from doctors or other providers outside the HMO's network. With an HMO plan, there are no deductibles or claim forms. Generally, after a copayment for each office visit, most medical expenses are covered at 100%. You must select a PCP to coordinate your care.

Supplemental (Copayment/Coinsurance) Plan

- EUTF Verdegard Administrators, formally known as HMA, Supplemental Medical and Prescription Drug

The supplemental plan is designed for active EUTF employees with coverage under a non-EUTF medical and prescription drug plan. If you have a non-EUTF medical and prescription drug plan through your spouse/partner or another source, you can enroll in this plan. Eligible medical and prescription drug expenses that are not covered by the primary medical plan, such as copayments or coinsurance, are paid under this plan. You may enroll in the supplemental plan **only** if you have primary medical and prescription drug plan coverage not provided through the State or Counties. If you also have Medicare or Med-QUEST coverage, your Medicare or Med-QUEST Explanation of Benefits (EOB) is required for reimbursement.

Claims can easily be submitted online at **verdegard-hi.com/eutf**. All claim submissions require an EOB from your primary medical plan and Medicare/Med-QUEST or pharmacy receipts and labels for all prescription drug reimbursements. Claims may also be submitted by mail or fax. Please mail a claim form, along with any supporting EOBs or receipts, to Verdegard Claims Dept., P.O. Box 135005, Honolulu, HI 96801-5005. Please fax any claims to **1-808-951-4620**.

Please note:

- To ensure proper posting, please use a separate claim form for each covered member and for services incurred in different plan years.
- This supplemental plan does not cover chiropractic benefits.
- All reimbursement payments are made payable to the covered individual who receives the services. For all minors under the age of 18, reimbursement payments are made payable to the primary Subscriber of the plan.
- **NEW**: Now, you can sign up to receive your reimbursement payments by Automated Clearing House (ACH).

Remember: Refer to Your Carrier Benefit Guides

The following sections provide a summary of the health and life insurance plans offered to active employees. Complete information on plans can be obtained directly from the health insurance carriers, from the EUTF Member self-service portal at **eutfbenefits.hawaii.gov**, or from the EUTF website at **eutf.hawaii.gov**. If there is any discrepancy between the information provided in this guide and that contained in the carrier's benefit guide, the language in the carrier's benefit guide will take precedence.

Health Care Terms and Definitions

The following is a list of important health care terms and definitions.

Claim: A written request for payment of benefits for services covered by your health plan.

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

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): This federal law requires employers with 20 or more employees to offer the option of purchasing continuation of coverage to qualified beneficiaries who would otherwise lose group health insurance coverage as the result of a COBRA qualifying event.

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

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

Covered Services: These are health care services that your health plan pays for based on your plan benefits. If your plan covers a service, you may have to pay a coinsurance, copayment or deductible.

Deductible: The amount you must pay for covered services before your plan begins to pay. The deductible is based on a calendar year and renews every January 1. Under the EUTF HMSA PPO 75/25 medical plan, the deductible is $300 per individual or up to $900 for family plans and applies to services provided by both in-network and out-of-network providers. The deductible must be met on a claim-by-claim basis and cannot be paid in advance. The deductible does not apply to all services. For services provided by an out-of-network provider, only the amount you pay on the eligible charge will be credited toward the deductible. Any difference between the eligible charge and the actual charge will not be credited toward the deductible.

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

HIPAA (Health Insurance Portability and Accountability Act of 1996): A federal law that calls for confidentiality standards and requires covered entities (such as the EUTF) to maintain strict use and disclosure policies and procedures to safeguard a member's Protected Health Information (PHI).

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

Leave of Absence Without Pay (LWOP): An employer-approved period of leave during which the employee is not paid but continues to be a State or County employee.

Limiting Age (for Dependent Children): The age dependents are no longer eligible for coverage. The limiting age for medical and prescription drug coverage is 26 years. The limiting age for dependents under dental and/or vision plans is 19 years, or 24 if dependents are unmarried and full-time students.

Maximum Out-of-Pocket (MOOP): The most you pay during a calendar year before your health insurance plan starts to pay 100% for covered services. This limit includes deductibles, coinsurance, copayments, or similar charges. This limit does not include premiums, noncovered services such as taxes, charges in excess of the maximum allowable fee, and other plan expenses. The MOOP protects members from catastrophic financial losses.

Medicare: A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD) or Amyotropic Lateral Sclerosis (ALS).

Network: A group of providers that contract with an insurance carrier to provide health care products and/or services for treatment at a reduced or fixed fee.

Open Enrollment: An annual period during which employees may enroll or disenroll from plans, change from one plan to another, or add or remove dependents outside of experiencing a qualifying event.

Out-of-Network or Non-Participating Provider: A physician, hospital, pharmacy, laboratory, or other health care provider that is not contracted with your insurance carrier to provide services. When you receive services from a non-participating provider, you owe the plan's standard copayment or coinsurance plus the difference between the non-participating provider's charge for the service and your insurance carrier's eligible charge (except for emergency services, air ambulance, and services from out-of-network providers received at an in-network facility).

For example, under the HMSA 90/10 PPO medical plan, if the non-participating provider's charge for a primary care office visit is $120, the plan's eligible charge is $100, and the out-of-network coinsurance is 30%, the plan will pay $70 ($100 x 70%) and you would pay $50 ($30 coinsurance plus $20 for the excess of the actual charge over the eligible charge) plus applicable taxes. If the primary care provider was a participating provider, your total cost would be $10 plus applicable taxes.

Out-of-Pocket Cost: Costs paid by the member related to deductibles, copayments, coinsurance, and any noncovered services.

Plan Year: For active employees, a 12-month period starting July 1 and ending June 30 the following year.

Premiums: The semi-monthly or monthly cost of your health insurance. Premiums are primarily influenced by utilization of services by members, benefit plan design, and cost of health care.

Primary Care Provider (PCP): A health care professional (usually an internist, family/general practitioner, or pediatrician) who provides a range of services such as prevention, wellness, and treatment for common illnesses. PCPs treat health-related issues and may coordinate your care with specialists.

Provider: An approved health care professional or facility that provides treatment or service.

Qualifying Event: An event such as loss of coverage, disenroll due to enrollment in other coverage, marriage, divorce, or the birth or adoption of a child that allows enrollment changes to your health plans during the plan year.

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

Prescription Drug

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

Diabetic Supplies: Includes equipment and supplies used in the management and treatment of diabetes as prescribed by a physician. This includes blood glucose monitors, blood glucose test strips, lancet devices, and lancets.

Formulary: A list of preferred prescription drugs covered by a prescription drug plan. A formulary is also called a drug list or preferred drug list.

Generic: A prescription drug that has the same active ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration rates these drugs to be as safe and effective as brand-name drugs.

Maintenance Medication: Prescriptions taken for an extended period of time to treat chronic conditions such as high blood pressure, diabetes, heart disease, or high cholesterol. Typically, a physician may write a prescription for these medications in a 90-day supply.

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

EUTF Health Plan Options

The charts on the following pages outline the **EUTF medical and prescription drug plan options**. They are intended to provide a condensed summary of plan benefits. Certain limitations, restrictions, and exclusions apply to all insurance plans. Complete information on plans can be obtained directly from the health insurance carriers, from the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** or from the EUTF website at **eutf.hawaii.gov**. If there should be any discrepancy between the information provided in this guide and that contained in the carrier's benefit guide, the language in the carrier's benefit guide will take precedence.

For charts summarizing the HSTA VB medical and prescription drug plan options, see pages 38-39.

hmsa An Independent Licensee of the Blue Cross and Blue Shield Association	**Preferred Provider Organization (PPO) Plans** • HMSA PPO 90/10 Plan • HMSA PPO 80/20 Plan • HMSA PPO 75/25 Plan
KAISER PERMANENTE® hmsa An Independent Licensee of the Blue Cross and Blue Shield Association	**Health Maintenance Organization (HMO) Plans** • Kaiser Permanente HMO Comprehensive • Kaiser Permanente HMO Standard • HMSA EUTF HMO
CVS caremark® KAISER PERMANENTE®	**Prescription Drug Plans** • CVS Caremark Prescription Drug Plan • Kaiser Permanente Prescription Drug Plan
verdegard	**Supplemental Plan:** Verdegard Administrators (formerly HMA)
DELTA DENTAL HDS Hawaii Dental Service	**Dental Plan:** Hawaii Dental Service (HDS)
vsp vision care	**Vision Plan:** Vision Service Plan (VSP)
securian FINANCIAL™	**Life Insurance:** Securian Financial

About CVS Caremark Prescription Drug Coverage for EUTF Members

General Information

The prescription drug plan includes programs that offer a financial incentive for participants to use the generic equivalent (or preferred brand, in the case of EUTF plans) medication without compromising care, as these medications have the same level of effectiveness. For the EUTF plans, preferred medications are usually priced lower than other brand-name medications and have lower copayments.

To comply with the Affordable Care Act, certain preventive care drugs (when prescribed) are covered with no copayment. Please contact CVS Caremark for additional information on coverage for these preventive care drugs.

The generic forms of tamoxifene, raloxifene, exemestane and anastrozole are covered with no copayment for women 35 years or older when prescribed for primary prevention of breast cancer. If you are eligible for this benefit, please have your physician call CVS Caremark at **1-877-418-4130** to complete a copayment exception form on your behalf.

Web Service

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

Customer Care

For assistance with questions about your plan, finding a participating pharmacy, ordering a new ID card, refilling your mail order, etc., you may call CVS Caremark toll-free at **1-855-801-8263** to speak with a representative 24 hours a day, seven days a week, or you may visit their customer service office in downtown Honolulu at Pauahi Tower, 1003 Bishop Street, Suite 704, Monday through Friday from 7:45 a.m. to 4:30 p.m.

Coordination of Benefits

Some participants may be enrolled in additional prescription drug coverage outside their EUTF or HSTA VB benefits. If this applies to you, please contact CVS Caremark Customer Care at 1-855-801-8263 to advise if your EUTF plan is secondary. If your plan is secondary, be sure to let the pharmacy know by presenting both of your prescription drug ID cards, and confirm that the pharmacy can bill both plans. Please note that CVS Mail Order Pharmacy and some non-participating pharmacies do not have the capability to bill more than one insurance plan and thus, unable to coordinate benefits. You also have the option to send in a paper claim form for reimbursement (see next page). Please also note that Coordination of Benefits does not guarantee 100% coverage of your medication. All EUTF plan parameters and guidelines will still apply. Coverage under your non-EUTF drug plan does not imply coverage under the EUTF drug plan.

Required Documentation for Paper Claims

If you go to a participating pharmacy and present your CVS prescription drug ID card, you do not need to file a claim form. However, you will need to file a paper claim form if:

- Your CVS prescription drug ID card was not presented at the time your prescription was filled and/or the participating pharmacy could not confirm your plan enrollment.
- You filled your prescription at a non-participating pharmacy.

You will be responsible for paying the full cost of the drug at the time of purchase, and reimbursement will be limited to the eligible charge less the out-of-network copayment and coinsurance. Paper claims must be submitted to CVS Caremark within one year from the date of purchase. To download a paper

claim form, go to **caremark.com/portal/asset/ paperclaim_std_eng.pdf**.

You must include all original pharmacy receipts in order for your claim to process. Cash register receipts will only be accepted for diabetes supplies. **Pharmacy receipts** must include:

- Patient's name
- Date of fill
- Prescription number
- Name of medication
- Metric quantity
- Day supply
- Prescribing doctor's name or NPI number
- Pharmacy name and address or pharmacy NABP number

Completed paper claim reimbursement request form with patient signature should be mailed to:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Maintenance Medications

Maintenance medications are those prescriptions taken for an extended period of time to treat chronic conditions such as high blood pressure, diabetes, heart disease, or high cholesterol. Participants are allowed three 30-day initial fills at the retail pharmacy for each new medication or new dosage amount in order to determine if the medication or dosage is correct. Members are required to fill a 90-day supply thereafter. If filling a 90-day supply either at a Retail 90 pharmacy or through the mail-order pharmacy, the member saves by paying 2 times the 30-day supply copayment.

The Mail Order Program is voluntary. Overall, the cost to the plan is lowest when prescriptions for maintenance medications are filled through the mail-order pharmacy. To start mail order, contact CVS Caremark at **1-855-801-8263**.

Specialty Medications

Specialty medications are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Coverage depends on where your prescription is filled and whether your provider files the claim with HMSA or CVS. Generally, if filled at a pharmacy, coverage is provided under your prescription drug plan, and if filled elsewhere (e.g., an inpatient hospital facility, a hospital-based outpatient treatment center, doctor's office, etc.), coverage is provided under your medical plan. Present both your HMSA and CVS ID cards at your doctor's office or any provider facility to ensure coverage of your medication. Please note that there is no coordination of benefits for specialty drugs across EUTF HMSA medical and CVS prescription drug plans. For information about coverage under the HMSA medical plan, refer to HMSA's Guide to Benefits, or contact HMSA.

For assistance with specialty prescriptions or to locate a specialty network pharmacy, call **1-855-801-8263**. For assistance with ordering specialty prescriptions at CVS Specialty, call **1-800-896-1464**.

Specialty Benefit Under the CVS Caremark Prescription Drug Plan

The EUTF plans have adopted the Advanced Control Specialty Formulary (ACSF). ACSF requires the use of preferred specialty medications prescribed for the treatment of certain conditions. For coverage of specialty medications, your physician may call **1-808-254-4414** to obtain a prior authorization or submit a medical exception request. To view the CVS Caremark Specialty Drug List, visit **caremark.com/eutf**.

Medications that fall within a specialty tier will be subject to the applicable coinsurance, up to a maximum copayment per fill. Exception: Oral oncology medications that are considered specialty medications have a $30 copayment. Specialty copayments are also subject to a $2,500 maximum

out-of-pocket per person per calendar year.

Utilization Management Programs

In an ongoing effort to effectively manage the prescription drug benefit, certain medications are subject to clinical guidelines as part of the prescription benefit plan design. The drug benefit includes the following four clinical guidelines:

1. **Quantity Limitations** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies, and input, review, and approval from the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee.
2. **Generic Step Therapy Program (GSTP)** – The EUTF encourages the use of generic medications as an alternative to certain brand medications as an affordable and effective form of treatment for many health conditions. In an effort to promote use of generic medications, CVS Caremark has a generic step therapy program in place for all EUTF active employees. For certain brand drugs, GSTP may require that you try generic drug treatment(s) prior to the use of a brand drug. Please contact CVS Caremark Customer Care at **1-855-801-8263** for more information. Also see sections labeled Dispensed as Written (DAW 1&2) Program and Tier 1 Strategy below.
3. **Prior Authorization (PA)** – Clinical prior authorization is a special preapproval process to ensure that certain therapy treatments or supplies are medically necessary before they are covered by the plan.
4. **Specialty Guideline Management (SGM)** – SGM uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. All specialty medications require prior authorization. Physicians may call SGM at **1-808-254-4414** to obtain prior authorization.

Dispensed as Written (DAW 1&2) Program

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

Tier 1 Strategy

Under the Tier 1 program, targeted generic medications will be excluded from the plan, and the brand drug counterparts will process with a generic member copayment. For details on which drugs fall under Tier 1, please contact CVS Caremark Customer Care at **1-855-801-8263**.

Maximum Out-of-Pocket Under the CVS Caremark Prescription Drug Plan

The CVS Caremark prescription drug plan is bundled with the HMSA medical plan that you select. If you change from one HMSA medical plan to another during open enrollment, your drug maximum out-of-pocket (MOOP) may change on the effective date of your new plan selection.

All applicable in-network drug copayments and coinsurance are accumulated on a calendar-year basis toward an annual MOOP amount. Once the MOOP amount is met, you will no longer pay applicable copayments and coinsurances for covered prescription drugs while enrolled in that plan for the remainder of the calendar year. If you change to a plan with a higher MOOP amount, you are responsible for meeting the new MOOP level, but all prior applicable copayments and coinsurance paid within the same calendar year toward one CVS Caremark plan can be credited toward the new MOOP amount for the new plan. If you change to a plan with a lower MOOP amount, there are no refunds of copayments or coinsurance paid toward the higher MOOP of the prior plan that are over the amounts of the MOOP for the new plan. All in-network copayments and coinsurance paid are applied prospectively to the applicable MOOP amount based upon the plan the member is enrolled in at the time.

EUTF Medical Plan Summaries

EUTF Medical and Prescription Drug – PPO Plan Coverage

MEDICAL	HMSA 90/10 PPO Plan		HMSA 80/20 PPO Plan		HMSA 75/25 PPO Plan	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Calendar Year Deductible[2]	None	$100/person $300/family	None	$250/person $750/family	$300/person $900/family	
Calendar Year Maximum Out-of-Pocket Limit[2]	$2,000/person $4,000/family		$2,500/person $5,000/family		$5,000/person $10,000/family	
Physician Office Visit	10%	30%	20%	40%	25%[3]	40%
Online Care (through hmsaonlinecare.com)	No charge	Not covered	No charge	Not covered	No charge	Not covered
Urgent Care Visit	10%	30%	20%	40%	25%[3]	40%
Emergency Room	10%	10%[3]	20%	20%[3]	25%	25%
Ambulance Air	10%	10%[3]	20%	20%[3]	25%	25%
Ambulance Ground	10%	30%	20%	40%	25%	40%
Inpatient Hospital Services	10%	30%	20%	40%	25%	40%
Outpatient Surgery	10%	30%	20%	40%	25%	40%
Outpatient Testing, Lab, and X-Ray Services	10%	30%	20%	40%	**Lab:** 25%[3] **Diagnostic testing and X-ray:** 25%	40%
Annual Preventive Health Evaluation	No charge	No charge[3]	No charge	No charge[3]	No charge[3]	No charge[3]
Well-Child Office Visit	No charge	30%[3]	No charge	40%[3]	No charge[3]	40%[3]
Preventive Screening	No charge	30%	No charge	40%	No charge[3]	40%
Inpatient Mental Health	10%	30%	20%	40%	**Facility:** 25% **Physician visit:** 25%[3]	40%
Outpatient Mental Health	10%	30%	20%	40%	**Facility:** 25% **Physician visit:** 25%[3]	40%
Hearing Aids	10% 1 device per ear every 60 months	30%	20% 1 device per ear every 60 months	40%	25% 1 device per ear every 60 months	40%
Chiropractic Services (administered through American Specialty Health, Inc.)	$15 for up to 20 visits per calendar year	Not covered	$15 for up to 20 visits per calendar year	Not covered	$15 for up to 20 visits per calendar year	Not covered

1 If you receive services from an out-of-network provider, you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge, except for emergency services, air ambulance, and services from out-of-network providers received at an in-network facility.

2 Amounts paid toward the deductible and the maximum out-of-pocket are measured on a calendar-year basis. However, if your new plan effective July 1, 2023, is with the same carrier, the amounts paid January 1, 2023 – June 30, 2023, will apply to your new plan deductible and maximum out-of-pocket. No refunds will be issued.

3 Deductible does not apply.

EUTF Medical and Prescription Drug – PPO Plan Coverage

PRESCRIPTION DRUG	CVS Caremark[4] EUTF HMSA PPO Plans		
	In-Network Pharmacy	Out-of-Network Pharmacy[5]	Retail 90/Mail Order[6]
Calendar Year Maximum Out-of-Pocket Limit[7]	90/10 and 80/20 PPO Plans: $4,350/person, $8,700/family 75/25 PPO Plan: $3,150/person, $6,300/family		
Day Supply	30/60/90	30/60/90	30/60/90
Generic	$5/$10/$15	$5/$10/$15 + 20% of eligible charges	$5/$10/$10
Preferred Brand	$25/$50/$75	$25/$50/$75 + 20% of eligible charges	$25/$50/$50
Non-Preferred Brand	$50/$100/$150	$50/$100/$150 + 20% of eligible charges	$50/$100/$100
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20% of eligible charges	$5/$10/$10
Other Insulin	$25/$50/$75	$25/$50/$75 + 20% of eligible charges	$25/$50/$50
Preferred Diabetic Supplies	No charge	20% of eligible charges	No charge
Other Diabetic Supplies	$25/$50/$75	$25/$50/$75 + 20% of eligible charges	$25/$50/$50
Oral Contraceptives (up to a 12-month supply)	No charge	No charge	No charge
Specialty Drugs/ Injectables[7]	30-day supply only $2,500/person calendar year maximum out-of-pocket limit **Specialty generic:** 10% of eligible charges, up to $200/fill **Specialty preferred brand:** 20% of eligible charges, up to $300/fill **Specialty non-preferred brand:** 30% of eligible charges, up to $400/fill **Oral oncology:** $30		**Retail 90:** 30-day supply only **Mail:** Not covered

4 This plan is the prescription drug coverage for the HMSA PPO medical plans and is administered by CVS Caremark.

5 If you receive services from an out-of-network pharmacy, you are responsible for the copayment + coinsurance and any cost difference between the actual and the eligible charge. These out-of-network costs are not applicable to the annual maximum out-of-pocket (MOOP). Mail order is not a benefit through out-of-network vendors.

6 For more information on Retail 90 and Mail Order, please call CVS Caremark at **1-855-801-8263**.

7 Applicable copayments and caps for specialty medications apply and are counted toward the total annual maximum out-of-pocket.

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

EUTF Medical Plan Summaries

EUTF Medical and Prescription Drug – HMO Plan Coverage

MEDICAL	Kaiser Permanente Comprehensive HMO[1]	Kaiser Permanente Standard HMO[1]	HMSA HMO
Calendar Year Deductible	None	None	None
Calendar Year Maximum Out-of-Pocket Limit[2]	$2,000/person $6,000/family	$2,500/person $7,500/family	$1,500/person $3,000/family
Physician Office Visit	$15	$20	$15
Online Care (through kp.org or hmsaonlinecare.com)	No charge	No charge	No charge
Urgent Care Visit	$15 (in area) 20% (out of area)	$20 (in area) 20% (out of area)	$15
Emergency Room	$50	$100	$100
Ambulance Air	20%	20%	20%
Ambulance Ground	20%	20%	20%
Inpatient Hospital Services	No charge	15%	No charge
Outpatient Surgery	$15	**Medical Office:** $20 **Ambulatory Surgery Center:** 15%	**Medical Office:** $15 **Ambulatory Surgery Center:** No charge
Outpatient Testing, Lab, and X-Ray Services	$15/day	**Basic lab and imaging:** $20 **Specialty lab and imaging:** 20% **Diagnostic testing:** 20%	**Lab:** No charge **Diagnostic testing:** No charge **X-ray:** $15 per X-ray
Annual Physical Exam	No charge	No charge	No charge
Well-Child Office Visit	No charge	No charge	No charge
Preventive Screening	No charge	No charge	No charge
Inpatient Mental Health	No charge	15%	No charge
Outpatient Mental Health	$15	$20	Facility: No charge Physician Services: $15
Hearing Aids	20% of charges for 1 device per ear every 36 months	20% of charges for 1 device per ear every 36 months	20% for 1 device per ear every 60 months
Chiropractic Services (administered through American Specialty Health, Inc.)	$15 for up to 20 visits per calendar year	$15 for up to 20 visits per calendar year	$15 for up to 20 visits per calendar year

1 **Kaiser Permanente Members only:**

a. Except for certain situations described in your Group Agreement and Guide to Your Health Plan, all claims, disputes, or causes of action arising out of or related to your Group Medical and Hospital Service Agreement, its performance, or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your Group Medical and Hospital Service Agreement.

b. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

2 **HMSA HMO Members:** Amounts paid toward the maximum out-of-pocket are measured on a calendar-year basis. However, if your new plan effective July 1, 2023, is with the same carrier, the amounts paid January 1, 2023 – June 30, 2023, will apply to your new plan maximum out-of-pocket. No refunds will be issued.

Kaiser Permanente Members: Amounts paid toward the maximum out-of-pocket, including both medical and prescription drug costs, are measured on a calendar-year basis. However, if your new plan effective July 1, 2023, is with the same carrier through EUTF, the amounts paid January 1, 2023 – June 30, 2023, will apply to your new plan maximum out-of-pocket. No refunds will be issued.

EUTF Medical and Prescription Drug – HMO Plan Coverage

PRESCRIPTION DRUG	Kaiser Permanente Comprehensive HMO		Kaiser Permanente Standard HMO		CVS Caremark/HMSA HMO[4]	
		Mail Order		Mail Order	HMO Network	Retail 90 & Mail Order[5]
Calendar Year Maximum Out-of-Pocket Limit	Applies toward the medical maximum out-of-pocket limit		Applies toward the medical maximum out-of-pocket limit		$4,350/person $8,700/family	
Day Supply	30/60/90		30/60/90		30/60/90	
Generic	**Tier 1[3]:** $5/$10/$15 **Tier 2[3]:** $10/$20/$30	**Tier 1[3]:** $5/$10/$10 **Tier 2[3]:** $10/$20/$20	**Tier 1[3]:** $5/$10/$15 **Tier 2[3]:** $15/$30/$45	**Tier 1[3]:** $5/$10/$10 **Tier 2[3]:** $15/$30/$30	$5/$10/$15	$5/$10/$10
Preferred Brand	$35/$70/$105	$35/$70/$70	$50/$100/$150	$50/$100/$100		$25/$50/$50
Non-Preferred Brand						$50/$100/$100
Preferred Insulin	$35/$70/$105	Not available through Mail Order	$50/$100/$150	Not available through Mail Order		$5/$10/$10
Other Insulin	**Generic:** $10/$20/$30		**Generic:** $15/$30/$45			$25/$50/$50
Preferred Diabetic Supplies	Appropriate drug copays apply		50% of applicable charges		No charge	
Other Diabetic Supplies						$25/$50/$50
Oral Contraceptives (up to a 12-month supply)	No charge		No charge		No charge	
Specialty Drugs/ Injectables	**Retail:** $75 (up to a 30-day supply) **Mail:** Not all specialty drugs can be mailed **Oral Oncology:** No charge		**Retail:** $75 (up to a 30-day supply) **Mail:** Not all specialty drugs can be mailed **Oral Oncology:** Applicable drug copays apply		30-day supply only $2,500/person calendar year maximum out-of-pocket limit **Specialty generic:** 10% of eligible charges, up to $200/fill **Specialty preferred brand:** 20% of eligible charges, up to $300/fill **Specialty non-preferred brand:** 30% of eligible charges, up to $400/fill **Oral Oncology:** $30	**Retail 90:** 30-day supply only **Mail:** Not covered

3 Tier 1 drugs are Generic Maintenance Drugs, which are specific Generic Drugs to treat chronic conditions. Tier 2 drugs are Other Generic Drugs.

4 This plan is the prescription drug coverage for the HMSA HMO medical plans and is administered by CVS Caremark. Applicable copayments and caps for specialty medications apply and are counted toward the total annual maximum out-of-pocket.

5 For more information on Retail 90 and Mail Order, please call CVS Caremark at **1-855-801-8263**.

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

EUTF Medical and Prescription Drug – Supplemental Plan Coverage

MEDICAL	Verdegard Supplemental Plan
Plan Year Benefit Maximum	All Services: $2,750 per person, including the Prescription Drug Sublimit listed below
Physician Office Visit	Copayment/Coinsurance covered
Urgent Care Visit	Copayment/Coinsurance covered
Emergency Room	Copayment/Coinsurance covered
Ambulance Air	Copayment/Coinsurance covered
Ambulance Ground	Copayment/Coinsurance covered
Inpatient Hospital Services	Copayment/Coinsurance covered
Outpatient Surgery	Copayment/Coinsurance covered
Outpatient Testing, Lab, and X-Ray Services	Copayment/Coinsurance covered
Annual Physical Exam	Copayment/Coinsurance covered
Well-Child Office Visit	Copayment/Coinsurance covered
Preventive Screening	Copayment/Coinsurance covered
Inpatient Mental Health	Copayment/Coinsurance covered
Outpatient Mental Health	Copayment/Coinsurance covered
PRESCRIPTION DRUG	**Verdegard Supplemental Plan**
Plan Year Benefit Maximum Prescription Drug Sublimit	$250 per person
Prescription Drug Copayment Reimbursement	Shall not exceed $20 per 30-day supply, $40 per 60-day supply, and $60 per 90-day supply Count toward the Plan Year Benefit Maximum

This supplemental medical and prescription drug plan is always the secondary payer. All covered services must first be paid by the primary medical and prescription drug plan before receiving any supplemental plan reimbursements. This plan does not coordinate benefits, preauthorizations are not required, and ID cards will not be provided.

Please contact the EUTF Customer Service team at **1-866-437-1992** for any assistance. Visit **verdegard-hi.com/eutf** for all plan documents and additional helpful information.

HSTA VB Health Plan Options

HSTA VB plan options were created for HSTA employees who were enrolled in the HSTA VEBA active plan(s) prior to January 1, 2011. Enrollment in HSTA VB health plans is limited to those currently enrolled and who have maintained continuous enrollment under HSTA VB health and/or life insurance plans. HSTA VB members must submit changes through the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** or complete an EC-1H enrollment form if making changes. New employees **may not** enroll in HSTA VB health plans.

Disenrolling From HSTA VB Plans

HSTA VB members may disenroll from HSTA VB plans but will not be allowed to re-enroll in HSTA VB plans in the future. Members who wish to leave HSTA VB plans and switch to EUTF plans during open enrollment must submit changes through the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** or complete an EC-1 enrollment form.

HSTA VB and EUTF Plan Enrollment

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

HSTA VB Health Plan Options

The charts on the following pages outline the **HSTA VB medical and prescription drug plan options**. They are intended to provide a condensed summary of plan benefits. Certain limitations, restrictions, and exclusions apply to all insurance plans. Complete information on plans can be obtained directly from the health insurance carriers, from the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** or from the EUTF website at **eutf.hawaii.gov**. If there should be any discrepancy between the information provided in this guide and that contained in the carrier's benefit guide, the language in the carrier's benefit guide will take precedence.

For charts summarizing the EUTF medical and prescription drug plan options, see pages 29-33.

hmsa An Independent Licensee of the Blue Cross and Blue Shield Association	**Preferred Provider Organization (PPO) Plans** • HMSA PPO 90/10 Plan • HMSA PPO 80/20 Plan
KAISER PERMANENTE	**Health Maintenance Organization (HMO) Plans** • Kaiser Permanente HMO Comprehensive
CVS caremark KAISER PERMANENTE	**Prescription Drug Plans** • CVS Caremark Prescription Drug Plan • Kaiser Permanente Prescription Drug Plan
DELTA DENTAL HDS Hawaii Dental Service	**Dental Plan:** Hawaii Dental Service (HDS) • HSTA VB Dental Plan • HSTA VB Supplemental Plan
vsp vision care	**Vision Plan:** Vision Service Plan (VSP)
securian FINANCIAL™	**Life Insurance:** Securian Financial

Note: *The enrollment of HSTA VEBA members into these health plans is a result of a State court ruling and does not create any constitutional or contractual right to the benefits provided by those plans. If the ruling is overturned or modified, the EUTF reserves the right to move former HSTA VEBA members into regular EUTF plans.*

About CVS Caremark Prescription Drug Coverage for HSTA VB Members

General Information

The prescription drug plan includes programs that offer a financial incentive for participants to use the generic equivalent medication without compromising care, as these medications have the same level of effectiveness.

To comply with the Affordable Care Act, certain preventive care drugs (when prescribed) are covered with no copayment. Please contact CVS Caremark for additional information on coverage for these preventive care drugs.

The generic forms of tamoxifen, raloxifene, exemestane and anastrozole are covered with no copayment for women 35 years or older when prescribed for primary prevention of breast cancer. If you are eligible for this benefit, please have your physician call CVS Caremark at **1-877-418-4130** to complete a copayment exception form on your behalf.

Web Service

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

Customer Care

For assistance with questions about your plan, finding a participating pharmacy, ordering a new ID card, refilling your mail order, etc., you may call CVS Caremark toll-free at **1-855-801-8263** to speak with a representative 24 hours a day, seven days a week, or you may visit their customer service office in downtown Honolulu at Pauahi Tower, 1003 Bishop Street, Suite 704, Monday through Friday from 7:45 a.m. to 4:30 p.m.

Coordination of Benefits

Some participants may be enrolled in additional prescription drug coverage outside their EUTF or HSTA VB benefits. If this applies to you, please contact CVS Caremark Customer Care at **caremark.com/eutf** to advise if your HSTA VB plan is secondary. If your plan is secondary, be sure to let the pharmacy know, and confirm that the pharmacy can bill both plans. Please note that CVS Mail Order Pharmacy and some non-participating pharmacies do not have the capability to bill more than one insurance plan and thus, unable to coordinate benefits. You also have the option to send in a paper claim form for reimbursement (see below). Please also note that Coordination of Benefits does not guarantee 100% coverage of your medication. All HSTA VB plan parameters and guidelines will still apply. Coverage under your non-HSTA VB drug plan does not imply coverage under the HSTA VB drug plan.

Required Documentation for Paper Claims

If you go to a participating pharmacy and present your CVS prescription drug ID card, you do not need to file a claim form. However, you will need to file a paper claim form if:

- Your CVS prescription drug ID card was not presented at the time your prescription was filled and/or the participating pharmacy could not confirm your plan enrollment.
- You filled your prescription at a non-participating pharmacy.

You will be responsible for paying the full cost of the drug at the time of purchase, and reimbursement will be limited to the eligible charge less the out-of-network copayment and coinsurance. Paper claims must be submitted to CVS Caremark within one year from the date of purchase. To download a paper claim form, go to **caremark.com/portal/asset/paperclaim_std_eng.pdf**.

You must include all original pharmacy receipts in order for your claim to process. Cash register receipts will only be accepted for diabetes supplies. **Pharmacy receipts** must include:

- Patient's name
- Date of fill
- Prescription number
- Name of medication
- Metric quantity
- Day supply
- Prescribing doctor's name or NPI number
- Pharmacy name and address or pharmacy NABP number

Completed paper claim reimbursement request form with patient signature should be mailed to:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Maintenance Medications

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

The Mail Order Program is voluntary. Overall, the cost to the plan is lowest when prescriptions for maintenance medications are filled through the mail order pharmacy. To start mail order, contact CVS Caremark at **1-855-801-8263**.

Specialty Medications

Specialty medications are high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Coverage depends on where your prescription is filled and whether your provider files the claim with HMSA or CVS. Generally, if filled at a pharmacy, coverage is provided under your prescription drug plan, and if filled elsewhere (e.g., an inpatient hospital facility, a hospital-based outpatient treatment center, doctor's office, etc.), coverage is provided under your medical plan. Present both your HMSA and CVS ID cards at your doctor's office or any provider facility to ensure coverage of your medication. Please note that there is no coordination of benefits for specialty drugs across HSTA VB HMSA medical and CVS prescription drug plans. For information about coverage under the HMSA medical plan, refer to HMSA's Guide to Benefits, or contact HMSA.

For assistance with specialty prescriptions or to locate a specialty network pharmacy, call **1-855-801-8263**. For assistance with ordering specialty prescriptions at CVS Specialty, call **1-800-896-1464**.

Utilization Management Programs

In an ongoing effort to effectively manage the prescription drug benefit, certain medications are subject to clinical guidelines as part of the prescription benefit plan design. The drug benefit includes the following four clinical guidelines:

1. **Quantity Limitations** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies, and input, review, and approval from the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee.
2. **Generic Step Therapy Program (GSTP)** – The EUTF encourages the use of generic medications as an alternative to certain brand medications as an affordable and effective form of treatment for many health conditions. In an effort to promote use of generic medications, CVS Caremark has a generic step therapy program in place for all HSTA VB active employees. For certain brand

drugs, GSTP may require that you try generic drug treatment(s) prior to the use of a brand drug. Please contact CVS Caremark Customer Care at **1-855-801-8263** for more information. Also see section labeled Dispensed as Written (DAW 2) Program on the below.

3. **Prior Authorization (PA)** – Clinical prior authorization is a special pre-approval process to ensure that certain therapy treatments or supplies are medically necessary before they are covered by the plan.
4. **Specialty Guideline Management (SGM)** – SGM uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. All specialty medications require prior authorization. Physicians may call SGM at **1-808-254-4414** to obtain prior authorization.

Dispensed as Written (DAW 2) Program

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

Maximum Out-of-Pocket Under the CVS Caremark Prescription Drug Plan

The CVS Caremark prescription drug plan is bundled with the HMSA medical plan that you select. If you change from one HMSA medical plan to another during open enrollment, your drug maximum out-of-pocket (MOOP) may change on the effective date of your new plan selection.

All applicable in-network drug copayments and coinsurance are accumulated on a calendar-year basis toward an annual MOOP amount. Once the MOOP amount is met, you will no longer pay applicable copayments and coinsurances for covered prescription drugs while enrolled in that plan for the remainder of the calendar year. If you change to a plan with a higher MOOP amount, you are responsible for meeting the new MOOP level, but all prior applicable copayments and coinsurance paid within the same calendar year toward one CVS Caremark plan can be credited toward the new MOOP amount for the new plan. If you change to a plan with a lower MOOP amount, there are no refunds of copayments or coinsurance paid toward the higher MOOP of the prior plan that are over the amounts of the MOOP for the new plan. All in-network copayments and coinsurance paid are applied prospectively to the applicable MOOP amount based upon the plan the member is enrolled in at the time.

HSTA VB Medical Plan Summaries

HSTA VB Medical and Prescription Drug – PPO and HMO Plan Coverage

MEDICAL	HMSA 90/10 PPO Plan		HMSA 80/20 PPO Plan		Kaiser Permanente Comprehensive HMO Plan[1]
	In-Network	Out-of-Network[2]	In-Network	Out-of-Network[2]	HMO Network
Calendar Year Deductible[3]	None	$100/person $300/family	None		None
Calendar Year Maximum Out-of-Pocket Limit[3]	$2,000/person $4,000/family		$2,500/person $5,000/family		$2,000/person $6,000/family
Physician Office Visit	10%	30%	20%		$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge	Not covered	No charge	Not covered	No charge
Urgent Care Visit	10%	30%	20%		$15 (in area) 20% (out of area)
Emergency Room	10%	10%[4]	20%		$50
Ambulance Air	10%	10%[4]	20%		20%
Ambulance Ground	10%	30%	20%		20%
Inpatient Hospital Services	10%	30%	20%		No charge
Outpatient Surgery	10%	30%	20%		$15
Outpatient Testing, Lab, and X-Ray Services	10%	30%	**Lab:** No charge **Diagnostic testing and X-ray:** 20%		$15 per day
Annual Physical Exam	No charge	No charge[4]	No charge		No charge
Well-Child Office Visit	No charge	30%[4]	No charge		No charge
Preventive Screening	No charge	30%	No charge		No charge
Inpatient Mental Health	10%	30%	20%		No charge
Outpatient Mental Health	10%	30%	20%		$15
Hearing Aids	10% 1 device per ear every 60 months	30%	20% 1 device per ear every 60 months		20% 1 device per ear every 36 months
Chiropractic Services (administered through American Specialty Health, Inc.)	$12 for up to 20 visits per calendar year	Not covered	$12 for up to 20 visits per calendar year	Not covered	$12 for up to 20 visits per calendar year

1 **Kaiser Permanente Members only:**

a. Except for certain situations described in your Group Agreement and Guide to Your Health Plan, all claims, disputes, or causes of action arising out of or related to your Group Medical and Hospital Service Agreement, its performance, or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your Group Medical and Hospital Service Agreement.

b. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

2 **HMSA Members:** If you receive services from an out-of-network provider, you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge, except for emergency services, air ambulance, and services from out-of-network providers received at an in-network facility.

3 Amounts paid toward the deductible and the maximum out-of-pocket are measured on a calendar-year basis. However, if your new plan effective July 1, 2023, is with the same carrier, the amounts paid January 1, 2023 – June 30, 2023, will apply to your new plan deductible and maximum out-of-pocket. No refunds will be issued.

4 Deductible does not apply.

HSTA VB Medical and Prescription Drug – PPO and HMO Plan Coverage

PRESCRIPTION DRUG	CVS Caremark[5] HSTA VB HMSA PPO Plans		Kaiser Permanente Comprehensive HMO Plan	
	In-Network Pharmacy/ Mail Order[7]	Out-of-Network Pharmacy[6]	HMO Network	Mail Order[7]
Calendar Year Maximum Out-of-Pocket Limit	$4,350/person $8,700/family		Applies toward the medical maximum out-of-pocket	
Day Supply	30/60/90	30/60/90	30/60/90	
Generic	$5/$9/$9	$5/$9/$9 + 30% of eligible charges	$10/$20/$30	$10/$20/$20
Brand	$15/$27/$27	$15/$27/$27 + 30% of eligible charges	$10/$20/$30	$10/$20/$20
Insulin	$5/$9/$9	$5/$9/$9 + 30% of eligible charges	$10/$20/$30	Not available through Mail Order
Diabetic Supplies	No charge	No charge	50% of eligible charges	
Oral Contraceptives (up to a 12-month supply)	No charge	No charge	No charge	
Oral Oncology	No charge	30% of eligible charges	No charge	

5 This plan is the prescription drug coverage for the HMSA PPO medical plans and is administered by CVS Caremark.

6 If you receive services from an out-of-network pharmacy, you are responsible for the copayment + coinsurance and any cost difference between the actual and the eligible charge. These out-of-network costs are not applicable to the annual maximum out-of-pocket (MOOP). Please note that specialty medications and injectables are covered under this plan and are subject to the applicable generic or preferred-brand copayment. Mail order is not a benefit through out-of-network vendors.

7 For more information on Mail Order, please call CVS Caremark at **1-855-801-8263** or Kaiser Permanente at **1-808-643-7979**.

Please note: Medications prescribed for treatment that are not approved by the Food and Drug Administration (FDA) are excluded from the plan.

Dental Benefits

Your dental benefits are provided by Hawaii Dental Service (HDS), and summaries of the plan benefits are shown in the table that follows.

For full plan details, including a plan brochure, visit the HDS dedicated EUTF page at **hawaiidentalservice.com/eutf**.

In-Network and Out-of-Network Dentists

To maximize your benefits and help minimize your out-of-pocket costs, it's best to visit an HDS dentist. To find an HDS dentist, you can search online at **hawaiidentalservice.com/eutf** or contact the HDS Customer Service team.

If you choose to have services performed by a dentist that is not part of the HDS provider network (an out-of-network dentist), you are responsible for the difference between the dentist charges and the amount paid by HDS in accordance with your plan. In most cases, you will need to pay in full at the time of service. The out-of-network dentist will render services and may provide you with the completed claim form (universal ADA claim form) to submit to HDS. You can mail the completed claim form for processing to:

HDS – Dental Claims
900 Fort Street Mall, Suite 1900
Honolulu, HI 96813-3705

HDS Online

Access your online account at the HDS dedicated EUTF page: **hawaiidentalservice.com/eutf**. Through your HDS online account, you can check on your eligibility for services, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, and download benefit statements from the convenience of your home computer or mobile device.

Register to access your HDS account online:

- Go to **hawaiidentalservice.com/eutf**.
- Click on **Login to EUTF Member Portal** to sign in or register for an online account.
- Follow the directions on-screen to create a new account.
- Complete the **Account Registration** form.
- Select **Yes** to **Request electronic Explanation of Benefits**.

HDS will then send you an email to activate your account. Please be sure to click on the link.

Please note that HDS members 18 years and older must register for their own account.

Dental Benefits Coverage Charts

EUTF, HSTA VB, and HSTA VB Supplemental Dental Plans

DENTAL BENEFIT	EUTF and HSTA VB	HSTA VB Supplemental	
Plan Maximum	$2,000	$750	
Deductible per Plan Year (July 1 – June 30)	$50/person	None	Does not apply to benefits covered at 100% and orthodontics
	Plan Covers	**Plan Covers**	**Frequency/Time Limitations**
Diagnostic			
Examinations	100%	50%	2 per calendar year
Bitewing X-Rays	100%	50%	2 per calendar year through age 14 1 per calendar year ages 15 and older
Other X-Rays	100%	50%	Full mouth X-rays limited to 1 every 5 years
Preventive			
Cleanings Additional cleanings or gum maintenance covered at 100% for expectant mothers and members with a history of cancer treatment (chemotherapy or radiation), diabetes, Sjögren's syndrome, stroke, heart attack, congestive heart failure, kidney failure, or organ transplant	100%	50%	2 per calendar year
Fluoride Additional fluoride treatments covered at 100% for members with a history of certain cancers, Sjögren's syndrome, or at medical risk for cavities	100%	50%	**EUTF:** 2 per calendar year through age 19 **HSTA VB and HSTA VB Supplemental:** 1 per calendar year through age 19
Silver Diamine Fluoride (SDF)	100%	50%	Up to 6 teeth per service date and fillings covered after 30 days of SDF treatment
Space Maintainers	100%	50%	Through age 17
Sealants	100%	50%	Through age 18 1 treatment per tooth per lifetime to permanent molars with no prior fillings on biting surfaces
Basic Care			
Fillings	80%	45%	Silver fillings; White-colored fillings limited to front teeth. White fillings on back teeth will be processed as the alternate benefit of the metallic equivalent; the patient is responsible for the cost difference up to the amount charged by the dentist.
Root Canals	80%	45%	
Gum/Bone Surgeries and Maintenance	80%	45%	Cleaning (maintenance) for gum disease limited to 2 per calendar year after qualifying gum treatment, where qualifying gum treatment is one or more of the following: • Root Planing and Scaling – 1 every 2 years per quadrant • Gum/Bone Surgeries – 1 every 3 years per quadrant
Oral Surgeries	80%	50%	

DENTAL BENEFIT	EUTF and HSTA VB	HSTA VB Supplemental	
	Plan Covers	Plan Covers	Frequency/Time Limitations
Major Care			
Crowns	60%*	45%	1 every 5 years per tooth when teeth cannot be restored with silver or white fillings Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent; the patient is responsible for the cost difference up to the amount charged by the dentist.
Fixed Bridges and Dentures	60%*	45%	1 every 5 years per tooth ages 16 and older
Implants	60%*	50%	**EUTF:** 1 every 5 years per tooth ages 19 and older **HSTA VB and HSTA VB Supplemental:** 1 every 5 years per tooth ages 16 and older. Implants are covered as an alternate benefit when one tooth is missing between two natural teeth.
Other Services			
Adjunctive General Services	80%	45%	
Athletic Mouth Guards	80%	45%	1 every 24 months through age 18
Emergency Treatment of Dental Pain (Palliative Treatment)	100%	50%	1 per visit per dental office for relief of pain
Orthodontics	50%	100%	**EUTF and HSTA VB:** Maximum amount payable by HDS for an eligible patient shall be $1,000 lifetime per case, paid in eight quarterly payments of $125. **HSTA VB Supplemental:** Maximum amount payable by HDS for an eligible patient shall be $750 lifetime per case, paid in eight quarterly payments of $93.75. Orthodontic services are not covered: • If services were started prior to the date the patient became eligible under this employer's plan. • If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. • If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.

* Coverage for these services is available after a waiting period of 12 months of continuous enrollment in the plan. If a subscriber has met the 12-month waiting period, his/her dependents will have met the waiting period requirement as well.

For the Dental Benefits Summary charts that list other covered services, limitations, and exclusions, visit the HDS dedicated EUTF page (**hawaiidentalservice.com/eutf**). Scroll down to download the appropriate Dental Plan Benefits Brochure for your group (EUTF Actives, HSTA VB Actives, HSTA VB Supplemental Actives).

Vision Benefits

Your vision benefits are provided by Vision Service Plan (VSP), and a summary of the plan's benefits is shown in the table that follows.

In-Network and Out-of-Network Providers

You get the best value from your VSP benefit when you visit a VSP doctor. If you see a non-VSP provider, you'll typically pay more out of pocket. You'll pay the provider in full and have 12 months to submit a claim to VSP for partial reimbursement, less plan copayments. Before seeing an out-of-network provider, call VSP at **1-866-240-8420**, or go online at **vsp.com** to search for a VSP doctor near you.

No ID Cards

There are no ID cards issued for VSP members. Simply notify your vision provider that you are a VSP member, and VSP providers will file a claim to VSP. You can download and print an ID card by setting up an online account at **vsp.com**.

VSP.com

Register at **vsp.com** to check your eligibility status for services, view your personalized benefit information, find a VSP doctor (nationwide), and get a Vision Benefit Statement detailing your past service. If you want an ID card for your reference, you can download and print one or bring up an electronic ID card on your smartphone!

To register, follow these simple steps:

1. Visit **vsp.com**.
2. Click on **CREATE AN ACCOUNT** at the top of the page.
3. Enter the member's SSN or member ID number.
4. Enter the member's first and last name.
5. Enter the member's date of birth.
6. Click **CONTINUE**.
7. Follow the steps to create a username and password.

Extra Discounts and Savings From VSP Providers

Glasses and Sunglasses

- Average 35%–40% savings on lens enhancements (such as tints, progressive lenses, anti-scratch coatings, etc.)*
- 30% off additional glasses and sunglasses, including lens enhancements, from the same VSP doctor on the same day as your exam, or 20% off from any VSP doctor within 12 months of your last exam

Contact Lenses

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

Laser Vision Correction

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

Retinal Screening

- Maximum $39 copay for routine retinal screening as an enhancement to your annual eye exam*

* Discounts not applicable at retail locations such as Costco, Walmart, and Sam's Club

Essential Medical Eye Care

Essential Medical Eye Care is supplemental coverage (in coordination with your medical coverage) for urgent and medical eye care. Services include:

- Fully covered retinal screening for members with diabetes
- Treatment of pink eye, eye injury, foreign body removal, and sudden changes in vision
- Services to treat and monitor ongoing conditions, such as dry eye, diabetic eye disease, glaucoma, and cataracts

VISION SERVICE PLAN (VSP)				
VISION BENEFIT	**Frequency**	**In-Network**	**In-Network Extra Discounts/Savings***	**Out-of-Network Plan Pays**
Exam	Every plan year	$10 copay	**Retinal screening:** $39 copay max	Up to $45
Prescription Glasses		$25 copay	N/A	
Frame	Every other plan year	$150 allowance	20% off out-of-pocket cost	Up to $47
Lenses				
Single-vision lenses	Every plan year	Included in $25 copay	**Lens enhancements:** Average 30-40% savings **Additional glasses and sunglasses:** 30% off from the same VSP doctor on the same day as your exam or 20% off from any VSP doctor within 12 months of your last exam	Up to $45
Lined bifocal lenses				Up to $65
Lined trifocal lenses				Up to $85
Standard progressive lenses				Up to $85
Premium progressive lenses		$80–$90 copay		
Custom progressive lenses		$120–$160 copay		
Lenticular lenses		No charge		Up to $125
Polycarbonate lenses for dependent children up to age 18		No charge		Not covered
UV protection		No charge		
Contact Lenses (instead of glasses)				
Contact lenses fitting and evaluation	Every plan year	$60 copay max	15% off	Not covered
Contact lenses (elective)		$130 allowance	N/A	Up to $105
Contact lenses (medically necessary)		No charge	N/A	Up to $210
Essential Medical Eye Care				
Retinal screening for members with diabetes	As needed	No charge	N/A	Not covered
Additional exams and services to treat urgent and medical eye care		$20 per exam	N/A	Not covered
Laser Vision Correction		Not covered	Average 15% off the regular price or 5% off the promotional price	Not covered

* Discounts not applicable at retail locations such as Costco, Walmart, and Sam's Club

Life Insurance Benefits

Your life insurance benefit is provided through Securian Financial and is $33,770 for active employees effective July 1, 2023.

Benefits will be reduced once you turn age 65 as follows:

- $21,951 for participants age 65 through 69
- $15,197 for participants age 70 through 74
- $10,131 for participants age 75 through 79
- $6,754 for participants age 80 and over

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

- **Conversion:** If your life insurance policy ends due to your retirement or the termination of your employment, you may convert your group term life coverage to an individual whole life insurance policy within the first 31 days after either event. You don't need to provide evidence of good health. If the life insurance policy is terminated, you may be eligible for a limited conversion—of up to $10,000—if you were covered under the policy for five years prior to the policy termination date.
- **Portability:** This provision allows a terminated participant to continue their life insurance at a group discounted rate instead of an individual rate, provided they meet the eligibility requirements. You must apply for portability of your life insurance coverage within 31 days after your employment ends.
- **Accelerated benefit:** You may receive an early lump-sum payment of 100% of your life insurance benefit if a physician has deemed you terminally ill with a life expectancy of less than 12 months.
- **Repatriation benefit:** If you die at least 200 miles from home, this additional benefit (equal to 10% of your life insurance amount) is available for the preparation and transportation of mortal remains.
- **Lifestyle benefits:** You have automatic access to a suite of additional services and resources, at no additional fee or required enrollment.
  - **Travel assistance services from RedpointWTP LLC.** 24/7 online, pre-trip resources and support for emergency assistance and other services when traveling 50+ miles from home. Visit **LifeBenefits.com/travel** or call **1-855-516-5433** in the U.S. and Canada (outside of the U.S. and Canada **1-415-484-4677**).
  - **Legal, financial, and grief resources through TELUS Health.** Comprehensive online, telephonic and in-person resources, including the opportunity to create a will for free and much more. Visit **LifeBenefits.com/Lfg** (username: lfg, password: resources) or call **1-877-849-6034**.
  - **Legacy planning resources from Securian Financial.** You may visit Securian Financial's website (**Securian.com/legacy**) to access self-help tools for getting a person's affairs in order in advance, as well as for dealing with the loss of a loved one. In addition, Securian Financial's funeral concierge service allows for coverage verification and direct payment to the funeral home so that services can be provided before the insurance settlement becomes available.
  - **Beneficiary financial counseling from PricewaterhouseCoopers LLP.** Beneficiaries receiving $25,000 or more will be invited to access professional guidance to help them make sound financial decisions regarding their policy proceeds. Resources include assessment, workbooks, newsletter, website access, and more. Information on how to access these services is provided with claims payment.

Beneficiary Changes

If you would like to change your beneficiary designation, visit **LifeBenefits.com**, and log in to verify, update, or change your beneficiary designation. If you have questions, contact Securian Financial toll-free at **1-877-291-8466**, Monday through Friday, 7:30 a.m. to 6 p.m. HST, excluding State-observed holidays. You can also call the local office at **1-808-536-9890**.

Premium Conversion Plan – State of Hawaii Employees Only

The Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the State Department of Human Resources Development (DHRD), which allows employees to purchase their health benefit plans offered through the EUTF on a pretax basis.

This tax savings benefit is made possible because the PCP qualifies as a Cafeteria Plan within the meaning of Section 125 of the Internal Revenue Code of 1986 ("Code"), as amended. This means that, by enrolling in the plan, the employee is authorizing the State to deduct health plan premium contributions from their gross pay **before** federal and State income taxes and Social Security taxes are withheld, which should result in an increase in take-home pay. For more information, visit the DHRD website at **dhrd.hawaii.gov**.

Enrolling in the PCP

Annual Open Enrollment Period (OEP) – Current Employees

During the annual open enrollment period (OEP), employees may enroll, make changes to, or cancel their existing PCP enrollment without experiencing an IRS-qualifying change-in-status event. Employees wishing to enroll, change, or cancel their PCP enrollment shall make their selection by completing the Open Enrollment event in the EUTF Member Self-Service Portal at **eutfbenefits.hawaii.gov** or in the "Plan Selection" section of the EUTF's EC-1/EC-1H enrollment form and submit it to their departmental Human Resources Office (HRO) designee prior to the end of the OEP. The PCP effective date for OEP enrollments/changes shall be July 1, the start of the new plan year.

New Hires/Newly Eligible Employees

New employees or newly eligible employees who enroll in a health benefits plan offered by the EUTF, and whose payroll deductions are processed through the State Department of Accounting and General Services (DAGS) are eligible to participate in the PCP. Employees shall make their selection by completing the New Hire/Newly Eligible event in the EUTF Member Self-Service Portal at **eutfbenefits.hawaii.gov** or in the "Plan Selection" section of the EUTF's EC-1/EC-1H enrollment form and file it with their HRO designee. The PCP enrollment shall become effective as soon as administratively possible on a **prospective** basis from the date the form is received.

Note: Once an employee makes a PCP election (e.g., enroll or waive coverage), it is not permissible to make any changes or cancellations to their election until the next designated OEP or unless an IRS-qualifying change-in-status event occurs. Basically, the IRS is saying, in exchange for the tax savings, the election must continue for the entire Plan Year which normally runs July 1 through June 30 each year.

EUTF Administrative Rules require that online enrollment or EC-1/EC-1H enrollment forms must be submitted within forty-five (45) days of the date of hire or event that made the employee newly eligible for coverage.

Making Changes

During the plan year, the only way an employee may make a PCP election change is if:

- The employee has an allowable IRS change-in-status event (e.g., marriage, birth or adoption, divorce, etc.);
- The change being requested is on account of and consistent with the IRS change-in-status event; and
- The PCP Election Change Form (PCP-2) is submitted to the employee's HRO designee within ninety (90) calendar days of the date of the qualified status change event.

The PCP enrollment, change, or cancellation shall become effective as soon as administratively

possible, on a **prospective** basis (except in the case of a new child, which may be retroactive to the date of birth, adoption, or placement for adoption) provided the forms are submitted within ninety (90) calendar days of the event.

Note: The PCP is not a health insurance coverage, rather it is a tax exemption type of benefit. Therefore, the PCP and EUTF have different administrative rules and are separately administered. Please refer to the **Common Qualifying Events – Additions and Deletions** on pages 54-58 for submission dates.

PCP Administrative Rules

To keep the PCP Plan qualified under the Code, the State must administer the plan in strict compliance with certain rules and regulations, such as those dealing with enrollments and cancellations. As such, by electing to participate in the PCP, please note that:

1. It is not permissible to make any changes to your PCP election (e.g., enroll or waive coverage) until the next OEP or unless an IRS-qualifying change-in-status event occurs.
2. Your authorization and enrollment in PCP will automatically continue year to year for the duration of the plan until you change or cancel your participation in the PCP during the OEP or as provided under number 3 below.
3. When you have an IRS-qualifying change-in-status event (e.g., marriage, birth or adoption, divorce, etc.), you must submit the PCP-2 form within ninety (90) calendar days of the date of the event, to change or cancel your reduction in pay (otherwise, changes or cancellations are only allowed during the OEP). To avoid the risk of losing money (forfeitures), you need to submit forms in a timely manner. Allowable changes/cancellations in pretax payroll deductions are always done **prospectively** after the HRO designee receives the PCP-2 forms, never retroactively, except in the case of a new child, as noted on the previous page.
4. The Special Enrollment of a newborn/newly adopted child may be retroactive to the date of birth/adoption/placement for adoption, provided the form is submitted within ninety (90) calendar days.
5. Your PCP payroll deduction, in the absence of an allowable IRS-qualifying change-in-status event cannot be changed or cancelled for the current plan year.
6. If you change/cancel your EUTF health insurance plan coverage, but your change/cancellation is not allowable under PCP rules, your PCP payroll deduction will remain in effect through the end of the plan year, and your payments will be forfeited until PCP change/cancellation forms are received during the next OEP.
7. If you cover your domestic partner or civil union partner (DP/CU), and your DP/CU meets the definition of a "qualified dependent" under Section 152 of the Code and qualifies as your dependent for federal income tax purposes, you may deduct the entire premium contribution on a pretax basis. Otherwise, the contribution amount for your DP/CU shall be done on an after-tax basis. You must submit the PCP Domestic/Civil Union Partnership Acknowledgement form (PCP-DP/CU), which can be obtained from your HRO designee or the DHRD website at **dhrd.hawaii.gov**.

Please keep in mind that this is only a summary of HRS Chapter 14-51, "Premium Conversion Plan," and is not the complete text.

County of Maui employees can also enroll, make changes to, or cancel their pre-tax enrollment through the EUTF Member Self-Service Portal or by using the EC-1 enrollment form during Open Enrollment or upon experiencing a Qualifying Event. The County of Maui administers the pre-tax program for their employees. Employees may contact the County of Maui for more information regarding their pre-tax program.

Eligibility and Enrollment

Eligibility

Eligibility for coverage is determined by the Hawaii Revised Statutes (HRS) and EUTF Administrative Rules adopted by the EUTF Board of Trustees. If you have any questions concerning eligibility provisions, please refer to the EUTF Administrative Rules posted on the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** and the EUTF website at **eutf.hawaii.gov**.

Employee Eligibility

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

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

Dependent Eligibility

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

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

Annual Certification of Student Status

EUTF Administrative Rules 1.02 and 5.05(b) specify that unmarried dependent-beneficiaries ages 19–23 who are full-time students may enroll in dental and/or vision plans. In order to maintain enrollment, student certification must be renewed annually. Student certification must be submitted to the EUTF 15 days prior to the dependent's birthday in order to avoid termination of their dental and/or vision plans. However, you have up to 45 days from the dependent-beneficiary's date of birth to submit their full-time student certification, and their coverage will be reinstated. Acceptable forms of student certification include:

- Signed letter from the school's registrar written on the school's letterhead indicating full-time student status
- A student enrollment verification form from **studentclearinghouse.org**

Copies of a class schedule, payment of tuition, or similar documents will not be accepted. The EUTF will mail a courtesy reminder a few months prior to the dependent's birthday.[1]

1 For dependents with a date of birth falling in the summer months of June through August, please submit proof of full-time student status for the previous spring semester.

IT IS YOUR RESPONSIBILITY TO NOTIFY THE EUTF WHEN DEPENDENTS ARE NO LONGER FULL-TIME STUDENTS.

Dependent(s) under vision and dental who are no longer full-time students or who have married will be terminated at the end of the appropriate pay period.

Special Eligibility Requirements for Domestic and Civil Union Partners

Domestic Partner (DP): A person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

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

An employee may enroll a domestic partner's children as dependents so long as the children meet the EUTF eligibility requirements applicable to the enrollment of dependent children.

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

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

Enrollment

Employee-Beneficiary Responsibility

Employee-beneficiaries are responsible for:

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

Employer Responsibility

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

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

How to Enroll

To enroll in EUTF health plans, submit enrollment requests and required supporting documents through the EUTF Member self-service portal at **eutfbenefits.hawaii.gov**. If you don't enroll through the EUTF Member self-service portal, submit your completed EC-1/EC-1H enrollment form and required supporting documents to your Departmental Human Resource Office, County Personnel Office, or DOE-EBU, P.O. Box 2360, Honolulu, HI 96804 (DOE employees). If you do not enroll eligible members of your family within 45 days (180 days for newborns and 90 days for acquiring non-EUTF coverage) from the time you or they first become eligible, you must wait until you experience a qualifying event or wait until the next open enrollment period. The plan year for active employees begins July 1 and ends June 30 of the following year.

Confirmation Notice and ID Cards

Once your enrollment is processed by the EUTF, you will be sent a Confirmation Notice indicating your enrollment and dependents covered (if any). Please review the Confirmation Notice and contact the EUTF if any errors are identified.

The EUTF will notify the health insurance carriers of your new enrollment, and you should receive identification cards from the insurance carriers shortly after. ID cards are not issued for Verdegard Administrators, American Specialty Health Group, Inc., Securian Financial, and VSP, as ID cards are not required to receive services.

Dual Enrollment Between Two EUTF Plans Is Not Allowed

No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment).

Employee and Spouse Both State and/or County Employees

In addition, if you and your spouse/DP/CUP are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), HRS.

When Can You Enroll?

Eligible employees may enroll in EUTF plans by submitting enrollment requests and required supporting documents through the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** or during regular or limited enrollment periods described in EUTF Administrative Rules. If you don't enroll through the EUTF Member self-service portal, submit your completed EC-1/EC-1H enrollment form and required supporting documents to your Departmental Human Resource Office, County Personnel Office, or DOE-EBU, P.O. Box 2360, Honolulu, HI 96804 (DOE employees). These enrollment periods include the following:

- **Within 45 days of initial hire date or newly eligible date.** A New Hire/Newly Eligible Enrollment Guide for EUTF benefits is available on the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** and on our website at **eutf.hawaii.gov**.

- **During the open enrollment period.**
- **If you experience a qualifying event.** Please refer to the Common Qualifying Events Additions and Deletions Charts on pages 54-58.

IMPORTANT: After the open enrollment period is completed (or, if you are a new hire, after your initial enrollment election period is over), generally you will not be allowed to change your benefit elections or add/delete dependents until next year's open enrollment, unless you have a Special Enrollment Event or a qualifying event. See Common Qualifying Events Additions and Deletions on pages 54-58.

End of Coverage

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

- Required premium payments are not made
- Death, subject to exceptions
- Noncompliance with the EUTF Administrative Rules
- Filing of fraudulent claims
- Dependent reaches the limiting age, or divorce; or losing full-time student status for dental/vision coverage

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

Effective Dates of Coverage for New Hires and Newly Eligible Employees

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

1. Your date of hire or date you become newly eligible for EUTF benefits
2. First day of the first pay period from your date of hire or date you become newly eligible for EUTF benefits (the 1st or the 16th of the month)
3. First day of second pay period from your date of hire or date you become newly eligible for EUTF benefits (the 1st or the 16th of the month)

For example, if the date of hire or date you became newly eligible is January 3, 2024:

- Option 1 effective date of coverage: January 3, 2024
- Option 2 effective date of coverage: January 16, 2024
- Option 3 effective date of coverage: February 1, 2024

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

If you are a **newly hired employee or enrolling in benefits for the first time**, your pay period deduction amounts may be **doubled** for at least one (1) to two (2) pay periods to accommodate processing time and the payroll lag.

Transfer of Employment

If you terminate employment and are rehired by the same public employer within the same pay period or the next consecutive pay period, you are considered as having transferred employment and shall be treated as if continuously enrolled in the EUTF benefit plans. If you terminate employment and are rehired by a different public employer (e.g., State to County) within the same pay period

or the next consecutive pay period, you are allowed to change between plans, including adding or deleting dependents and changing coverage tiers.

For purposes of this section only, the different public employers are: (1) State, including executive, legislative, and judicial branches, Department of Education, University of Hawaii, Hawaii Health Systems Corporation, Office of Hawaiian Affairs, and all charter schools; (2) City and County of Honolulu and Board of Water Supply; (3) County of Hawaii; (4) County of Kauai; and (5) County of Maui.

Effective Date of Termination

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

Rejection of Enrollment

Enrollment in EUTF benefit plans is contingent on meeting eligibility criteria detailed in the EUTF Administrative Rules. Enrollment applications may be rejected if incomplete. An enrollment application shall be rejected if:

- The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
- The application is not filed within the time limitations prescribed by the EUTF Administrative Rules (see **Common Qualifying Events Additions/Deletions** on pages 54-58);
- The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
- The employee-beneficiary owes past-due contributions or other amounts to the EUTF; or
- Acceptance of the application would violate applicable federal or State law or any other provision of the rules.

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

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

If you are going on an authorized leave without pay (LWOP), health plan options include:

- **Cancelling EUTF Coverage.** You may cancel your EUTF coverage by submitting an enrollment request through the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** or by submitting an EC-1/EC-1H form within 45 days of the beginning of an LWOP. You must upload a copy of your L-1 form or attach a copy of your L-1 form to your EC-1/EC-1H form within 45 days of the beginning of an LWOP. Employees may reenroll in the same benefit plans upon return from an LWOP by submitting an enrollment request through the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** or by submitting an EC-1/EC-1H form within 45 days of your return from an LWOP.
- **Continuing EUTF Coverage.** You may continue coverage while on an LWOP by submitting premium payments directly to the EUTF. Employees may submit payment to the EUTF using personal check, cashier's check, or money order. Premiums can also be paid electronically through automatic deductions from the employee's checking account, savings account, credit card, or with an electronic check. Information on electronic premium payment options can be found on the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** or on the website at **eutf.hawaii.gov**.

- If any employee on an LWOP fails to cancel EUTF plans by submitting an enrollment request through the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** or by submitting an EC-1/EC-1H form or fails to continue coverage by making payments to the EUTF, he or she will be cancelled for nonpayment from all plans (except for the EUTF life insurance plan) and will not be able to re-enroll until the next open enrollment period (except for certain qualified leave under FMLA or USERRA, where coverage can be reinstated upon return from leave).

If at any time the EUTF fails to receive an employee-beneficiary's premium deduction or receives only a partial deduction from his/her payroll, he/she will receive a Contribution Shortage Reminder Notice from the EUTF.

If the employee-beneficiary fails to pay the premium shortage by the date specified in the Contribution Shortage Reminder Notice, his/her plans will be cancelled retroactive to the date of the last paid premium. Reinstatement of the terminated employee-beneficiary and their dependent's health benefit coverage which was cancelled for nonpayment, will be allowed if, within 60 days from the date of the notice of cancellation, payment is made in full of past and currently due premiums. To be eligible for reinstatement, the terminated member must not have been terminated for nonpayment of premiums within 12 months from the date of the notice of cancellation. Otherwise, employees may only re-enroll during the next open enrollment or qualifying event occurring within the next plan year, except in instances of return from FMLA or USERRA leave.

Address Changes

Employees are responsible for reporting address changes to their employer as soon as possible. Address changes for employees in departments under the State of Hawaii (including Executive Branch, Legislature, Office of Hawaiian Affairs, and Hawaii Health Systems Corporation) must be submitted through HiPAY. Once the address change is processed, the EUTF will notify the health carriers of your new address. Be advised that all address changes must go through your employer, as health plan carriers are not able to make changes.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 45 days of your or your dependents' other coverage ending.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 45 days after the marriage, adoption, or placement for adoption. You must request enrollment within 180 days after a birth.

You and/or your Dependents may also enroll in this Plan if you or your Dependents have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your Dependents lose eligibility for that coverage or become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends or is determined to be eligible for such assistance.

Common Qualifying Events – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Adoption	Enrollment must be completed in the EUTF Member self-service portal* within **45** days of adoption or placement for adoption date. **Adoption decree or placement for adoption documents, Social Security number, and birth certificate** submitted within **45** days from the adoption date.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Birth	Enrollment must be completed in the EUTF Member self-service portal* within **180** days of birth date. **Birth certificate and Social Security number** must be submitted with enrollment. Hospital certificate is acceptable as temporary supporting document while awaiting **birth certificate**.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Civil Union	Enrollment must be completed in the EUTF Member self-service portal* within **45** days of civil union. **Civil Union Certificate, Affidavit of Dependency, and Social Security number** submitted within **45 days** from the civil union date. **Birth certificate, student certification** (a letter from the school registrar's office or certificate from the National Student Clearinghouse, if applicable) and **Social Security number** if adding any dependent children within **45** days from the civil union marriage date.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Court Order (aka Qualified Medical Child Support Order-QMCSO) (to cover eligible dependent)	EUTF receives the order directly from the Child Support Enforcement Agency (CSEA). No EC-1/EC-1H is required if employee is already enrolled in plans. If not enrolled, employee has **45** days from the Event Date to submit an **EC-1/EC-1H form**.* If enrollment is not completed within **45** days, employee and child(ren) will be added to the lowest-cost PPO plan.	Event Date	Plan changes allowed if required by court order. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Domestic Partnership	Enrollment must be completed through the EUTF Member self-service portal* within **45** days of notarized signature. **Notarized Declaration of Domestic Partnership, Affidavit of Dependency & Acknowledgement, and two sets of documents** showing proof of shared residency submitted within 45 days from the domestic partnership notary date. Documents available at **eutf.hawaii.gov**. **Birth certificate, student certification** (a letter from the school registrar's office or certificate from the National Student Clearinghouse, if applicable) and **Social Security number** if adding any dependent children within **45** days from the domestic partnership date.	Employee can choose: The Event Date (notary date), first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.

* If a hardcopy EC-1 Form is preferred, please visit the EUTF website at **eutf.hawaii.gov**.

Common Qualifying Events – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Guardianship (Employee wishes to add child to EUTF plans)	Enrollment must be completed in the EUTF Member self-service portal* within **45** days of guardianship date. **Guardianship decree, Social Security number, and birth certificate** submitted within **45** days from the guardianship date	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Loss of Coverage (Employee and/or dependent loses health coverage and wishes to enroll in EUTF or HSTA VB plans)	Enrollment must be completed in the EUTF Member self-service portal* within **45** days of loss of coverage. **Letter from previous employer or carrier** detailing type of coverages lost (i.e., medical, drug, dental, vision), date of loss of coverage, and names of any covered dependents. **Birth certificate, student certification** (if applicable), and **Social Security number** if adding any dependent children, **marriage certificate** if adding spouse, within **45** days of loss of coverage.	The first day following the day non-EUTF coverage was lost.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Marriage	Enrollment must be completed in the EUTF Member self-service portal* within **45** days of marriage, along with **marriage certificate** and **Social Security number**. **Birth certificate**, **student certification** (a letter from the school registrar's office or certificate from the National Student Clearinghouse, if applicable), and **Social Security number** if adding any dependent children within **45** days from the marriage date.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Newly Eligible Student (Unmarried dependent age 19 through 23 becomes a full-time student)	Enrollment must be completed in the EUTF Member self-service portal* within **45** days from school start date. **Student certification:** A letter from an accredited school on school letterhead with registrar's signature confirming full-time status or certificate from the National Student Clearinghouse within 45 days from school start date.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in dental and/or vision plans if not already enrolled.
Eligible Student – yearly certification on child's birthdate (already enrolled in EUTF plans) (Unmarried dependent age 19 through 23 is a full-time student)	Enrollment must be completed in the EUTF Member self-service portal prior to child's birth date. **Student certification:** A letter from an accredited school on school letterhead with registrar's signature confirming full-time status or certificate from the National Student Clearinghouse within **45**** days of student's birthdate. Transcripts are not accepted. No enrollment change request is required.	N/A	No plan changes allowed.

* If a hardcopy EC-1 Form is preferred, please visit the EUTF website at **eutf.hawaii.gov**.

** If proof of full-time student's status is not received prior to the student's birthdate, his/her coverage (dental and vision for Active Employee dependents) will be terminated effective the end of the pay period during which the birthdate occurs. If EUTF receives proof of full-time student status within 45 days from the student's birthdate, his/her coverage will be reinstated without a break in coverage.

Common Qualifying Events – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
New Hire/Newly Eligible Employee (New employee wishes to enroll in EUTF plans)	Enrollment must be completed in the EUTF Member self-service portal* within **45 days** from new hire/newly eligible start date. **1) Marriage certificate, Civil Union certificate,** or **Domestic Partnership forms** (see above) if enrolling a spouse/DP; **2) Social Security number; 3) Birth certificate** for dependent children; **4) Student certification** from an accredited school on school letterhead with registrar's signature confirming full-time status or certificate from the National Student Clearinghouse, within **45 days** from date of hire if enrolling a dependent age 19 through 23, in dental and/or vision.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	N/A
Retirement	**EC-2 form** and **ERS Retirement Estimate Letter** must be submitted within **60** days of retirement date. If Medicare-eligible, **a copy of Medicare Part B ID card, Direct Deposit Agreement form**, and **letter from Social Security** indicating Medicare Part B premium paid. If paying all or a portion of your health benefit premium, **ERS Pension Deduction Form or ACH Deduction Form**. All documents must be submitted within **60 days** of retirement date.	Retirement Date	N/A
Return From Leave of Absence Without Pay (LWOP) (Applies only to employees who waived their plans while on LWOP or for USERRA or FMLA)	Enrollment must be completed in the EUTF Member self-service portal within **45** days after returning from an LWOP.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	Employee must enroll in the same plans (and with the same dependents, if eligible).

* If a hardcopy EC-1 Form is preferred, please visit the EUTF website at **eutf.hawaii.gov**.

Common Qualifying Events – Deletions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Disenroll Due to Enrollment in Other Coverage (Employee or dependent gets coverage from another plan and wishes to cancel EUTF or HSTA VB plans)	Enrollment must be completed in the EUTF Member self-service portal* within **90** days of acquisition of coverage. **Letter from carrier or employer** detailing type of coverage enrolled in (i.e., medical, drug, dental, vision), effective date of coverage, and names of covered dependents within **90** days from the date of acquisition.	If coverage is gained on the 1st of the month, EUTF coverage ends on the last day of the month preceding. If coverage is gained on the 16th of the month, EUTF coverage ends on the 15th of the month. Otherwise, coverage ends on the first day of the pay period following the acquisition of non-EUTF coverage.	Employee may enroll in the supplemental health benefit plan effective the first day of the pay period following the cancellation of their EUTF coverage.
Child is No Longer a Full-time Student** (Employee must terminate dental and vision coverage for a child from age 19 through 23)	Enrollment must be completed in the EUTF Member self-service portal* as soon as the dependent child is no longer a full-time student.	Coverage ends on the first day of the pay period following the school's end date.	No
Death of Dependent	Enrollment must be completed in the EUTF Member self-service portal* as soon as reasonably practical. **Death certificate** or **copy of obituary** as soon as available.	Coverage ends on the date of the dependent's death or on the first day of the pay period following the dependent's death.	N/A
Divorce** (Employee must terminate coverage for former spouse and stepchildren or civil union partner)	Enrollment must be completed in the EUTF Member self-service portal* within **45** days of divorce; however, it will be accepted and processed regardless of when form is received. Submit **pages 1 and 2 of divorce decree along with the signature page** within **45** days from the date of the divorce.	If submitted within 60 days of the divorce, coverage ends on the first day of the first pay period following the divorce. If submitted 60+ days following the divorce, coverage ends prospectively on the first day of the first pay period following EUTF's receipt of the enrollment change request and the employee will be responsible for the employee and employer contributions of premiums for the ineligible dependent(s).	No
Legal Separation** (Employee may terminate coverage for spouse and stepchildren)	Enrollment must be completed in the EUTF Member self-service portal* within **45** days of date of legal separation. **Court documents** establishing legal separation along with the signature page within **45** days from separation date.	If submitted within 60 days, coverage ends on the first day of the first pay period following the legal separation. If submitted 60+ days, coverage ends prospectively on the first day of the first pay period following EUTF's receipt of the enrollment change request and the employee will be responsible for the employee and employer contributions of premiums for the ineligible dependent(s).	No

Note: Employers must notify EUTF of an employee's Demographic Change, Bargaining Unit change, or Death.

* If a hardcopy EC-1 Form is preferred, please visit the EUTF website at **eutf.hawaii.gov**.

** If the EUTF is not notified of ineligible dependent(s) within 60 days of their becoming ineligible, the affected dependent(s) coverage will be terminated prospectively, and the employee will be responsible for the employee and employer contributions of premiums for the ineligible dependent(s).

Common Qualifying Events – Deletions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Leave of Absence Without Pay Lasting More Than 30 Days (Employee may waive all plans excluding life insurance or continue coverage by paying his/her share of premium)	Enrollment must be completed in the EUTF Member self-service portal* within **45** days from beginning of an LWOP to waive plans. **L-1 form** provided by the employer within **45** days from beginning of an LWOP.	If employee cancels plans, the cancellation is effective the first day of the pay period following the LWOP.	No
Nonpayment Termination	N/A	Coverage is cancelled as of the first day following the last period for which full payment was made. Employee can make a full payment of all contributions due within 60 days of the cancellation and have previous coverage reinstated, if coverage has not been cancelled due to nonpayment within 12 months of the date of the notice of cancellation.	N/A
Termination of Domestic Partnership** (Employee must terminate coverage for domestic partner and domestic partner's dependents)	Enrollment must be completed in the EUTF Member self-service portal* within **45** days of the termination of domestic partnership; however, it will be accepted and processed regardless of when it is received.	If submitted within 60 days of the termination of domestic partnership, coverage ends on the first day of the first pay period following the termination of domestic partnership. If submitted 60+ days following the termination of domestic partnership, coverage ends prospectively on the first day of the first pay period following the EUTF's receipt of the enrollment change request and the employee will be responsible for the employee and employer contributions of premiums for the ineligible dependent(s).	No
Termination of Employment	**Termination Close of Business (COB)** must be submitted by the Employer within **30** days of the termination. However, it will be accepted and processed regardless of when the form is received.	Coverage ends the first day of the pay period following the last day of employment.	N/A

Note: Employers must notify EUTF of an employee's Demographic Change, Bargaining Unit change, or Death.

*If a hardcopy EC-1 Form is preferred, please visit the EUTF website at **eutf.hawaii.gov**.

**If the EUTF is not notified of ineligible dependent(s) within 60 days of their becoming ineligible, the affected dependent(s) coverage will be terminated prospectively, and the employee will be responsible for the employee and employer contributions of premiums for the ineligible dependent(s).

Future Retirees

Applying for Your Retirement Benefits

Employees who wish to file for retirement must do so with the Employees' Retirement System (ERS). After filing for retirement with ERS, employees need to submit an EC-2 form and the following documents to the EUTF in order to obtain retiree health and life insurance benefits:

- Page(s) of the ERS Retirement Estimate Letter that reflect ERS Membership Date and Total Years of Service
- If you must pay a portion of your retiree health premiums, a completed ERS Pension Deduction Authorization Agreement or ACH Authorization Deduction Agreement

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

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

Additional resources, including a Pre-Retirement Checklist, Medicare Checklist, Retiree Health Benefits Highlights Guide, required EUTF forms, and Medicare enrollment information are available on the EUTF website at **eutf.hawaii.gov**. The EUTF also conducts Pre-Retirement workshops and webinars. Please visit our website for more information on upcoming workshops and how to attend.

Enrollment or Changes in Enrollment Upon Retirement

An employee-beneficiary may enroll or change coverages in the health benefit plans offered or sponsored by the EUTF and obtain coverage for eligible dependent-beneficiaries when they become a retired member of the ERS as defined in 87A-1HRS. 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 EUTF within sixty (60) days of retirement or within sixty (60) days of certification from the ERS of a disability retirement. Retired employee-beneficiaries are eligible to enroll in EUTF benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the date of retirement.

Portability of Annual Maximums and Annual Limits Between Active and Retiree Plans

If you are thinking about retirement during the upcoming plan year, you should consider plan annual maximums and annual limits for medical, dental, vision, and prescription drug benefits. Retiree prescription drug plans have an annual maximum for specialty drugs only. **Benefits that are paid under the active employee plans are counted against the maximums and limitations of the retiree plans of the same carrier if they occur within the same calendar year.**

Medical Maximum Out-of-Pocket Example

Jane is an active employee in the EUTF HMSA 90/10 PPO Plan. On July 1, 2023, Jane meets her $2,000 calendar-year maximum out-of-pocket under the plan. She incurs additional medical expenses of $100 in August 2023, which are paid at 100% since her maximum out-of-pocket was satisfied. Jane retires on September 1, 2023, and enrolls in the EUTF HMSA Non-Medicare Retiree PPO plan. She proceeds to have additional medical services totaling $1,000 before the end of 2023.

As an active employee, Jane's maximum out-of-pocket was $2,000 per calendar year, but as a retiree, her maximum out-of-pocket is $2,500 per calendar year. Therefore, instead of 100% coverage for the additional $1,000 of medical expenses, Jane is responsible for 10% on $500 of the additional expenses, to meet the $2,500 maximum out-of-pocket under her retiree plan.

Medical Deductible Example

On January 1, 2023, Jill was an active employee enrolled in the EUTF HMSA 90/10 PPO Plan. She met her individual out-of-network deductible of $100 in May 2023. Jill retires on June 1, 2023, and enrolls in the EUTF HMSA Retiree PPO plan. The $100 deductible she met under the active employee plan will apply to the retiree plan since it falls within the same calendar year. Jill will not be subject to an additional deductible under the retiree plan in 2023.

Important Notices

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

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

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

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

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

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

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

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

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

These benefits will be provided subject to the same plan limits, deductibles, copayments, and coinsurance applicable to other medical and surgical benefits provided under the plan. For more information on WHCRA benefits, contact HMSA or Kaiser Permanente. This Notice is also available on the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** and on the plan's website at **eutf.hawaii.gov**.

PRIVACY NOTICE REMINDER

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

This plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this notice when you enroll in the plan. You can get another copy of this notice from our Member Services Branch at **1-808-586-7390** or toll-free

at **1-800-295-0089**. The Privacy Notice is also available on the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** and on the plan's website at **eutf.hawaii.gov**.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP)

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

Direct Access to OB/GYN Providers

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

SPECIAL EXTENSION OF COVERAGE FOR A STUDENT ON A MEDICALLY NECESSARY LEAVE OF ABSENCE

If the plan receives a written certification from a covered child's treating physician that:

1. The child is suffering from a serious illness or injury, and
2. A leave of absence (or other change in enrollment) from a postsecondary institution is medically necessary, and the loss of postsecondary student status would result in a loss of health coverage under the plan, then the plan will extend the child's dental and/or vision coverage for up to one year.

This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (1) one year later or (2) the date on which coverage would otherwise terminate under the terms of the plan. Contact the EUTF Office at **1-808-586-7390** or toll-free at **1-800-295-0089** for more information.

NOTICE REGARDING THE WELLNESS PROGRAM

The wellness programs are voluntary wellness programs available to participants enrolled in the group health plan and are designed to promote health or prevent disease. The programs are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment (HRA) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA questionnaire, participate in medical examinations, or to work with a health coach.

The information from your HRA questionnaire will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections From Disclosure of Medical Information

Our group health plan is required by law to maintain the privacy and security of your personally identifiable health information.

Information collected from wellness program participants will only be received by EUTF in aggregate form. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, our group health plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separately from your personnel records, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken by the group health plan to avoid any data breach, and in the event a HIPAA data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the EUTF Office at **1-808-586-7390** or toll-free at **1-800-295-0089**.

AVAILABILITY OF SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. In accordance with law, our plan provides you with a Summary of Benefits and Coverage (SBC) as a way to help you understand and compare medical plan benefits. The SBC summarizes and compares important information, including what is covered, what you need to pay for various benefits, what is not covered, and where to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC. To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, and the Uniform Glossary that defines many terms in the SBC, go to **eutf.hawaii.gov**, or for a paper copy, contact **1-808-586-7390** or toll-free at **1-800-295-0089**.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Important Notice From the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) About Prescription Drug Coverage for People With Medicare

This notice is for people who may become eligible for Medicare during the next 12 months.

Please read this notice carefully, and keep it where you can find it.

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

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

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

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

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

- HMSA 75/25 PPO Plan (as administered by CVS Caremark)
- HMSA 80/20 PPO Plan (as administered by CVS Caremark)
- HMSA 90/10 PPO Plan (as administered by CVS Caremark)
- HMSA HMO Plan (as administered by CVS Caremark)
- HSTA VB HMSA 90/10 PPO Plan (as administered by CVS Caremark)
- HSTA VB HMSA 80/20 PPO Plan (as administered by CVS Caremark)
- Kaiser Permanente HMO plans (as administered by Kaiser Permanente)

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

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the CVS Caremark-administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser Permanente).** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

YOUR RIGHT TO RECEIVE A NOTICE

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

WHY CREDITABLE COVERAGE IS IMPORTANT (WHEN YOU WILL PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN)

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage, your monthly premium will always be at least 19%

higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage, you may also have to wait until the next Medicare open enrollment period to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any one of the following options:

Your Choices	What You Can Do	What This Option Means to You
Option 1	You can select or keep your current medical and prescription drug coverage under the CVS Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser Permanente), and **you do not have to enroll in a Medicare prescription drug plan.**	You will continue to be able to use your prescription drug benefits through the CVS Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser Permanente). • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (October 15 through December 7 of each year). • As long as you are enrolled in creditable drug coverage, you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	You can select or keep your current medical and prescription drug coverage with the CVS Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser Permanente) **and also enroll in a Medicare prescription drug plan.** If you enroll in a Medicare prescription drug plan, you will need to pay the Medicare Part D premium, if applicable, out of your own pocket.	Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all your current health and prescription drug benefits. Having dual prescription drug coverage under this plan and Medicare means that this plan will coordinate its drug payments with Medicare, as follows: • For Medicare-eligible retirees and their Medicare-eligible dependents, Medicare Part D coverage pays primary, and the group health plan pays secondary. • For Medicare-eligible active employees and their Medicare-eligible dependents, the group health plan pays primary, and Medicare Part D coverage pays secondary. Note that you may not drop just the prescription drug coverage under the CVS Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser Permanente). That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this plan's next open enrollment period. Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as: • PDPs may have different premium amounts; • PDPs cover different brand-name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail-order services.

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

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

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

PARA MÁS INFORMACIÓN SOBRE SUS OPCIONES BAJO LA COBERTURA DE MEDICARE PARA RECETAS MÉDICAS.

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

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

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

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
201 Merchant Street, Suite 1700
Honolulu, HI 96813

Phone number: **1-808-586-7390** or toll-free at **1-800-295-0089**

As in all cases, EUTF and, when applicable, Kaiser Permanente reserve the right to modify benefits at any time, in accordance with applicable law. This document is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

Administrative Appeals

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

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary, or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long-term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long-term care, offered or sponsored by the EUTF.
5. In addition to the appeal rights outlined in this section, an aggrieved person may have a right to file an external appeal if denial is due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time. Contact EUTF for a full description of any external review rights.

The first step in the appeal process is an appeal to the EUTF administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the EUTF's office within one hundred eighty (180) days of the date of the adverse decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the EUTF administrator nor the Board shall be required to hear any appeal that is filed after the one-hundred-eighty-day (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.

Appeals can be mailed to the EUTF at 201 Merchant Street, Suite 1700, Honolulu, HI 96813 or faxed to **1-808-586-2161**. If the aggrieved person is dissatisfied with the administrator's action, or if no action is taken by the administrator on the aggrieved person's written appeal within thirty (30) days of its being filed in the EUTF's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the Board. A written appeal to the Board must be filed in duplicate in the EUTF's office within ninety (90) days of the administrator's actions. If no action is taken by the administrator within thirty (30) days of the written appeal to the administrator being filed in the EUTF's office, then the written appeal to the Board must be filed in duplicate in the EUTF's office within one hundred twenty (120) days of the written appeal to the administrator being filed in the EUTF's office.

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

1. The aggrieved person's name, address, and telephone number;
2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;
3. A description of the decision with respect to which relief is requested, including the date of the decision;
4. A complete statement of the relevant and material facts;

5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

Appeals to the EUTF Board of Trustees can be mailed to the EUTF at 201 Merchant Street, Suite 1700, Honolulu, HI 96813 or faxed to **1-808-586-2161**. Subject to applicable federal and State law, the Board may reject any appeal that does not contain the foregoing information.

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

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

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

For emergency appeals of eligibility, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

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

The EUTF Administrative Rules can be found on the EUTF Member self-service portal at **eutfbenefits.hawaii.gov** and on the EUTF website at **eutf.hawaii.gov**.

Who to Contact

For Questions About...	Please Contact...
Eligibility and EUTF Information	**eutf.hawaii.gov** EUTF Member Services Branch **1-808-586-7390** (Oahu) or toll-free: **1-800-295-0089** Monday through Friday, 7:45 a.m.–4:30 p.m. HST, excluding State holidays
Hawaii Medical Service Association (HMSA)	**hmsa.com/eutf** **1-808-948-6499** (Oahu) or toll-free: **1-800-776-4672** (Neighbor Islands) Monday through Friday, 7 a.m.–7 p.m. HST Saturday, 9 a.m.–1 p.m. HST **In person:** **HMSA Center @ Honolulu** HMSA Building 818 Keeaumoku St. Honolulu, HI 96814 Monday through Friday, 8 a.m.–5 p.m. HST Saturday, 9 a.m.–2 p.m. HST **HMSA Center @ Pearl City** Pearl City Gateway 1132 Kuala St., Suite 400 Pearl City, HI 96782 Monday through Friday, 9 a.m.–6 p.m. HST Saturday, 9 a.m.–2 p.m. HST **HMSA Center @ Kahului** Puunene Shopping Center 70 Hookele St., Suite 1220 Kahului, HI 96732 Monday through Friday, 9 a.m.–6 p.m. HST Saturday, 9 a.m.–2 p.m. HST **HMSA Center @ Hilo** Waiakea Center 303A E. Makaala St. Hilo, HI 96720 Monday through Friday, 9 a.m.–6 p.m. HST Saturday, 9 a.m.–2 p.m. HST **HMSA Center @ Lihue** 3-3295 Kuhio Highway, Suite 202 Lihue, HI 96766 Monday through Friday, 8 a.m.–4 p.m. HST

Kaiser Permanente	kp.org/eutf **1-808-432-5250** (Oahu) or toll-free: **1-844-276-6628** (Neighbor Islands) Monday through Friday, 7 a.m.–7 p.m. HST Saturday, 9 a.m.–1 p.m. HST Walk-In Service: 711 Kapiolani Blvd. Honolulu, HI 96813 Monday through Friday, 8 a.m.–4:30 p.m., excluding State observed holidays
CVS Caremark (CVS) For HMSA members	caremark.com **1-855-801-8263** TTY: **711** (24 hours a day, 7 days a week) Walk-In Service: **Pauahi Tower** 1003 Bishop Street, Suite 704 Monday through Friday, 7:45 a.m.–4:30 p.m. HST
Verdegard Administrators (formerly HMA)	verdegard-hi.com/eutf Oahu: **1-808-951-4643** or toll-free: **1-866-437-1992** For phone calls, the hours are: Monday through Friday, 7:30 a.m.–7 p.m. HST, Saturday, 9 a.m.–1 p.m. HST For walk-ins, the hours are: Monday through Friday, 7:30 a.m.–5 p.m. HST Office located: 1440 Kapiolani Blvd., Suite 1000
Hawaii Dental Service (HDS)	hawaiidentalservice.com/eutf **1-808-529-9310** or toll-free **1-866-702-3883** Over the phone: Monday through Friday, 7:30 a.m.–6 p.m. HST, except State observed holidays Walk-In Hours: Monday through Friday, 8 a.m.–4:30 p.m., except State observed holidays Office located: Pioneer Plaza, 900 Fort Street Mall, Suite 1900
Vision Service Plan (VSP)	vsp.com Oahu: **1-808-532-1600** or toll-free **1-800-522-5162** Monday through Friday, 7:30 a.m.-6 p.m. HST Toll-free: **1-866-240-8420** Through March 9, 2024: Monday through Saturday, 4 a.m.-3 p.m. HST From March 10, 2024: Monday through Saturday, 3 a.m.-2 p.m. HST

American Specialty Health (ASH)	ashlink.com/ash/hmsa for HMSA members ashlink.com/ash/kaiserhic for Kaiser Permanente members Toll-free: **1-800-678-9133** 10/1/22–3/31/23: Sunday through Saturday, 8:00 a.m.–8:00 p.m. HST, excluding Thanksgiving Day and Christmas Day 4/1/23–9/30/23: Monday through Friday, 2:00 a.m.–5:00 p.m. HST, excluding ASH-observed holidays
Securian Financial	LifeBenefits.com/EUTF Local office: **1-808-536-9890** or toll-free: **1-877-291-8466** Monday through Friday, 7:30 a.m.–6 p.m. HST, except State observed holidays Email: **lifebenefits@securian.com**
Social Security Administration (SSA)	ssa.gov **1-800-772-1213**
Centers for Medicare & Medicaid Services	cms.gov **1-800-MEDICARE**

EXHIBIT C

EC-1 Enrollment Form Instructions

I. Employee Data

Select the Enrollment Type for which you are submitting the Enrollment form. Mark the New Hire box if you're newly hired, the Qualifying Event box if you are making changes outside of the Open Enrollment period, or the Open Enrollment box during the annual or limited Open Enrollment period. If submitting the enrollment form for a qualifying event, give a brief description of the event and input the date the qualifying event occurred. Common qualifying events include: **Disenroll due To Enrollment in Other Coverage, Adoption, Birth, Civil Union Partner, Court Order, Death, Divorce, Domestic Partnership, Guardianship, Ineligible Student, Approved Leave of Absence Without Pay/Waive (LWOP/Waive), Approved Leave of Absence Without Pay/Re-enroll (LWOP/Re-enroll), Legal Separation, Loss of Coverage, Marriage, Moving Out of the Coverage Area, New Hire, Newly Eligible Employee, Newly Eligible Student, Reinstatement of Employment, or Termination of Domestic Partnership**. Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

Carefully consider when you would like your health plans and premium deductions to begin and check the appropriate box. You can select one of the following:

- (Option #1) Coverage starts on the date of hire or event date. Premium contributions start 1st day of the pay period in which the date of hire or event date occurs.
- (Option #2) Coverage and contributions start 1st day of the first pay period following the date of hire or event date.
- (Option #3) Coverage and contributions start 1st day of the second pay period following the date of hire or event date.

If no selection is made, Option #1 will be used, and you will be responsible for the full premium in said pay period. Loss of Coverage and Disenroll due To Enrollment in Other Coverage must start on event date (Option #1).

III. Plan Selection

Mark all plans you wish to be enrolled in. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan you select. If you do not want any plan coverage, mark the "Cancel/Waive" box. If no selection is made and you currently have coverage, EUTF will assume no changes are being made. **State and County Contributions:** No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled on more than one retiree/active employee plan (dual enrollment). In addition, if you and your spouse/partner are both retirees/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes.

For State and Maui County Employees Only: : The Premium Conversion Plan (PCP) is a voluntary benefit plan, that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. For State employees, PCP is administered by the Department of Human Resources Development (DHRD). For County of Maui employees, PCP is administrated by the County of Maui. By enrolling in the PCP, you are allowing deductions for your health plan premium contributions from your gross pay before federal, State and social security taxes are withheld. Since there may be tax implications, please visit the DHRD website at dhrd.hawaii.gov or County of Maui intranet for more information. State employees making mid-plan year elections, should inquire with their Human Resources Office or DHRD on completing a PCP-2 form (the PCP-2 form is not required of County of Maui employees). Enrollment in the PCP is not automatic. Mark the "Enroll" or "Cancel/Waive" box. If no election is made (i.e., left blank), new enrollments shall default to "Not Enrolled" and existing PCP enrollments shall continue. **For All Other County Employees**: Premium Conversion Plan (PCP) is administered by the Budget and Fiscal Services Department. Please contact your Department Personnel Office for more information on available options.

IV. Dependent Information

Complete dependent information and indicate plan selection if adding, removing or continuing coverage for dependents. If you are adding/removing more than five dependents and additional rows are needed, please attach another sheet to your enrollment form. If this is your first time enrolling dependents in EUTF plans, please submit required proof documents including a marriage certificate if adding your spouse or partner and a birth certificate and guardianship or adoption decree (if applicable), if adding a child(ren). If a dependent child is age 19 to 24, unmarried and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Required proof documents must be submitted to the EUTF within 45 days of the event date. Social security numbers are required for all newly added dependents. Detailed eligibility information including required proof documents for other life events are available online at eutf.hawaii.gov. **Use the following Relationship codes:**

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

V. Other Insurance Information

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

VI. Employee Signature

Read, sign and date the form. Submit your EC-1 form to your department human resource office or enrollment designee for verification, signature and routing to EUTF. DOE employees please submit your EC-1 form to the address printed on the top right-hand corner of the enrollment form. To ensure proper processing, all required fields must be completed, and proper documentation submitted timely.

EXHIBIT C

EC-1H Enrollment Form Instructions

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

I. Employee Data

Select the Enrollment Type for which you are submitting the Enrollment form. Mark the New Hire box if you're newly hired, the Qualifying Event box if you are making changes outside of the Open Enrollment period, or the Open Enrollment box during the annual or limited Open Enrollment period. If submitting the enrollment form for a qualifying event, give a brief description of the event and input the date the qualifying event occurred. Common qualifying events include: **Disenroll due to Enrollment in Other Coverage, Adoption, Birth, Civil Union Partner, Court Order, Death, Divorce, Domestic Partnership, Guardianship, Ineligible Student, Approved Leave of Absence Without Pay/Waive (LWOP/Waive),**

Approved Leave of Absence Without Pay/Re-enroll (LWOP/Re-enroll), Legal Separation, Loss of Coverage, Marriage, Moving Out of the Coverage Area, New Hire, Newly Eligible Employee, Newly Eligible Student, Reinstatement of Employment, or Termination of Domestic Partnership. Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

Carefully consider when you would like your health plans and premium deductions to begin and check the appropriate box. You can select one of the following:

- (Option #1) Coverage starts on the date of hire or event date. Premium contributions start 1st day of the pay period in which the date of hire or event date occurs.
- (Option #2) Coverage and contributions start 1st day of the first pay period following the date of hire or event date.
- (Option #3) Coverage and contributions start 1st day of the second pay period following the date of hire or event date.

If no selection is made, Option #1 will be used, and you will be responsible for the full premium in said pay period. Loss of Coverage and Disenroll due to Enrollment in Other Coverage must start on event date (Option #1).

III. Plan Selection

Mark all plans you wish to be enrolled in. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan you select. If you do not want any plan coverage, mark the "Cancel/Waive" box. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.

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

For State Employees Only: The Premium Conversion Plan (PCP) is a voluntary benefit plan, that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. For State employees, PCP is administered by the Department of Human Resources Development (DHRD). By enrolling in the PCP, you are allowing deductions for your health plan premium contributions from your gross pay before federal, State and social security taxes are withheld. Since there may be tax implications, please visit the DHRD website at dhrd.hawaii.gov for more information. State employees making mid-plan year elections, should inquire with their Human Resources Office or DHRD on completing a PCP-2 form. Enrollment in the PCP is not automatic. Mark the "Enroll" or "Cancel/ Waive" box. If no election is made (i.e., left blank), new enrollments shall default to "Not Enrolled" and existing PCP enrollments shall continue.

IV. Dependent Information

Complete dependent information and indicate plan selection if adding, removing or continuing coverage for dependents. If you are adding/removing more than five dependents and additional rows are needed, please attach another sheet to your enrollment form. If this is your first time enrolling dependents in EUTF plans, please submit required proof documents including a marriage certificate if adding your spouse or partner and a birth certificate and guardianship or adoption decree (if applicable), if adding a child(ren). If a dependent child is age 19 to 24, unmarried and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Required proof documents must be submitted to the EUTF within 45 days of the event date. Social security numbers are required for all newly added dependents. Detailed eligibility information including required proof documents for other life events are available online at eutf.hawaii.gov. **Use the following Relationship codes:**

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

V. Other Insurance Information

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

VI. Employee Signature

Read, sign and date the form. Please submit your completed EC-1H form to DOE-EBU, PO Box 2360, Honolulu, HI 96804. To ensure proper processing, all required fields must be completed, and proper documentation submitted timely.

EXHIBIT C

Hawaii Employer-Union Health Benefits Trust Fund

Submit completed form to your personnel office.

DOE employees submit to:
DOE-EBU
PO Box 2360
Honolulu HI, 96804

EUTF ACTIVE EMPLOYEE EC-1 HEALTH BENEFITS ENROLLMENT FORM

All BUs and Employees Excluded from all Bargaining Units

Complete each section thoroughly, please print clearly

Enrollment Type (*you must check one box*): ☐ **New Hire** ☐ **Qualifying Event** ☐ **Open Enrollment**

New Hire or Qualifying Event Date: _____ **Qualifying Event Description:** _____

Full Legal Name: _____ Social Security No. or HB#: _____
Last, First M.I.

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

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner Gender: ☐ Male ☐ Female Birthdate: _____
Marriage Date: _____

Home Phone: _____ Cell Phone: _____ Email: _____

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

Note: If you will be adding your spouse or partner to your health plans, you must also indicate this information under the "Dependent Information" section.

COVERAGE START DATE

DO NOT SKIP THIS SECTION. Read the "EC-1 Enrollment Form Instructions" and complete this section before moving on. Mark one option.

Option #1 ☐ Coverage starts day of the event. Premium contributions start 1st day of the pay period in which the effective date of coverage occurs. ***(IF NO OPTION IS SELECTED, OPTION #1 WILL BE USED.)***

Option #2 ☐ Coverage and premium contributions start 1st day of the first pay period following event date (1st or the 16th of the month).

Option #3 ☐ Coverage and premium contributions start 1st day of the second pay period following event date (1st or the 16th of the month).

PLAN SELECTION EFFECTIVE 7/1/24 THROUGH 6/30/25

Medical, Chiro and Prescription Drug (select one)				
HMSA PPO 90/10 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $555.98	☐ Two-Party $1,350.64	☐ Family $1,722.26
HMSA PPO 80/20 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $336.66	☐ Two-Party $817.68	☐ Family $1,042.42
HMSA PPO 75/25 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $52.40	☐ Two-Party $127.26	☐ Family $162.20
HMSA HMO Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $590.64	☐ Two-Party $1,435.00	☐ Family $1,829.96
Kaiser Permanente HMO Comprehensive Medical, Chiro and Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $334.08	☐ Two-Party $812.34	☐ Family $1,037.40
Kaiser Permanente HMO Standard Medical, Chiro and Prescription Drug Monthly Employee Premium	☐ Cancel/Waive	☐ Self $52.06	☐ Two-Party $126.50	☐ Family $161.38
Verdegard Supplemental Medical and Prescription Drug (formerly HMA) (Must have coverage under a non-EUTF health plan to be eligible for Supplemental)	☐ Cancel/Waive	☐ Self $13.88	☐ Two-Party $24.74	☐ Family $26.78
Dental (select one)				
Hawaii Dental Service Monthly Employee Premium	☐ Cancel/Waive	☐ Self $14.76	☐ Two-Party $29.52	☐ Family $48.54
Vision (select one)				
Vision Service Plan Monthly Employee Premium	☐ Cancel/Waive	☐ Self $1.68	☐ Two-Party $3.14	☐ Family $4.10
Life (select one)				
Securian	☐ Cancel/Waive	☐ Self	No cost to employee	
Premium Conversion Plan* (State and Maui County Employees only) (if no election is made (i.e., left blank), the PCP election shall default to "Not Enrolled")	☐ Cancel/Waive	☐ Enroll		

* **State and Maui County Employees Only:** The Premium Conversion Plan (PCP) is a voluntary benefit plan that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. Refer to the EC-1 instructional page for more information. Enrollment in the PCP is not automatic. Mark the "Enroll" or "Cancel/Waive" box. If no election is made (i.e., left blank), new enrollments shall default to "Not Enrolled" and existing PCP enrollments shall continue.

EXHIBIT C

Employee's Name: _____

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

Complete dependent (including spouse and children) information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First Name, Middle Initial	Birthdate	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐									

If dependents are age 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov.

OTHER INSURANCE INFORMATION

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

Type of Plan: (eg. Medical, Dental)	Name of Plan: (eg. HMSA, Quest)	Subscriber's Name(s):

EMPLOYEE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I understand that if I waive coverage for myself or my dependents that I/they cannot enroll for benefits in EUTF's Plan unless eligible at the next Open Enrollment period or earlier, if there is a mid-year Special Enrollment event such as loss of other coverage, marriage, birth or adoption. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans elected. I authorize my employer or finance officer to make the pre-tax or after-tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. I agree to immediately notify the Fund in writing of any changes that would result in the loss or change of eligibility of my or any of my dependent- beneficiary's benefits. I understand that the Fund reserves the right to terminate benefits and to seek recovery of any overpayment of benefits resulting from my failure to provide written notice within forty-five (45) days of the event that caused the change or ineligibility. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalties for perjury.

_____ _____

Employee Signature *Date*

Official Use Only

Department ID#	Department	Division/School	Bargaining Unit

Date Received in Office	DPO Phone Number	DPO Fax Number

DPO (or employer designee) Printed Name	Date of DPO (or employer designee) Signature

DPO (or employer designee) Signature

By signing this EC-1 form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.

Comments:

Rev. 07/01/2024

EXHIBIT C

Hawaii Employer-Union Health Benefits Trust Fund

Submit completed form to:
DOE-EBU
PO Box 2360
Honolulu HI, 96804

HSTA VB ACTIVE EMPLOYEE
EC-1H HEALTH BENEFITS ENROLLMENT FORM

Bargaining Unit 05 (Formerly Under HSTA VEBA)

Complete each section thoroughly, please print clearly

Enrollment Type (*you must check one box*): **Qualifying Event** ☐ **Open Enrollment**

Qualifying Event Date: _____ **Qualifying Event Description:** _____

Full Legal Name: _____ Social Security No. or HB#: _____
Last, First M.I.

Mailing Address: _____
City State Zip Code

Residence Address: _____
City State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner
Marriage Date: _____

Gender: ☐ Male ☐ Female

Birthdate: _____

Home Phone: _____ Cell Phone: _____ Email: _____

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

Note: If you will be adding your spouse or partner to your health plans, you must also indicate this information under the "Dependent Information" section.

COVERAGE START DATE

DO NOT SKIP THIS SECTION. Read the "EC-1 Enrollment Form Instructions" and complete this section before moving on. Mark one option.

Option #1 ☐ Coverage starts day of the event. Premium contributions start 1st day of the pay period in which the effective date of coverage occurs. ***(IF NO OPTION IS SELECTED, OPTION #1 WILL BE USED.)***

Option #2 ☐ Coverage and premium contributions start 1st day of the first pay period following event date (1st or the 16th of the month).

Option #3 ☐ Coverage and premium contributions start 1st day of the second pay period following event date (1st or the 16th of the month).

PLAN SELECTION EFFECTIVE 7/1/24 THROUGH 6/30/25

Medical, Chiro and Prescription Drug and Vision (select one)				
HSTA VB HMSA PPO 90/10 Medical, Chiro, CVS Prescription Drug and VSP Vision Monthly Employee Premium	☐ Cancel/Waive	☐ Self $433.90	☐ Two-Party $1,051.82	☐ Family $1,340.96
HSTA VB HMSA PPO 80/20 Medical, Chiro, CVS Prescription Drug and VSP Vision Monthly Employee Premium	☐ Cancel/Waive	☐ Self $306.00	☐ Two-Party $741.52	☐ Family $945.00
HSTA VB Kaiser Permanente HMO Comprehensive Medical, Chiro, Prescription Drug and VSP Vision Monthly Employee Premium	☐ Cancel/Waive	☐ Self $270.40	☐ Two-Party $657.74	☐ Family $840.76
Other Plans				
Dental - Hawaii Dental Service Monthly Employee Premium	☐ Cancel/Waive	☐ Self $16.18	☐ Two-Party $32.38	☐ Family $53.26
Supplemental Dental - Hawaii Dental Service Monthly Employee Premium	☐ Cancel/Waive	☐ Self $7.56	☐ Two-Party $15.10	☐ Family $22.66
Vision – Vision Service Plan Monthly Employee Premium	☐ Cancel/Waive	☐ Self $1.68	☐ Two-Party $3.14	☐ Family $4.10
Life - Securian	☐ Cancel/Waive	☐ Self	No cost to employee	
Premium Conversion Plan* (State Employees only) (if no election is made (i.e., left blank), the PCP election shall default to "Not Enrolled")	☐ Cancel/Waive	☐ Enroll		

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

*** State Employees Only:** The Premium Conversion Plan (PCP) is a voluntary benefit plan that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. Refer to the EC-1 instructional page for more information. Enrollment in the PCP is not automatic. Mark the "Enroll" or "Cancel/Waive" box. If no election is made (i.e., left blank), new enrollments shall default to "Not Enrolled," and existing PCP enrollments shall continue.

Employee's Name: _____

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

DEPENDENT INFORMATION

Complete dependent (including spouse and children) information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First Name, Middle Initial	Birthdate	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐
☐	☐	☐						☐	☐	☐

If dependents are age 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov.

OTHER INSURANCE INFORMATION

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

Type of Plan: (eg. Medical, Dental)	Name of Plan: (eg. HMSA, Quest)	Subscriber's Name(s):

EMPLOYEE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I understand that if I waive coverage for myself or my dependents that I/they cannot enroll for benefits in EUTF's Plan unless eligible at the next Open Enrollment period or earlier, if there is a mid-year Special Enrollment event such as loss of other coverage, marriage, birth or adoption. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans elected. I authorize my employer or finance officer to make the pre-tax or after-tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. I agree to immediately notify the Fund in writing of any changes that would result in the loss or change of eligibility of my or any of my dependent- beneficiary's benefits. I understand that the Fund reserves the right to terminate benefits and to seek recovery of any overpayment of benefits resulting from my failure to provide written notice within forty-five (45) days of the event that caused the change or ineligibility. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalties for perjury.

_____ _____

Employee Signature *Date*

Official Use Only

Department ID#	Department	Division/School	Bargaining Unit

Date Received in Office	DPO Phone Number	DPO Fax Number

DPO (or employer designee) Printed Name	Date of DPO (or employer designee) Signature

DPO (or employer designee) Signature

By signing this EC-1 form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.

Comments:

EXHIBIT C

EXHIBIT C

State of Hawaii
Department of Budget and Finance
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813

EXHIBIT C

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

Effective January 1, 2024 – December 31, 2024

RETIREE HEALTH BENEFITS HIGHLIGHTS GUIDE

(EUTF and HSTA VB)

EXHIBIT C

Aloha Retirees,

We are pleased to present the *2024 Retiree Health Benefits Highlights Guide*. This Highlights Guide provides key information about the health benefit plans available to you for calendar year January 1, 2024, through December 31, 2024. In the past, we distributed a full *Retiree Health Benefits Reference Guide* but have moved some of the detailed (and unchanged) information to our website for you to refer to at your convenience.

This year's open enrollment runs from October 16-31, 2023. Any changes made during open enrollment will take effect on January 1, 2024. The open enrollment period is your annual opportunity to make any changes to your enrollment in our health benefit plans.

Our goal is to provide you with quality health benefit plans, which you earned through the dedication and hard work you provided as a State or County employee. The information contained in this *Highlights Guide* is designed to help you make the benefit choices that best meet your needs for the coming year. Our EUTF website has additional tools and resources to help you make the best use of your benefits throughout the year.

This guide and other useful information are posted on the EUTF website at **eutf.hawaii.gov**. Please visit for updated news and resources. If you need any assistance, you can reach our helpful staff at **1-808-586-7390**, or toll-free at **1-800-295-0089**.

Mahalo,

Jacqueline Ferguson-Miyamoto, Chair

EUTF Board of Trustees

Mandatory Medicare Part B Enrollment

All Medicare-Eligible Retirees and Covered Dependents

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

Proof of Medicare Part B Enrollment

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

Required Documents

If you and/or your dependents are Medicare eligible (generally, are age 65 or older, qualified disabled, or have end-stage renal disease) and are covered under EUTF retiree medical and/or prescription drug plans, you must submit the following to the EUTF:

- Copy of your and/or your dependent's Medicare card (indicating enrollment in Medicare Part B)
- Direct Deposit Agreement Form for reimbursement of your and your spouse's/partner's Medicare Part B premiums
- Social Security Administration (SSA) or Centers for Medicare & Medicaid Services (CMS) letter and/or invoice for you and/or your spouse/partner indicating the Medicare Part B premium amount. Medicare retirees that pay a higher income-related monthly adjusted premium must submit a copy of their SSA/CMS letter to the EUTF each year. Reimbursements of the difference between the higher income-related monthly adjusted Medicare Part B premium and the standard Medicare Part B premium is limited to a two-year lookback period. If you are assessed the higher income-related Medicare Part B premium, you will likely be assessed by CMS a Medicare Part D premium, which will not be reimbursed by EUTF.

More information can be found under the Medicare section of the EUTF website (**eutf.hawaii.gov/medicare/overview**).

Table of Contents

This Retiree Plan has been determined to be a "Retiree Only Plan," meaning it is not subject to many group health requirements, including HIPAA Non-Discrimination, Mental Health Parity, and the Affordable Care Act.

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

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

To find out whether the prescription drug coverage under the medical plan options offered by the EUTF are creditable or not, you should review the Plan's Medicare Part D Notice of Creditable Coverage available on page 44.

NOTE: If you are enrolled in SilverScript prescription drug coverage or the Kaiser Permanente Senior Advantage plan, you already have Medicare prescription drug coverage, and this notice does not apply to you.

Introduction

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

The EUTF is a State agency administratively attached to the State of Hawaii Department of Budget and Finance and is governed by a 10-member, governor-appointed board of trustees.

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

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

Disclaimer

This Highlights Guide offers general information on your health and other benefit plans that are exclusively governed by the Hawaii Revised Statutes, the EUTF Administrative Rules as they are amended from time to time, and the carrier plan documents—all of which are available on the EUTF website at **eutf.hawaii.gov**. Nothing in this Guide is intended to amend, change, or contradict these documents. This Guide is not a legal document or contract, and the information in this Guide is not intended as legal advice or to create any legal or contractual liabilities.

Various health plan providers offer services to EUTF members that are specific products of the provider. These services are not a part of the health benefits package provided to you by the State of Hawaii and its Counties by virtue of your employment or membership in the EUTF. These services are provided only as pilot programs and are subject to modification or termination at any time by the service provider, EUTF, and/or the State at their sole discretion. The State and EUTF expressly do not promise, do not warrant, do not guarantee, and make no representation that these services will be available to EUTF active or retired employees or their beneficiaries at any time in the future or in any form or manner.

Individuals With Special Needs

This Highlights Guide can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990. Please contact the EUTF office at **1-808-586-7390** or toll-free at **1-800-295-0089**, for special needs.

What's New for 2024

The following changes are effective January 1, 2024, unless otherwise specified:

HMSA

1. Added the Human Papillomavirus Virus (HPV) screening benefit, in accordance with U.S. Preventive Services Task Force Grade A & B recommendations, at the same benefit level as screening services to the EUTF and HSTA VB retiree plans.
2. Increased the benefit maximum for the orthodontic treatment of orofacial anomalies from $5,500 to $6,900 under the EUTF and HSTA VB retiree plans.
3. Added the Virta Diabetes Management Program under the EUTF and HSTA VB retiree plans. There is no member cost share and a lifetime limit of 24 months.
4. Changed to allow coverage of specialty drugs administered in the physician's office (including ambulatory infusion suites and home IV/infusion sites) under the EUTF and HSTA VB retiree plans (effective July 1, 2023).

Kaiser Permanente

5. Increased the benefit maximum for the orthodontic treatment of orofacial anomalies from $5,500 to $6,898 under the EUTF and HSTA VB non-Medicare retiree plans.

Humana

6. Added Post-Discharge In-Home Personal Care Services at no member cost share for a minimum of 4 hours per day, up to a maximum of 8 hours total per discharge, for certain in-home support services following a discharge from a skilled nursing facility or from an inpatient hospitalization.

CVS Caremark

7. Added the Tier 1 Strategy to the EUTF non-Medicare retiree plans, where select brand products will process at a generic copay when the cost for the brand is less than the generic. Member pays the generic copay or the cost of the drug whichever is less (effective July 1, 2023).
8. Added prior authorization requirement for anti-diabetic GLP-1 (e.g., Ozempic, Rybelsus, Trulicity, Victoza) and GIP/GLP-1 agonists agents (e.g., Mounjaro) to the EUTF non-Medicare retiree plans (effective July 1, 2023).

HDS

9. Added Total Health Plus, a supplemental set of benefits that provides 100% coverage for additional cleanings and/or fluoride treatments for high risk patients with certain medical conditions or diagnoses, under the retiree plan (effective January 1, 2023).

Premium Rate Changes

For information about the 2024 monthly premium rates that take effect January 1, 2024, see the Monthly Health Plan Premiums section, starting on page 29.

Recurring Electronic Premium Deduction Requirement

NOTE: If you retired on or after **October 1, 2020**, and are responsible for paying a portion of your or your dependent's monthly health benefits premium, you are required to enroll in a recurring electronic premium deduction (Hawaii Law Act 62, SLH 2020).

The EUTF offers two options:

- ACH deductions from your bank
- Employees' Retirement System of the State of Hawaii (ERS) pension deductions

Enrollment forms for ACH or ERS pension deductions are available at the back of this guide or on the EUTF website at **eutf.hawaii.gov**.

Visit the EUTF Website

Be sure to visit the EUTF website at **eutf.hawaii.gov**. Not only does it provide more details than this Highlights Guide about your specific benefit plans, it includes resources to help support your health and well-being, news articles, health plan provider contacts, frequently asked questions, forms and documents to print and download, and much more.

Important Enrollment Information

About Open Enrollment

Now is the time for you to review whether the health coverage you have for yourself and your family continues to best meet your needs. During the open enrollment election period, you can:

- Add, change, or drop a plan
- Add or remove dependents
- Change coverage tiers, such as changing from Self to Family, or Family to Two-Party

If you decide to keep your current plans, you don't need to take action. You are not required to complete any forms to continue your current coverage.

If you are making changes, complete and submit the EC-2 enrollment form at the back of this guide or on the website at eutf.hawaii.gov (or the EC-2H enrollment form for those enrolled in the HSTA VB benefit plans).

For open enrollment change requests, submit your completed EC-2/EC-2H enrollment form and required supporting documents to the EUTF via U.S. mail (201 Merchant Street, Suite 1700, Honolulu, HI 96813) or in-person by October 31, 2023, for changes to be effective January 1, 2024. The EUTF will not contact you regarding outstanding supporting documents and late submissions will not be accepted.

Required Supporting Documents

Enrollment Type	Required Documents
Self	No documents required
Adding a Spouse/Partner	• Marriage or Civil Union Certificate • Domestic Partnership forms (available at eutf.hawaii.gov)
Adding a Dependent Child	• Birth Certificate • Guardianship Decree (if legal guardian) • Adoption Decree (if child is placed for adoption or adopted)
Dependent Children Ages 19 through 23	• Student Certification from accredited school on school letterhead with registrar's signature confirming full-time status or certificate from the National Student Clearinghouse (transcripts and class schedules are not accepted).

Important Dates

October 16–31, 2023: Open enrollment election period

January 1, 2024: Premium changes take effect and the Base Monthly Contribution (BMC) may change

January 31, 2024: For retirees responsible for paying a portion of heath benefit premiums, new monthly retiree premiums deducted from ERS pension or ACH from your bank.

January 1, 2024 – December 31, 2024: Retiree benefit plan coverage period

Eligible for Medicare?

If you or your dependents are eligible for Medicare—or will be this year—please be sure to review the Medicare section of the EUTF website (**eutf.hawaii.gov/medicare/overview**), so you are aware of how this will affect your plans, as well as the statutory Medicare Part B enrollment requirements (see page 4).

EUTF Retiree Open Enrollment Virtual Fair

October 16–31, 2023

The EUTF will be hosting a virtual open enrollment fair in place of in-person informational sessions. You can attend virtually from your laptop, tablet, or PC!

At the virtual fair, you will be able to:

- Attend a live webinar presentation by an EUTF representative
- Watch on-demand video presentations from HMSA, Kaiser Permanente, Humana, CVS Caremark/SilverScript, VSP, HDS, and Securian
- Learn about health plan and premium changes (effective January 1, 2024)
- Learn money saving tips

How to attend the fair

On the day of the fair, go to **eutf.hawaii.gov/learning-center** and click on "Retiree Open Enrollment Fair." You'll be able to view on-demand video presentations from the EUTF and each of the insurance carriers and attend an EUTF live webinar. Please see the schedule below for a list of live webinars.

DATE	TIME
Monday–Friday, October 16-20, 2023	**9:00-9:30 a.m.** **10:00–10:30 a.m.**
Wednesday–Friday, October 25-27, 2023	

Technology needed to attend

Participants will need a computer and internet access to attend. For the best experience, use an up-to-date version of Google Chrome (preferred), Safari, or Firefox from a desktop/laptop.

Your Open Enrollment Checklist

☐ **Know your current coverage.** What plans are you currently enrolled in? And which dependents are you covering? You may contact EUTF at **1-808-586-7390** or toll-free at **1-800-295-0089**, to confirm your current coverage.

☐ **Learn more about the choices available to you.** You have a number of resources to help:

- **Read this *2024 Retiree Health Benefits Highlights Guide*** for the summaries of your plan options, including what's new or changing for 2024 (see page 7).
- **Visit the EUTF website at eutf.hawaii.gov** for full details about the plans, including extra programs supporting your health and wellness, tips to help you save on health care costs, and more. It also includes links to the insurance carriers' websites. Questions regarding specific plan provisions should be directed to the carriers (see pages 49-50).
- **Attend the online Open Enrollment Virtual Fair** to get more details and ask questions of our EUTF Outreach & Training Specialist. See page 10 for the schedule.

☐ **Check your costs.** You can find the monthly premium rates on pages 32-33 of this Highlights Guide. The premium amounts listed show the full cost for each plan.

To determine whether you need to pay a portion of the monthly premiums, you will also need to review the 2024 Base Monthly Contribution (BMC) and employer contribution amounts, which were not available at the time this Guide went to press. Please visit the EUTF website at **eutf.hawaii.gov** in December for the 2024 Base Monthly Contribution amount to determine the contributions that take effect January 1, 2024.

Dependents No Longer Eligible?

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

☐ **Enrolling Dependents?** Gather your supporting documents. You may add or remove dependents from your plan, including a spouse/partner or eligible children. Please visit the "EUTF Retiree – Eligibility" webpage (**eutf.hawaii.gov/retirees/eutf-retiree/eligibility**) for eligibility definitions and information on required supporting documents.

If your dependent is eligible for Medicare, he/she must be enrolled in Medicare Part B to be covered under your EUTF or HSTA VB retiree medical and/or prescription drug plans (see page 4).

☐ **Make a decision about which plans best suit your needs,** and whether you want to keep or change your current coverage.

- **If you decide to keep your current plans, you don't need to do anything.** You are not required to complete any forms to keep your current coverage.
- **If you wish to make any changes,** complete the next step.

☐ **If you are making changes,** complete and submit the EC-2 enrollment form at the back of this guide or on the website at **eutf.hawaii.gov** (or the EC-2H enrollment form for those enrolled in the HSTA VB benefit plans).

- **Submit your completed enrollment form and required supporting documents to the EUTF via U.S. mail (201 Merchant Street, Suite 1700, Honolulu, HI 96813) or in-person by October 31, 2023.** If you are submitting by U.S. mail, enrollment forms and required supporting documents must be postmarked by October 31, 2023.
- **If you are enrolling in EUTF plans for the first time,** you must submit a copy of your ERS retirement estimate letter and electronic premium deduction form (if responsible for paying for a portion of your or your dependent's monthly health benefits premium).

NOTE: **Forms and required supporting documents postmarked after October 31, 2023, will be rejected.**

The EUTF will send you an enrollment confirmation notice after the processing of open enrollment forms is completed.

Health Plan Basics

Medical and Prescription Drug Plans

Since Medicare has a significant impact on our retiree medical and prescription drug plans, EUTF retirees are separated into two groups:

- **Non-Medicare Retirees** – Retirees and their eligible dependents who are not yet eligible for Medicare. State and County employees who retire before becoming Medicare eligible may select non-Medicare medical and prescription drug plan options for themselves and their eligible dependents. See pages 14-16 for these benefit summaries.
- **Medicare Retirees** – Retirees and their eligible dependents who are enrolled in Medicare. Hawaii Revised Statutes 87A and EUTF Administrative Rules require that you enroll in Medicare Part B when eligible in order to enroll in any EUTF or HSTA VB retiree medical and/or prescription drug plan (see page 4). See pages 17-19 for these benefit summaries.

Premiums are based on the Medicare status of the retiree.

Dental, Vision, and Life Insurance Plans

The EUTF and HSTA VB retiree dental, vision, and life insurance plans are the same for both non-Medicare and Medicare retirees. See pages 26-28 for these benefit summaries.

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

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

Your premium reimbursement will be the lesser of:

- The actual cost of the medical and prescription drug plan, or
- The amount of the State or County contribution for the most comparable Kaiser Permanente health plan.

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

Benefit Summaries: Non-Medicare

Retirees who are not yet eligible for Medicare may enroll in non-Medicare retiree medical and prescription drug plan options. The charts on the following pages outline both EUTF and HSTA VB* plan options.

These charts are intended to provide a summary of plan benefits. Certain limitations, restrictions, and exclusions apply to all insurance plans. For complete information on plan benefits, please refer to the *HMSA Guide to Benefits* or the *Kaiser Permanente Hawaii's Guide to Your Health Plan*. You may download them from the EUTF website at **eutf.hawaii.gov** or request them directly from HMSA or Kaiser Permanente. Plan benefits vary based on the plan selected.

In the case of a discrepancy between the information provided in this Highlights Guide and what is listed in the carrier's benefit summary, the language in the carrier's benefit summary will take precedence.

* HSTA VB plan options were created for HSTA retirees who were enrolled in the HSTA VB retiree plans prior to January 1, 2011. These plans are no longer accepting new enrollees.

EUTF Medical and Prescription Drug Benefits — Non-Medicare

MEDICAL	HMSA 90/10 PPO Plan		Kaiser Permanente HMO Plan[1]
	In-Network	Out-of-Network	HMO Network
Calendar Year Deductible	$100/person $300/family		None
Calendar Year Maximum Out-of-Pocket Limit	$2,500/person $7,500/family		$2,000/person $6,000/family
Lifetime Benefit Maximum	None		None
Physician Office Visit	10%[2]	30%	$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge[2]	Not covered	No charge
Urgent Care Visit	10%[2]	30%	$15 (in service area) 20% (out of service area)
Emergency Room	10%[2]	10%[2]	$50 (in service area) 20% (out of service area)
Ambulance Air	20%	20%	20%
Ambulance Ground	20%	30%	20%
Inpatient Hospital Services	10%[2]	30%	No charge
Outpatient Surgery	10%[2]	30%	$15
Outpatient Testing, Lab, and X-Ray Services	20%[2]	30%	$15
Annual Physical Exam	No charge[2]	30%[2]	No charge
Preventive Screening	20%[2]	30%	No charge
Inpatient Mental Health	10%[2]	30%	No charge
Outpatient Mental Health	10%[2]	30%	$15
Chiropractic Services	Not covered	Not covered	Not covered

PRESCRIPTION DRUG	CVS PPO Drug Plan[3]			Kaiser Permanente HMO Plan[4]	
	In-Network	Out-of-Network[5]	Retail 90/ Mail Order	HMO Network	Mail Order
Day Supply	30/60/90			30/60/90	
Generic	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10	$15/$30/$45	$15/$30/$30
Preferred Brand	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30		
Non-Preferred Brand	$30/$60/$90	$30/$60/$90 + 20%	$30/$60/$60		
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10	$15/$30/$45	Not covered
Other Insulin	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30		
Preferred Diabetic Supplies	No charge	20%	No charge	$15/$30/$45	$15/$30/$30
Other Diabetic Supplies	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30		
Specialty Drugs/Injectables	20% (up to a 30-day supply) Up to $250 per fill; $2,000 maximum out-of-pocket per calendar year; $30 copay for oral oncology specialty medications Mail Pharmacy: Not covered			$15 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

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

[2] Not subject to the deductible

[3] This plan is the prescription drug coverage for the HMSA PPO medical plan option and is administered by CVS Caremark. Note: Maintenance medications can be filled at any retail network pharmacy or through mail order but must be filled in a 90-day supply after the first three 30-day initial fills.

[4] The Kaiser Permanente prescription drug coverage is included under the Kaiser Permanente HMO medical plan.

[5] If you receive services from an out-of-network pharmacy, you will pay full price for the prescription and must file a claim for reimbursement. You are responsible for the copayment, including the penalty %, and any difference between the actual charge and the eligible charge.

HSTA VB Medical and Prescription Drug Benefits — Non-Medicare

MEDICAL	HMSA 90/10 PPO Plan		Kaiser Permanente HMO Plan[1]
	In-Network	Out-of-Network	HMO Network
Calendar Year Deductible	None	$100/person $300/family	None
Calendar Year Maximum Out-of-Pocket Limit	$2,000/person $6,000/family		$2,000/person $6,000/family
Lifetime Benefit Maximum	$2,000,000 for all individuals combined; $25,000/calendar year thereafter		None
Physician Office Visit	10%	30%	$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge	Not covered	No charge
Urgent Care Visit	10%	30%	$15 (in service area) 20% (out of service area)
Emergency Room	10%	10%[2]	$50 (in service area) 20% (out of service area)
Ambulance Air	10%	10%[2]	20%
Ambulance Ground	10%	30%	20%
Inpatient Hospital Services	10%	30%	No charge
Outpatient Surgery	10%	30%	$15
Outpatient Testing, Lab, and X-Ray Services	10%	30%	$15
Annual Physical Exam	No charge (limits apply)	No charge[2] (limits apply)	No charge
Preventive Screening	10%	30%	No charge
Inpatient Mental Health	10%	30%	No charge
Outpatient Mental Health	10%	30%	$15
Chiropractic Services (administered through American Specialty Health, Inc.)	$12 (20 visits/year)	Not covered	$12 (20 visits/year)

PRESCRIPTION DRUG	CVS PPO Drug Plan[3]		Kaiser Permanente HMO Plan[4]	
	In-Network/Mail Order	Out-of-Network[5]	HMO Network	Mail Order
Day Supply	30/60/90		30/60/90	
Generic	$5/$9/$9	$5/$9/$9+30%	$10/$20/$30	$10/$20/$20
Brand	$15/$27/$27	$15/$27/$27+30%		
Insulin	$5/$9/$9	$5/$9/$9+30%	$10/$20/$30	Not covered
Diabetic Supplies	No charge	No charge	50%	50%
Specialty Drugs/Injectables	Generic/brand copays apply Mail Pharmacy: Not covered		$10 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

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

[2] Not subject to the deductible

[3] This plan is the prescription drug coverage for the HMSA PPO medical plan option and is administered by CVS Caremark.

[4] The Kaiser Permanente prescription drug coverage is included under the Kaiser Permanente HMO medical plan.

[5] If you receive services from an out-of-network pharmacy, you will pay full price for the prescription and must file a claim for reimbursement. You are responsible for the copayment, including the penalty %, and any difference between the actual charge and the eligible charge.

Benefit Summaries: Medicare

Retirees who are enrolled in Medicare may enroll in Medicare retiree medical and prescription drug plan options. The charts on the following pages outline both EUTF and HSTA VB* plan options.

These charts are intended to provide a summary of plan benefits. Certain limitations, restrictions, and exclusions apply to all insurance plans. For complete information on plan benefits, please refer to the *HMSA Guide to Benefits,* the *Humana Medicare Advantage PPO Guidebook for Hawaii*, or the *Kaiser Permanente Enrollment Guide*. You may download them from the EUTF website at **eutf.hawaii.gov** or request them directly from HMSA, Humana, or Kaiser Permanente. Plan benefits vary based on the plan selected.

In the case of a discrepancy between the information provided in this Highlights Guide and what is listed in the carrier's benefit summary, the language in the carrier's benefit summary will take precedence.

* HSTA VB plan options were created for HSTA retirees who were enrolled in the HSTA VB retiree plans prior to January 1, 2011. These plans are no longer accepting new enrollees.

Medicare 101

For a general overview of Medicare, including how to enroll, information about Medicare Part B and Part D coverage, and answers to frequently asked questions, be sure to visit the EUTF "Medicare – Overview" webpage (**eutf.hawaii.gov/medicare/overview**).

EUTF Medical and Prescription Drug Benefits — Medicare

MEDICAL	HMSA 90/10 PPO Plan (Supplemental Plan to Medicare)		Humana Medicare Advantage Plan	Kaiser Permanente Senior Advantage Plan[1]
	In-Network	Out-of-Network	In-Network/ Out-of-Network	HMO Network
Calendar Year Deductible	$100/person $300/family		$100/person	None
Calendar Year Maximum Out-of-Pocket Limit	$2,500/person $7,500/family		$2,500/person	$2,000/person $6,000/family
Lifetime Benefit Maximum	None		None	None
Physician Office Visit	10%[2]	30%	10%[2]	$15
Online Care (through hmsaonlinecare.com, myhumana.com, or kp.org)	No charge[2]	Not covered	Primary Care: No charge Specialist: 10% Behavioral Health and Substance Abuse: No charge	No charge
Urgent Care Visit	10%[2]	30%	10%[2]	$20
Emergency Room	10%[2]	10%[2]	10%[2] (waived if admitted within 24 hours)	$50
Ambulance Air	20%	20%	10%	20%
Ambulance Ground	20%	30%	10%	20%
Inpatient Hospital Services	10%[2]	30%	10%	No charge
Outpatient Surgery	10%[2]	30%	10%	$15
Outpatient Testing, Lab, and X-Ray Services	20%[2]	30%	10%	No charge
Annual Physical Exam	No charge[2]	30%[2]	No charge[2]	No charge
Preventive Screening	20%[2]	30%	No charge[2]	No charge
Inpatient Mental Health	10%[2]	30%	10%	No charge
Outpatient Mental Health	10%[2]	30%	Facility: 10% Physician visit: 10%[2]	$15
Chiropractic Services	Not covered	Not covered	10%[2] For Medicare-covered services only (manual manipulation of the spine to correct subluxation)	$15

PRESCRIPTION DRUG	SilverScript (SSI) Medicare Part D PPO Drug Plan[3]		Kaiser Permanente Senior Advantage Plan[4]	
	In-Network/Mail Order	Out-of-Network[5]	HMO Network	Mail Order
Day Supply	30/60/90		30/60/90	
Generic	$5/$10/$10	$5/$10/$10 + 20%	$15/$30/$45	$15/$30/$30
Preferred Brand	$15/$30/$30	$15/$30/$30 + 20%		
Non-Preferred Brand	$30/$60/$60	$30/$60/$60 + 20%		
Insulin	$5/$10/$10	$5/$10/$10 + 20%	$15/$30/$45	Not covered
Diabetic Supplies	No charge Meters: Covered by Medicare Part B and the HMSA and Humana medical plans	20% Meters: Covered by Medicare Part B and the HMSA and Humana medical plans	Lancets, strips, and meters: 20% Syringes/needles: $15/$30/$45	Lancets, strips, and meters: 20% Syringes/needles: $15/$30/$30
Specialty Drugs (including high-cost drugs as defined by CMS) and Injectables	20% (up to a 30-day supply) Up to $250 per fill; $2,000 In-Network maximum out-of-pocket per calendar year $30 copay for oral oncology specialty medications Mail Pharmacy: Not covered	50% $30 copay (up to a 30-day supply) + 20% for oral oncology specialty medications	$15 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

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

[2] Not subject to the deductible

[3] The EUTF's Medicare Part D prescription drug plan is administered by SilverScript (SSI), the Medicare Part D administrator for CVS Caremark. This plan is the prescription drug coverage for Medicare retirees enrolled in the HMSA and Humana PPO medical plan options and for stand-alone drug coverage.

[4] The Kaiser Permanente Medicare Part D prescription drug coverage is included under the Kaiser Permanente Senior Advantage medical plan.

[5] If you receive services from an out-of-network pharmacy, you will pay full price for the prescription and must file a claim for reimbursement. You are responsible for the copayment, including the penalty %, and any difference between the actual charge and the eligible charge.

HSTA VB Medical and Prescription Drug Benefits — Medicare

MEDICAL	HMSA 90/10 PPO Plan		Kaiser Permanente Senior Advantage Plan[1]
	In-Network	Out-of-Network	HMO Network
Calendar Year Deductible	None	$100/person $300/family	None
Calendar Year Maximum Out-of-Pocket Limit	$2,000/person $6,000/family		$2,000/person $6,000/family
Lifetime Benefit Maximum	$2,000,000 for all individuals combined; $25,000/calendar year thereafter		None
Physician Office Visit	10%	30%	$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge	Not covered	No charge
Urgent Care Visit	10%	30%	$20
Emergency Room	10%	10%[2]	$50
Ambulance Air	10%	10%[2]	20%
Ambulance Ground	10%	30%	20%
Inpatient Hospital Services	10%	30%	No charge
Outpatient Surgery	10%	30%	$15
Outpatient Testing, Lab, and X-Ray Services	10%	30%	No charge
Annual Physical Exam	No charge (limits apply)	No charge[2] (limits apply)	No charge
Preventive Screening	10%	30%	No charge
Inpatient Mental Health	10%	30%	No charge
Outpatient Mental Health	10%	30%	$15
Chiropractic Services (administered through American Specialty Health, Inc.)	$12 (20 visits/year)	Not covered	$12 (20 visits/year)

PRESCRIPTION DRUG	SilverScript (SSI) Medicare Part D PPO Drug Plan[3]		Kaiser Permanente Senior Advantage Plan[4]	
	In-Network/Mail Order	Out-of-Network[5]	HMO Network	Mail Order
Day Supply	30/60/90		30/60/90	
Generic	$3/$9/$9	$3/$9/$9 + 30%	$10/$20/$30	$10/$20/$20
Brand	$9/$27/$27	$9/$27/$27 + 30%		
Insulin	$3/$9/$9	$3/$9/$9 + 30%	$10/$20/$30	Not covered
Diabetic Supplies	No charge Meters: Covered by Medicare Part B and the HMSA PPO medical plan	30% Meters: Covered by Medicare Part B and the HMSA PPO medical plan	20%	20%
Specialty Drugs/Injectables	Generic/brand copays apply Mail Pharmacy: Not covered		$10 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

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

[2] Not subject to the deductible

[3] The HSTA VB's Medicare Part D prescription drug plan is administered by SilverScript (SSI), the Medicare Part D administrator for CVS Caremark. This plan is the prescription drug coverage for Medicare retirees enrolled in the HMSA PPO medical plan option.

[4] The Kaiser Permanente Medicare Part D prescription drug coverage is included under the Kaiser Permanente Senior Advantage medical plan.

[5] If you receive services from an out-of-network pharmacy, you will pay full price for the prescription and must file a claim for reimbursement. You are responsible for the copayment, including the penalty %, and any difference between the actual charge and the eligible charge.

Coordination of Benefits for Medicare

When a retiree is covered by more than one health insurance plan, Coordination of Benefits (COB) determines which plan should be the primary and secondary payer for services.

Medicare Secondary Payer

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

Medicare Annual Deductible

The Medicare annual deductible is applied for most Medicare Part A and B services and must first be satisfied before Medicare benefits can be applied. Medicare annual deductibles are based on a calendar year and are adjusted annually. Medicare annual deductibles for 2023* are as follows:

- 2023 Medicare Part A Hospital Deductible $1,600
- 2023 Medicare Part B Medical Deductible $226

* Medicare annual deductibles for 2024 were not available at the time of print.

Coordination of Benefits (COB)

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

To help coordinate your benefits, please give your providers the information about your Medicare and EUTF plans. COB examples are provided on the following pages. Retirees will be responsible for any non-covered charges such as taxes.

Note: If you are enrolled in the Humana Medicare Advantage PPO plan or Kaiser Permanente Senior Advantage plan, there is no Coordination of Benefits with Medicare.

Coordination of Medicare Benefits Examples

Table of Claims Examples

Claim	Service	Date of Service	Charge	Medicare Part B Payment	HMSA Plan Payment	HMSA Member Owes	Humana Member Owes
#1	Office Visit	1/3/2024	$105.00	$0.00	$94.50	$10.50	$10.50
	Diagnostic Test (Outpatient)	1/3/2024	$121.00	$0.00	$96.80	$24.20	$102.10
			$226.00	$0.00	$191.30	$34.70	$112.60
#2	Office Visit	2/3/2024	$105.00	$84.00	$21.00	$0.00	$10.50
	Diagnostic Test (Outpatient)	2/3/2024	$128.00	$102.40	$25.60	$0.00	$12.80
			$233.00	$186.40	$46.60	$0.00	$23.30
#3	Inpatient Hosp. – Room & Board	2/20/2024	$15,000.00	$13,400.00	$1,600.00	$0.00	$1,500.00
#4	Prosthesis	2/20/2024	$500.00	$400.00	$0.00	$100.00	$50.00

Example 1: Medicare/HMSA Coordination With Medicare Part B Annual Deductible

Reminder: No COB for Humana or Kaiser Permanente

If you are enrolled in the Humana Medicare Advantage PPO plan or Kaiser Permanente Senior Advantage plan, there is no Coordination of Benefits with Medicare.

Claim #1:

Medicare/HMSA: Member received services from an HMSA participating provider who accepts Medicare assignment. There will be no payment by Medicare, as Medicare will apply $226.00 toward the annual Medicare Part B deductible. (At this point, the annual Medicare Part B deductible is met.) HMSA will process the office visit claim at 90% of eligible charge and the outpatient diagnostic test claim at 80% of eligible charge. The member owes the 10% balance of the office visit claim and the 20% balance of the outpatient diagnostic claim, plus any non-covered charges such as taxes.

Humana: There is no COB on the Humana plan. All in- and out-of-network claims are submitted to and processed by Humana. Humana will pay the office visit claim at 90% of eligible charge, and the member owes the 10% balance. Humana will pay the outpatient diagnostic test claim at 90% of eligible charge after the member pays the $100 annual deductible. The member owes $100, plus 10% of the remaining eligible charge ($2.10), for the outpatient diagnostic test claim. (At this point, the $100 deductible is met.)

Claim #2:

Medicare/HMSA: Because the annual Medicare Part B deductible was met with Claim #1, Medicare will apply plan benefits (80% of eligible charge in this illustration), and HMSA will coordinate payment of the remaining balance of eligible charges. Although the member owes a zero balance in eligible charges, the member may be responsible for any non-covered charges such as taxes.

Humana: There is no COB on the Humana plan. Humana will pay the office visit claim at 90% of eligible charge, and the member owes the 10% balance. Since the annual deductible was met with Claim #1, Humana will pay the outpatient diagnostic test claim at 90% of eligible charge, and the member owes the 10% balance.

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

Claim #3:

Medicare/HMSA: Member received services at an HMSA participating facility that accepts Medicare assignment. Member has not had any previous inpatient visits within the last 60 days. Medicare Part A will process 100% of facility charges less the Medicare Part A deductible of $1,600.00. (At this point, the Medicare Part A deductible is met.) HMSA will coordinate payment of the remaining balance of eligible charges. Although member owes a zero balance in eligible charges, the member may be responsible for any non-covered charges such as taxes.

Humana: There is no COB on the Humana plan. Humana will pay the inpatient hospital claim at 90% of eligible charge, and the member owes the 10% balance, limited to the Annual Maximum Out-of-Pocket of $2,500 per covered individual. Once the member has reached the Annual Maximum Out-of-Pocket, covered services will be paid by the Humana plan at 100%.

Example 3: Medicare/HMSA Coordination With HMSA Annual Deductible

Claim #4:

Medicare/HMSA: Member received services from an HMSA participating provider who accepts Medicare assignment. Because the annual Medicare Part B deductible was met with Claim #1, Medicare will apply plan benefits (80% of eligible charge in this illustration). Durable Medical Equipment benefits are subject to a $100 annual deductible, and, therefore, $100 is applied to the HMSA deductible. Member owes $100 in addition to any non-covered charges such as taxes. (At this point, the $100 deductible is met.)

Humana: There is no COB on the Humana plan. Humana will pay the prosthesis claim at 90% of eligible charge, and the member owes the 10% balance.

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

Humana Medicare Advantage PPO Plan

Enrollment

If you plan to enroll in the EUTF Humana Medicare Advantage PPO plan, you must:

- Be enrolled in Medicare Part A and B
- Attach a copy of your Medicare card to your EC-2 enrollment form. To avoid a break in coverage, your EC-2 must be signed and dated prior to the date of your retirement.
- Reside in Humana's Medicare Advantage service area*

If you plan to enroll your spouse/partner/disabled child:

- Your spouse/partner/disabled child must be enrolled in Medicare Part A and B.
- You must attach a copy of his/her Medicare card to your EC-2 enrollment form.
- Your spouse/partner/disabled child must sign the EC-2 enrollment form.
- Your spouse/partner/disabled child must reside in Humana's Medicare Advantage service area.*
- The maximum enrollment in the Family Tier is three (3) individuals, including you.

Important things to know if you enroll in the EUTF Humana Medicare Advantage PPO plan:

- If you enroll in a non-EUTF Medicare Advantage plan and/or a non-EUTF Medicare prescription drug plan, you will be disenrolled from the EUTF Humana Medicare Advantage plan and/or the EUTF SilverScript Medicare prescription drug plan.
- If you are enrolled in a non-EUTF individual Medicare Part D prescription drug plan (not an EUTF Medicare prescription drug plan) and you enroll in the EUTF Humana plan, you will be disenrolled from the individual Medicare Part D prescription drug plan.
- If you are enrolled in an HSTA VB retiree plan and change to the EUTF Humana plan, you will not be allowed to re-enroll in HSTA VB retiree plans in the future.
- The EUTF Humana plan does not include prescription drug coverage, so if you enroll in the EUTF Humana plan and want prescription drug coverage, you should also enroll in the EUTF SilverScript Medicare prescription drug plan.

* For retirees and their spouse/partner/disabled child residing in the State of Hawaii, Humana's service area includes all of the Hawaiian Islands.

For retirees and their spouse/partner/disabled child residing on the Mainland, please contact Humana to verify your residential address is in Humana's service area. When calling Humana, please identify yourself as a retiree of the EUTF/State of Hawaii Group plan. Toll-free: **1-888-908-6518**, open 7:00 a.m. to 7:00 p.m. HST, Monday to Friday. Humana's phone system may answer your call after hours. Please leave a message, and a Humana Customer Service representative will call you back by the end of the next business day.

Kaiser Permanente Senior Advantage Plan

The following requirements apply to all Medicare-eligible retirees and dependents for enrollment in the Kaiser Permanente HMO medical and prescription drug plan who:

- Enroll in Medicare Part A and B; and
- Reside in the Kaiser Permanente Senior Advantage service area. This area excludes those living on Kauai, Molokai, Lanai, and parts of Hawaii Island, which include Pahala, Naalehu, and Hawaii Volcanoes National Park. Members living in these areas will remain enrolled in the Kaiser Permanente HMO medical plan.

Retirees who enroll in Medicare Part A and B

Retirees who meet the above criteria will automatically be enrolled in the Kaiser Permanente Senior Advantage plan.

Covered dependents who enroll in Medicare Part A and B

Covered dependents who meet the above criteria will also automatically be enrolled in the Kaiser Permanente Senior Advantage plan.

If the retiree is not yet Medicare eligible but their covered dependent enrolls in Medicare Part A and B, the covered dependent will automatically be enrolled in the Kaiser Permanente Senior Advantage plan. The retiree will remain on the Kaiser Permanente HMO medical plan.

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

Moving Out of State? (Geographic Relocation)

If you're a Kaiser Permanente Senior Advantage member who moves out of state, and you wish to change your medical and prescription drug coverage to the EUTF HMSA PPO medical and SilverScript prescription drug plan, you may do so.

Submit an EC-2 form (or EC-2H form for HSTA VB members) to the EUTF indicating your change of address within 45 days of your relocation date. The effective date of coverage will begin on the first of the month after the later of the relocation and notification dates.

Benefits for All Retirees

All retirees have the following benefits available to them:

- **Dental** and **Vision** plans – coverage for both non-Medicare and Medicare retirees and their eligible dependents
- **Life Insurance** plan – coverage for only non-Medicare and Medicare retirees (no dependent coverage)

Dental Benefits for EUTF and HSTA VB Retirees and Dependents

Your retiree dental benefits are provided by Hawaii Dental Service (HDS), and a high-level summary of the plan's benefits is shown below.

Your HDS plan now includes Total Health Plus, a set of supplemental benefits. With HDS Total Health Plus, if you are diagnosed with certain medical conditions or diseases, you will have access to 100% coverage for additional cleanings and/or fluoride treatments. This added coverage is designed to prevent oral disease and cavities for those diagnosed with diabetes, cancer, stroke, kidney failure, and more. Those who are pregnant are also qualified for additional cleanings and/or fluoride treatments.

For full plan details, visit the HDS dedicated EUTF webpage (**hawaiidentalservice.com/eutf**). Click on the "Login to EUTF Member Portal" button to sign in or register for an online account. With an online account, you can check on your eligibility for services, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, and receive paperless benefit statements from the convenience of your home computer or mobile device.

HAWAII DENTAL SERVICE (HDS) DENTAL PLAN	
DENTAL BENEFIT	**Plan Covers**
Calendar Year Plan Maximum per person	**$2,000**
Diagnostic	
Examinations – 2 per calendar year	**100%**
Bitewing X-Rays – 2 per calendar year through age 14, 1 per calendar year ages 15 and older	**100%**
Other X-Rays – full mouth X-Rays limited to 1 every 5 years	**100%**
Preventive	
Cleanings – 2 per calendar year, additional cleanings or gum maintenance covered for expectant mothers and members with a history of cancer treatment (chemotherapy or radiation), diabetes, Sjögren's syndrome, stroke, heart attack, congestive heart failure, kidney failure, or organ transplant	**100%**
Fluoride – 2 per calendar year through age 19, additional fluoride treatments for members with a history of certain cancers, Sjögren's syndrome, or at medical risk for cavities	**100%**
Silver Diamine Fluoride	**100%**
Space Maintainers – through age 17	**100%**
Sealants – through age 18 (one treatment per tooth per lifetime to permanent molars with no prior fillings on biting surfaces)	**100%**

HAWAII DENTAL SERVICE (HDS) DENTAL PLAN (continued)	
DENTAL BENEFIT	**Plan Covers**
Basic Care	
Fillings – silver fillings; white-colored fillings limited to front teeth	**60%**
Root Canals	**60%**
Gum Surgeries and Maintenance – cleaning (maintenance) for gum disease limited to 2 per calendar year after qualifying gum treatment where qualifying gum treatment is one or more of the following: • Root Planing and Scaling – 1 every 2 years per quadrant • Gum/Bone Surgeries – 1 every 3 years per quadrant	**60%**
Oral Surgeries	**60%**
Major Care	
Crowns – 1 every 5 years when teeth cannot be restored with silver or white fillings; white crowns limited to front teeth and bicuspids	**60%**
Fixed Bridges and Dentures – 1 every 5 years; age 16 and over	**60%**
Implants	**60%**
Other Services	
Emergency Treatments of Dental Pain	**100%**

For the Dental Benefits Summary chart that lists other covered services, limitations, and exclusions, visit the HDS webpage (**hawaiidentalservice.com/eutf**). Scroll down to download the Dental Plan Benefits Brochure (for EUTF and HSTA VB Retirees).

Vision Benefits for EUTF and HSTA VB Retirees and Dependents

Your retiree vision benefits are provided by Vision Service Plan (VSP), and a high-level summary of the plan's benefits is shown below.

VISION SERVICE PLAN (VSP)			
Vision Exam and Eyewear Benefits: Members can have an eye exam and choose between a pair of lenses or contact lenses every calendar year. Frames are covered every other calendar year.			
VISION BENEFIT	**Frequency**	**In-Network**	**Out-of-Network Plan Pays**
Exam	**Every calendar year**	**$10 copay**	**Up to $45**
Prescription Glasses		**$25 copay**	
Frame	Every other calendar year	$150 allowance plus 20% off out-of-pocket cost*	Up to $47
Lenses	Every calendar year		
Single-vision lenses		Included in $25 copay	Up to $45
Lined bifocal lenses		Included in $25 copay	Up to $65
Lined trifocal lenses		Included in $25 copay	Up to $85
Impact-resistant lenses for dependent children up to age 18		Included in $25 copay	Not covered
Standard progressive lenses		Included in $25 copay	Progressive lenses – up to $85
Premium progressive lenses		$80–$90 copay	
Custom progressive lenses		$120–$160 copay	
Lenticular lenses		No charge	Up to $125
UV protection		No charge	Not covered
Contact Lenses	**Every calendar year**		
Contact lenses (elective)		$130 allowance	Up to $105
Contact lenses (medically necessary)		No charge	Up to $210
Contact lenses fitting and evaluation		$60 copay max	Not covered

Extra Discounts and Savings from VSP Providers

Glasses and Sunglasses

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

Retinal Screening

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

Contact Lenses

- VSP partners with leading contact lens manufacturers to provide VSP members exclusive offers. Check out **vsp.com** for details

Laser Vision Correction

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

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

Life Insurance Benefits for EUTF and HSTA VB Retirees

Your retiree life insurance benefit is $1,487.

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

- **Terminal illness benefit:** If you are diagnosed as terminally ill with a life expectancy of 12 months or less, you may request early payment of 100% of your life insurance benefit.
- **Repatriation benefit:** If you die 200 miles or more from home, this additional benefit (equal to 10% of your life insurance amount) is available for the preparation and transportation of mortal remains.
- **Lifestyle benefits:** You have automatic access to a suite of additional services and resources, at no additional fee or required enrollment.
  - **Travel assistance services from RedpointWTP LLC.** You have 24/7 online, pre-trip resources and support for emergency travel assistance and other services when traveling 50+ miles from home. These include medical relocation and medical or security evacuation, passport, visa, immunization and currency conversion info, assistance replacing lost or stolen luggage or other critical items, or repatriation of mortal remains. Visit **LifeBenefits.com/travel** or call **1-855-516-5433** in the U.S. and Canada (outside of the U.S. and Canada **+1-415-484-4677**).
  - **Legal, financial, and grief resources through LifeWorks.** Access professional services for a variety of needs—from legal matters and financial situations to coping with loss—through comprehensive web and mobile resources, as well as consultations. Included are resources such as will prep templates and other key legacy documents—and a free, 30-minute consultation per issue, by phone or in an attorney's office (additional services available at 25% discount). In addition, telephone consults or a 45-minute counseling session per issue are available on other topics, like budget analysis, tax planning, or grief support. You can also access a financial fitness assessment online. Visit **LifeBenefits.com/LFG** (user name: lfg, password: resources) or call **1-877-849-6034**.
  - **Legacy planning resources from Securian.** Access a variety of online information, tools, and resources, including end-of-life and funeral planning, final arrangements, important directives, and survivor assistance. After a claim is started, there are additional services available to beneficiaries by phone. Funeral concierge services allow for coverage verification and direct payment to a funeral home so services can be provided before insurance payment is made. Same-day funeral home assignment services reduce concern about paying funeral expenses by working with the funeral home or lending agency. Visit **Securian.com/legacy**.

Beneficiary changes

If you would like to change your beneficiary designation, visit **LifeBenefits.com**, and log in to verify, update, or change your beneficiary designation. If you have not logged on yet or you have questions, contact Securian Financial, toll-free, at **1-877-291-8466**, Monday–Friday, 7:30 a.m.–6:00 p.m. HST, excluding State-observed holidays. You can also call the local office at **1-808-536-9890**.

Monthly Health Plan Premiums

Retirees who receive less than 100% employer contribution toward the Base Monthly Contribution (BMC), or whose ERS membership date is on or after July 1, 2001, and enrolling a dependent, may be responsible for monthly premium payments to the EUTF. See pages 32-33 for the 2024 monthly health plan rates.

You may use the Retiree Premium Worksheet, located on the EUTF website (**eutf.hawaii.gov/retirees/eutf-retiree/premiums-contributions**), or the online Retiree EUTF Premium Calculator (**eutf.hawaii.gov/eutf-premium-calculators**) to calculate your monthly premium cost.

Premium Payment Options

Retirees who make monthly payments to the EUTF can pay by the following options:

- Employees' Retirement System of the State of Hawaii (ERS) pension deduction
- ACH deductions (checking or savings)

Complete the appropriate form at the back of this guide or on our website at **eutf.hawaii.gov**.

Determination of Employer Contribution for Retiree Plans

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

- ERS membership date (typically the date the employee was hired)
- Length of service, taking into account breaks in service and excluding sick leave (as determined by ERS)
- The BMC amount, which determines the maximum amount the employer will contribute toward your retiree coverage

Recurring Electronic Premium Deduction Requirement

NOTE: If you retired on or after **October 1, 2020**, and are responsible for paying a portion of your or your dependent's monthly health benefits premium, you are required to enroll in a recurring electronic premium deduction (Hawaii Law Act 62, SLH 2020).

The EUTF offers two options:

- ACH deductions from your bank
- Employees' Retirement System of the State of Hawaii (ERS) pension deductions

Enrollment forms for ACH or ERS pension deductions are available at the back of this guide or on the EUTF website at **eutf.hawaii.gov**.

ERS Retirement Estimate Letter

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

Base Monthly Contribution (BMC)

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

- Medicare enrollment
- Coverage tier (Self, Two-Party, Family)
- ERS membership date (typically the hire date)
- Length of service, taking into account breaks in service and excluding sick leave (as determined by ERS)

The BMC is adjusted every January 1, based on the percentage increase or decrease in the Medicare Part B premium rate from the previous year. Since the Medicare Part B premium rate is published later in the year, retirees should refer to the EUTF website toward the end of the 2023 year for the 2024 BMC amounts.

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

Employer Contribution Table

Years of Credited Service	Employer's Contribution Percentage of the Base Monthly Contribution* if your ERS Membership Date Is:		
(excluding sick leave)	On or Before 6/30/96	On or Between 7/1/96–6/30/01	On or After 7/1/01**
Less than 10 years	50%	0%	0%
10 years, less than 15	100%	50%	50%
15 years, less than 25	100%	75%	75%
25 years or more	100%	100%	100%

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

** If your ERS membership date is on or after 7/1/01, the monthly employer-sponsored contribution will be applied to the self-only BMC.

Employer Contribution Percentages

If the retiree falls in the 100% category and started prior to July 1, 2001, they will most likely pay nothing. If the retiree falls in the 50%, 75%, or on or after July 1, 2001 category, please see the **Retiree EUTF Premium Calculator** (**eutf.hawaii.gov/eutf-premium-calculators/**) or complete the EUTF Retiree Premium Worksheet to determine the retiree's share of premiums. If the retiree falls in the 0% category, they will pay the full premium amount.

The retiree pays the difference between the total monthly premium for the plans selected and the amount of the employer contribution set by the BMC calculation. For retirees with membership dates on or after July 1, 2001, the monthly employer's contribution is limited to the LESSER of:

1. The BMC percentage from the table above multiplied by the self-Medicare or non-Medicare BMC, or
2. The self-premiums for the plans enrolled.

For example, the monthly employer contribution for a Medicare retiree enrolled in two-party HMSA medical, SilverScript prescription drug, HDS dental, and VSP vision with membership date July 1, 2007, and retired with 15 years of service would be $534.18* as calculated as follows (premiums from page 32):

1. $617.78 = 75% x Medicare self BMC of $823.70*
2. $534.18 = $486.86 HMSA self medical and SilverScript self prescription drug + $43.78 HDS self dental + $3.54 VSP self vision

The retiree will be responsible for monthly premiums of $506.64 as calculated below:

1. Total monthly premiums of $1,040.82 = $948.34 HMSA two-party medical and SilverScript two-party prescription drug + $85.38 HDS two-party dental + $7.10 VSP two-party vision
2. Less monthly employer contribution of $534.18*
3. Monthly employee share of premiums $506.64

* Since the 2023 BMC is not available at this time, this example uses the 2023 BMC and the 2024 premiums.

It is important to note that plan premiums usually increase each year, and at a certain point, some plan premiums may exceed 100% of the BMC. All retirees, including those in the 100% category, should review the plan premiums and the BMC amount annually to determine if they will be required to contribute to the cost of coverage.

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

EUTF Monthly Retiree Premiums Effective January 1, 2024, through December 31, 2024		
Benefit Plan	**Type of Enrollment**	**Total Premium[1]**
MEDICAL AND PRESCRIPTION DRUG PLANS – MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$251.52
	Two-Party	$490.10
	Family	$726.60
Humana Medicare Advantage PPO Medical Plan	Self	$51.88
	Two-Party (both Medicare)	$103.76
	Three-Party (all Medicare; maximum of 3 enrollees)	$155.64
SilverScript Prescription Drug Plan	Self	$235.34
	Two-Party	$458.24
	Family	$679.44
Kaiser Permanente Senior Advantage Medical and Prescription Drug Plan	Self	$462.50
	Two-Party	$901.84
	Family	$1,336.60
MEDICAL AND PRESCRIPTION DRUG PLANS – NON-MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$581.96
	Two-Party	$1,133.96
	Family	$1,681.08
CVS Caremark Prescription Drug Plan	Self	$244.24
	Two-Party	$475.68
	Family	$705.26
Kaiser Permanente HMO Comprehensive Medical and Prescription Drug Plan	Self	$763.08
	Two-Party	$1,541.42
	Family	$2,273.98
DENTAL PLAN		
HDS Dental	Self	$43.78
	Two-Party	$85.38
	Family	$104.62
VISION PLAN		
VSP Vision	Self	$3.54
	Two-Party	$7.10
	Family	$9.52
LIFE INSURANCE		
Securian Life Insurance (Retiree only)	Self	$4.12

[1]The 2024 Retiree premiums do not include an EUTF administrative fee.

HSTA VB Monthly Retiree Premiums Effective January 1, 2024, through December 31, 2024		
Benefit Plan	**Type of Enrollment**	**Total Premium[2]**
MEDICAL AND PRESCRIPTION DRUG PLANS – MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, SilverScript Prescription Drug, and VSP Vision Plans	Self	$541.24
	Two-Party	$1,054.72
	Family	$1,560.86
Kaiser Permanente Senior Advantage Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$473.54
	Two-Party	$923.60
	Family	$1,367.82
MEDICAL AND PRESCRIPTION DRUG PLANS – NON-MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, CVS Caremark Prescription Drug, and VSP Vision Plans	Self	$795.52
	Two-Party	$1,550.10
	Family	$2,295.34
Kaiser Permanente HMO Comprehensive Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$752.22
	Two-Party	$1,519.46
	Family	$2,240.64
DENTAL PLAN		
HDS Dental	Self	$51.80
	Two-Party	$101.02
	Family	$123.82
VISION PLAN		
VSP Vision	Self	$3.54
	Two-Party	$7.10
	Family	$9.52
LIFE INSURANCE		
Securian Life Insurance (Retiree only)	Self	$4.12

[2] The 2024 Retiree premiums do not include an EUTF administrative fee.

EUTF Monthly Retiree COBRA Premiums Effective January 1, 2024, through December 31, 2024		
Benefit Plan	**Type of Enrollment**	**Total Premium[1]**
MEDICAL AND PRESCRIPTION DRUG PLANS – MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$256.55
	Two-Party	$499.90
	Family	$741.13
Humana Medicare Advantage PPO Medical Plan	Self	$52.91
	Two-Party (both Medicare)	$105.83
	Three-Party (all Medicare; maximum of 3 enrollees)	$158.75
SilverScript Prescription Drug Plan	Self	$235.60
	Two-Party	$458.74
	Family	$680.18
Kaiser Permanente Senior Advantage Medical and Prescription Drug Plan	Self	$471.75
	Two-Party	$919.87
	Family	$1,363.33
MEDICAL AND PRESCRIPTION DRUG PLANS – NON-MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$593.59
	Two-Party	$1,156.63
	Family	$1,714.70
CVS Caremark Prescription Drug Plan	Self	$248.74
	Two-Party	$484.46
	Family	$718.28
Kaiser Permanente HMO Comprehensive Medical and Prescription Drug Plan	Self	$778.34
	Two-Party	$1,572.24
	Family	$2,319.45
DENTAL PLAN		
HDS Dental	Self	$44.65
	Two-Party	$87.08
	Family	$106.71
VISION PLAN		
VSP Vision	Self	$3.61
	Two-Party	$7.24
	Family	$9.71

[1] The 2024 Retiree COBRA premiums do not include an EUTF administrative fee.

HSTA VB Monthly Retiree COBRA Premiums Effective January 1, 2024, through December 31, 2024		
Benefit Plan	**Type of Enrollment**	**Total Premium[2]**
MEDICAL AND PRESCRIPTION DRUG PLANS – MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, SilverScript Prescription Drug, and VSP Vision Plans	Self	$546.06
	Two-Party	$1,064.15
	Family	$1,574.78
Kaiser Permanente Senior Advantage Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$483.01
	Two-Party	$942.07
	Family	$1,395.17
MEDICAL AND PRESCRIPTION DRUG PLANS – NON-MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, CVS Caremark Prescription Drug, and VSP Vision Plans	Self	$810.93
	Two-Party	$1,580.16
	Family	$2,339.84
Kaiser Permanente HMO Comprehensive Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$767.26
	Two-Party	$1,549.84
	Family	$2,285.45
DENTAL PLAN		
HDS Dental	Self	$52.83
	Two-Party	$103.04
	Family	$126.29
VISION PLAN		
VSP Vision	Self	$3.61
	Two-Party	$7.24
	Family	$9.71

[2] The 2024 Retiree COBRA premiums do not include an EUTF administrative fee.

Retirees are offered the choice between COBRA Continuation Coverage and Retiree Coverage at retirement and if Retiree coverage is elected, the Retiree has no further COBRA rights under this Plan. However, covered Dependents may have COBRA rights available if one of the following events results in a loss of coverage:

- The death of the Retiree;
- A divorce of the Retiree and Spouse; or
- Cessation of Dependent child's dependent status.

Events that Allow You to Change Your Elections

Once the open enrollment period is over, you are not allowed to change your benefit elections or add/delete dependents until the next year's open enrollment, unless you have a qualifying event or change to enrollment as outlined in the EUTF Administrative Rules. For more information about qualifying events, visit the EUTF website (**eutf.hawaii.gov**), and go to the "Enrollment Overview" page for your Retiree group.

This section outlines if and when benefits can be changed during the plan year (January 1 through December 31). The following chart lists common events that may allow certain changes in benefits during the year as outlined in the EUTF Administrative Rules. The events are listed by additions and deletions and include required documents, submission deadlines, and effective dates.

Events that Allow You to Change Your Elections – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date (Pay periods occur on the 1st and 16th)
Adoption	EC-2/EC-2H form within **45** days of adoption date. **Adoption decree or placement for adoption** documents and **birth certificate** submitted within 45 days from the adoption date Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	Retiree can choose: the event date, first day of the pay period following the event date, or first day of the 2nd pay period following the event date
Birth	EC-2/EC-2H form within **180** days of birth date. **Birth certificate & Social Security number (SSN) or Taxpayer Identification Number (TIN) must be submitted with EC-2/EC-2H form.** Hospital certificate is acceptable as a temporary supporting document while awaiting birth certificate. Enrollment may be rejected if the SSN or TIN is missing for the person for whom enrollment is being requested.	Retiree can choose: the event date, first day of the pay period following the event date, or first day of the 2nd pay period following the event date
Civil Union	EC-2/EC-2H form within **45** days of civil union. **Civil Union Certificate** and **Affidavit of Dependency** submitted within **45** days from the civil union date Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	Retiree can choose: the event date, first day of the pay period following the event date, or first day of the 2nd pay period following the event date
Domestic Partnership	EC-2/EC-2H form within **45** days of notarized signature. **Notarized Declaration of Domestic Partnership, Affidavit of Dependency & Acknowledgement**, and **two sets of documents proving cohabitation** submitted within **45** days from the domestic partnership date; documents available at **eutf.hawaii.gov** Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	Retiree can choose: the event date, first day of the pay period following the event date, or first day of the 2nd pay period following the event date
Enrollment in Medicare Part B (Retiree wishes to change from current medical and prescription drug plan to another Medicare plan option)	EC-2/EC-2H form within **60** days of the Medicare Part B effective date. **Proof of enrollment** in Medicare Part B (i.e., copy of MBI card) submitted within 60 days from the Medicare Part B effective date. Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	Medicare Part B effective date or the first of the month following EUTF's receipt of the EC-2/EC-2H, whichever is later
Geographic Relocation (Kaiser members who move outside the Kaiser service area)	EC-2/EC-2H form within **45** days of Relocation date Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	Non-Medicare – The first day of the pay period following the relocation Medicare – The first of the month after the later of the relocation and notification dates

Events that Allow You to Change Your Elections – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date (Pay periods occur on the 1st and 16th)
Loss of Coverage (Retiree and/or dependent loses health coverage and wishes to enroll in EUTF or HSTA VB plans)	EC-2/EC-2H form within **45** days of loss of coverage. **Letter from previous employer or carrier** detailing type of coverages lost (i.e., medical, drug, dental, vision), date of loss of coverage, names of any covered dependents, **marriage certificate**, and **birth certificate** for dependent children submitted within **45** days from loss of coverage date Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	The first day following the day non-EUTF coverage was lost
Marriage	EC-2/EC-2H form within **45** days of marriage. **Marriage certificate** (and **birth certificate** if adding dependent children) submitted within **45** days from the marriage date Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	Retiree can choose: the event date, first day of the pay period following the event date, or first day of the 2nd pay period following the event date
Newly Eligible Student Dependent (Unmarried dependent age 19 thru 23 becomes a full-time student)	EC-2/EC-2H form within **45** days from school start date. **Student certification:** a letter from an accredited school on school letterhead with registrar's signature confirming full-time status or letter from National Student Clearinghouse submitted within **45** days of becoming a full-time student; transcripts and class schedules are not accepted Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	Retiree can choose: the event date, first day of the pay period following the event date, or first day of the 2nd pay period following the event date
Reinstatement into Medical and/or Prescription Drug Plans (Due to failure to provide proof of enrollment in Medicare Part B)	**Proof of Medicare Part B enrollment**, which must include MBI number and effective date (e.g., MBI card or SSA letter) Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	The later of the effective date of the Medicare Part B coverage or the medical and/or prescription drug coverage enrollment date
Retirement	EC-2/EC-2H form within **60** days of retirement date. If Medicare eligible, copy **of Medicare Part B card, Direct Deposit Agreement form**, and **Letter from Social Security** showing annual Part B premium submitted within **60** days from the date of retirement. **ERS Retirement Estimate Letter** **ERS pension deduction form or ACH deduction form** if paying for all or a portion of your health benefit premium submitted within 60 days from the date of retirement Enrollment may be rejected if the Social Security Number or Tax Identification Number is missing for the person for whom enrollment is being requested.	Retirement date

Events that Allow You to Change Your Elections – Deletions

Qualifying Event	Required Documents and Submission Deadline	Effective Date (Pay periods occur on the 1st and 16th)
Disenroll Due to Enrollment in Other Coverage (Retiree or dependent gets coverage from another plan and wishes to cancel EUTF or HSTA VB plans)	EC-2/EC-2H form within **45** days of acquisition of coverage. **Letter from carrier or employer** detailing type of coverages enrolled in (i.e., medical, drug, dental, vision), effective date of coverage, and names of covered dependents submitted within **45** days from the date of acquisition	End of pay period in which retiree acquires coverage from a non-EUTF plan, except when the retiree acquires coverage from the non-EUTF plan on the 1st or 16th of the month, in which case coverage ends at the end of the prior pay period
Death	EC-2/EC-2H form as soon as reasonably practical. **Death certificate** or **copy of obituary** submitted as soon as available	Date of death or last day of pay period in which death occurs for dependents
Divorce (Retiree must terminate coverage for former spouse)	EC-2/EC-2H form within **45** days of divorce. **Pages 1 and 2 of divorce decree along with the signature page** submitted within **45** days from the date of the divorce	First day of the pay period following the divorce
Failure to Enroll in Medicare Part B (Retirees and their dependents who are eligible to enroll in Medicare Part B must enroll to be covered under EUTF and HSTA VB medical and prescription drug plans)	None	The date retiree or Medicare-eligible dependent first became eligible for Medicare Part B Retiree and/or dependent can be re-enrolled by submitting a copy of their Medicare card
Failure to Pay (Retiree owes a shortage, but does not pay shortage by due date. Enrollment will be cancelled)	None	If enrollment is cancelled, retiree may only re-enroll during the next plan year (open enrollment or special enrollment event) or if full payment is made of all contributions due within sixty (60) days from the date of the notice of cancellation and has not been cancelled for non-payment within twelve (12) months of the date of notice of cancellation
Ineligible Student (Dependent child no longer a full-time student)	EC-2/EC-2H form as soon as the dependent child is no longer enrolled as a full-time student	First day of the pay period following the date the child was no longer enrolled as a full-time student
Legal Separation (Retiree must terminate coverage for former spouse)	EC-2/EC-2H form within **45** days of date of legal separation **Court documents** establishing legal separation submitted within **45** days from separation date	First day of the pay period following the legal separation

Events that Allow You to Change Your Elections – Deletions

Return to Work (Retiree returns to State or County employment)	**Contact the Employees' Retirement System of the State of Hawaii (ERS) and EUTF** to inform them you will be returning to work. Retiree can enroll in Active Employee plans	The event date is the date the retiree returns to work. The employee will then be treated like any New Hire and have the same 3 (three) options to choose as their effective date
Surviving Spouse/Partner Remarries or Enters Into Another Partnership (Surviving spouse or partner will be cancelled from EUTF or HSTA VB plans)	EC-2/EC-2H form within **45** days of marriage or new domestic partnership	The first day of the pay period following the marriage or new partnership

Required Notices

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

EUTF Important Notices

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

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

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

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

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

PRIVACY NOTICE REMINDER

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

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. You can get another copy of this Notice from our Member Services Branch at **1-808-586-7390** or toll-free at **1-800-295-0089**. The Privacy Notice is also available on the Plan's website at **eutf.hawaii.gov**.

NOTICE REGARDING THE WELLNESS PROGRAM

The Wellness Programs are voluntary wellness programs available to participants enrolled in the group health plan and are designed to promote health or prevent disease. The programs are administered according to federal rules permitting

employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the Wellness Program, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA questionnaire, participate in medical examinations, or work with a health coach.

The information from your HRA questionnaire will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the Wellness Program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections From Disclosure of Medical Information

Our group health plan is required by law to maintain the privacy and security of your personally identifiable health information.

Information collected from Wellness Program participants will only be received by EUTF in aggregate form. Although the Wellness Program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, our group health plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellness Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a health coach in order to provide you with services under the Wellness Program.

In addition, all medical information obtained through the Wellness Program will be maintained separate from your personnel records, and no information you provide as part of the Wellness Program will be used in making any employment decision. Appropriate precautions will be taken by the group health plan to avoid any data breach, and in the event a HIPAA data breach occurs involving information you provide in connection with the Wellness Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the EUTF Office at **1-808-586-7390** or toll-free at **1-800-295-0089**.

NOTE: If you are enrolled in the HMSA or Humana Medicare Advantage PPO plans with SilverScript prescription drug coverage, or the Kaiser Permanente Senior Advantage plan, you already have Medicare prescription drug coverage and this notice does not apply to you.

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

This notice is for people who may become eligible for Medicare during the next 12 months.

Please read this notice carefully and keep it where you can find it.

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

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

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

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

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

- The CVS Caremark Drug Coverage available through the HMSA PPO Plan (either EUTF early retirees or HSTA VB early retirees)
- The Kaiser Permanente HMO Medical Plan

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

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the CVS prescription drug plan or the Kaiser Permanente HMO plan and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage**. You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

YOUR RIGHT TO RECEIVE A NOTICE

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

WHY CREDITABLE COVERAGE IS IMPORTANT (WHEN YOU WILL PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN)

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next Medicare open enrollment period to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any one of the following options:

Your Choices	What this option means to you:
If you are enrolled in EUTF PPO medical plan (with prescription drug coverage through CVS) and you become eligible for Medicare, you can select or keep your EUTF medical and prescription drug coverage.	•If you or your covered dependent(s) are enrolled in the HMSA PPO plan and Medicare, you will still have medical coverage with EUTF and you will **automatically be enrolled in the EUTF SilverScript Medicare Part D plan**. •If you enroll in a non-EUTF Medicare Part C or D plan, you will be disenrolled from the EUTF SilverScript Plan because Medicare allows you to enroll in only one Medicare Part D plan. **If you are an HSTA VB Retiree, you will also be disenrolled from the medical, vision, and chiropractic plans as prescription drug coverage is bundled as part of the entire medical plan.** Please call EUTF before enrolling in another Medicare Part D prescription drug plan. •At the next EUTF Open Enrollment or upon experiencing a mid-year qualifying event, you will be able to make election changes.
If you are a Kaiser Permanente plan participant and you are enrolled in Medicare Part A and B, you must enroll in Kaiser Permanente's Senior Advantage plan (unless you live in Kauai, Molokai, Lanai, and parts of Hawaii Island, which include Pahala, Naalehu, and Hawaii Volcanoes National Park).	•If you or your covered dependent(s) are enrolled in the Kaiser Permanente HMO plan and Medicare, you will **automatically be enrolled in the Kaiser Permanente EUTF Senior Advantage plan**, including prescription drug coverage. You understand enrollment in the EUTF Senior Advantage plan is required, and this will automatically end your enrollment in another Medicare plan. Failure to enroll in the EUTF Senior Advantage plan will result in termination of your EUTF medical and prescription coverage. •If you enroll in a non-EUTF Medicare Part D plan, you will be disenrolled from the Kaiser Permanente Senior Advantage plan because Medicare allows you to enroll in only one Medicare Part C & D plan. **You will also be disenrolled from the medical plan (and, for HSTA VB Retirees, vision and chiropractic plans) as prescription drug coverage is part of the entire medical plan.** Please call EUTF before enrolling in another Medicare Part C & D prescription drug plan. •At the next EUTF Open Enrollment, you will be able to make election changes.

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

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

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

PARA MÁS INFORMACIÓN SOBRE SUS OPCIONES BAJO LA COBERTURA DE MEDICARE PARA RECETAS MÉDICAS.

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

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

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

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
201 Merchant Street, Suite 1700, Honolulu, HI 96813
Phone number: **1-808-586-7390** or toll-free at **1-800-295-0089**

As in all cases, EUTF and, when applicable, Kaiser Permanente reserve the right to modify benefits at any time, in accordance with applicable law. This document (dated October 1, 2021) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

Who to Contact

For Questions About:	Please Contact:
Eligibility and EUTF Information	**eutf.hawaii.gov** EUTF Member Services **1-808-586-7390** or toll-free: **1-800-295-0089** Monday through Friday, 7:45 a.m.–4:30 p.m. HST, except State observed holidays
Hawaii Medical Service Association (HMSA)	**hmsa.com/eutf** **1-808-948-6499** (Oahu) Toll-free: **1-800-776-4672** (Neighbor Islands) Monday through Friday, 7:00 a.m.–7:00 p.m. HST Saturday 9:00 a.m.–1:00 p.m. HST
Humana	**your.humana.com/eutf** **1-888-908-6518** Monday through Friday, 7:00 a.m.–7:00 p.m. HST *When calling Humana, please identify yourself as a retiree of the EUTF/State of Hawaii Group plan.*
Kaiser Permanente	**kp.org/eutf** **1-808-432-5250** (Oahu) or toll-free: **1-844-276-6628** (Neighbor Islands) TTY: 711 Monday through Friday, 7:00 a.m.–7:00 p.m. HST Saturday 9:00 a.m.–1:00 p.m. HST **kp.org/fitrewards** (for non-Medicare retirees) **1-877-771-2746** **silverandfit.com** (for Medicare retirees) **1-877-427-4788**
American Specialty Health (ASH)	HMSA and Kaiser Permanente Chiropractic Benefit (HSTA VB only) **ashlink.com/ash/hmsa** for HMSA members **ashlink.com/ash/kaiserhic** for Kaiser Permanente members Toll-free: **1-888-981-2746** October through March: Sunday through Saturday, 8:00 a.m.–8:00 p.m. HST, excluding Thanksgiving Day and Christmas Day April through September: Monday through Friday, 2:00 a.m.–5:00 p.m. HST, excluding ASH-observed holidays
CVS Caremark (CVS) Non-Medicare Retirees	**CVS Caremark (CVS):** Non-Medicare Retirees **caremark.com** **1-855-801-8263** TTY: 711 24 hours a day, 7 days a week
SilverScript (SSI) Medicare Retirees	**SilverScript (SSI):** Medicare Retirees **eutf.silverscript.com** **hstavb.silverscript.com** **1-877-878-5715**

Hawaii Dental Service (HDS)	hawaiidentalservice.com/eutf **1-808-529-9310** or toll-free: **1-866-702-3883** Over the phone: Monday through Friday, 7:30 a.m.–6 p.m. HST, except State observed holidays Walk-In Hours: Monday through Friday, 8 a.m.–4:30 p.m. HST, except State observed holidays Office located: Pioneer Plaza, 900 Fort Street Mall, Suite 1900
Vision Service Plan (VSP)	eutf.vspforme.com Toll-free: **1-866-240-8420** Oahu: **1-808-532-1600** or toll-free: **1-800-522-5162** Monday through Saturday, 3:00 a.m.–8:00 p.m. HST Sunday, 8:00 a.m.–8:00 p.m. HST
Securian	LifeBenefits.com/EUTF **1-808-536-9890** or toll-free: **1-877-291-8466** Monday through Friday, 7:30 a.m.–6:00 p.m. HST, except State-observed holidays Email: **lifebenefits@securian.com**
Social Security Administration (SSA)	ssa.gov **1-800-772-1213**
Centers for Medicare & Medicaid Services	cms.gov **1-800-MEDICARE**

NOTES

NOTES

Important Forms

EC-2 and EC-2H Enrollment Form Instructions

Retiree Data

Select the event for which you are submitting the enrollment form. Mark the Retirement box if you're newly retired, the Qualifying Event box if you are making changes outside of the Open Enrollment period, or the Open Enrollment box during the annual or limited Open Enrollment period. If submitting the enrollment form for a qualifying event, give a brief description of the event and the date the qualifying event occurred. Complete all information about yourself and your spouse/partner. The race and ethnicity section is optional. Please refer to the back page of these instructions for more information on completing the race and ethnicity section.

Coverage Start Date

This section only needs to be completed if filing for adoption, placement for adoption, birth, marriage, domestic partner, guardianship, or newly eligible student, and you pay towards health plan benefits. Select one of the three choices for when your coverage and premium contributions will begin.

- (Option #1) Coverage starts on the event date. Premium contributions start 1st day of the pay period in which the event date occurs.
- (Option #2) Coverage and contributions start 1st day of the first pay period following the event date.
- (Option #3) Coverage and contributions start 1st day of the second pay period following the event date.

If no selection is made, Option #1 will be used, and you will be responsible for the full premium in said pay period.

Plan Selection

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

> Note: If you are currently enrolled in the Kaiser HMO Medical Plan and have assigned your Medicare Benefits to KP and either select the "Cancel/Waive" box or enroll in either the HMSA PPO 90/10 Medical plan or the CVS Caremark Prescription Drug plan, you are also confirming your intent to dis-enroll from the Kaiser Permanente Senior Advantage plan as well.

Dependent Information

Complete dependent information and indicate plan selection if adding or removing dependents. If you are adding/removing more than three dependents and additional rows are needed, please attach another sheet to your enrollment form. If this is your first time enrolling dependents in EUTF plans, please submit required proof documents including marriage certificate if adding your spouse/partner and a birth certificate and guardianship or adoption decree (if applicable) if adding a child(ren). If a dependent child is age 19 to 24, unmarried and covered under your medical, drug, dental, and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Required proof documents must be submitted to the EUTF within 45 days of the event date. Social security numbers are required for all newly added dependents. Detailed eligibility information including required proof documents for other life events are available online at eutf.hawaii.gov.

Medicare

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

Other Insurance Information

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

Retiree/Dependent Signature

Read, sign and date the form.

> **Note:** Dependent signature(s) and Date(s) are required if the dependent is enrolling or disenrolling in/from the Humana, Kaiser HMO Coverage or CVS/SilverScript plans. Failure for both the retiree and dependent(s) to sign when applicable, may result in continued Medicare enrollment with Humana, Kaiser Permanente or CVS/SilverScript.

Submit your EC-2 or EC-2H form and required supporting documents to the EUTF office. Please see address at bottom of page 2 of the enrollment form. To ensure proper processing, all required fields must be complete and proper documentation submitted timely. Required supporting documents are due within 45 days of the qualifying event date, with exception to birth (180 days) and open enrollment (postmarked by October 31, 2023).

Optional Race and Ethnicity Questionnaire

You may voluntarily choose to provide your race and ethnicity in the Retiree Data section of the EC-2 form. You can't be denied coverage because you don't fill them out. Please refer to the options below.

Are you of Hispanic, Latino/a, or Spanish origin?

- No, not of Hispanic, Latino/a, or Spanish origin
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, of another Hispanic, Latino/a, or Spanish origin
- Choose not to answer

What is your race?

- American Indian or Alaska Native
- Black or African American
- White
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Choose not to answer

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Hawaii Employer-Union Health Benefits Trust Fund

EUTF RETIREES
EC-2 HEALTH BENEFITS ENROLLMENT FORM

RETIREE DATA

Complete each section thoroughly. Please print clearly

Enrollment Type (Must check one box): ☐ **Retirement** ☐ **Qualifying Event** ☐ **Open Enrollment**

Retirement or Qualifying Event Date: _____ **Qualifying Event Description:** _____

Full Name: _____ Social Security No.: _____
Last Name, First Name, Middle Initial

Mailing Address: _____
Street Name Apt No.
_____
City, State Zip Code

Residence Address: _____
Street Name Apt No.
_____
City, State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner Gender: ☐ Male ☐ Female ☐ Gender X

Marriage Date: _____ Birthdate: _____

Former Employer Department/Division: _____ Bargaining Unit: _____

Home Phone: _____ Cell Phone: _____ Email: _____

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

Note: If you will be adding your spouse/partner to your health plans, you must also indicate this information under the "Dependent Information" section.

Optional Race and Ethnicity Disclosure

Are you of Hispanic, Latino/a, or Spanish origin? _____ What is your race? _____

COVERAGE START DATE

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

☐ Coverage starts day of the event and premium contributions start 1st day of the pay period in which the effective date of coverage occurs. **(if no selection is made, this option will be used.)**

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

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

PLAN SELECTION

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

Medical (select one)				
HMSA PPO 90/10 Medical ** (does not include Prescription Drug)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Kaiser HMO Medical ** (includes Kaiser Prescription Drug)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Humana Medicare Advantage (Medicare A & B required)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Prescription Drug				
CVS Caremark Prescription Drug ** (not a valid selection with Kaiser)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Dental				
Hawaii Dental Service	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Vision				
Vision Service Plan	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Life				
Securian Life Insurance	☐ Cancel/Waive	☐ Self		

***** NOTE:** If you are currently enrolled in the Kaiser HMO Medical Plan and have assigned your Medicare Benefits to KP and either select the "Cancel/Waive" box or enroll in either the HMSA PPO 90/10 Medical Plan or the CVS Caremark Prescription Drug Plan, you are also confirming your intent to disenroll from the Kaiser Permanente Senior Advantage Plan as well.*

EXHIBIT C

Retiree's Name: _____

State and County Contributions: *No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled by more than one retiree/active employee (dual enrollment). In situations where you and your spouse/partner are both retiree/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. However, both retirees/active employees are able to select EUTF Self-Only plans. Lastly, if dependents are ages 19 to 24, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. (Detailed eligibility information is available at eutf.hawaii.gov)*

Complete dependent information (including spouse/partner/disabled child) and indicate plan selection if adding/removing dependents

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

Optional Race and Ethnicity Disclosure (Dependents)

- Are any of your dependents of Hispanic, Latino/a, or Spanish origin?_____
- What is your dependent's race?_____

MEDICARE

Are you and/or any of your dependents eligible for Medicare Part A & B? ☐ Yes (complete section below) ☐ No

Name	Medicare Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date

State law requires that retirees and their dependents enroll in Medicare Part B when they become eligible in order to be enrolled in EUTF/HSTA VB retiree medical and/or prescription drug coverage, HRS Chapter 87A-23(4). Please submit a copy of your Medicare card.
Kaiser Members: Kaiser Permanente is a Medicare Advantage plan. Medicare eligible members residing in the Hawaii Senior Advantage Service Area are required to enroll in the EUTF Senior Advantage Plan. I understand that my signature confirms enrollment in the EUTF Senior Advantage Plan and this will automatically end my enrollment in another Medicare plan.

OTHER INSURANCE INFORMATION

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

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

RETIREE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans elected.

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

_____ _____

Retiree Signature *Date*

_____ _____

*Dependent (Spouse/Partner) Signature *** *Date*

_____ _____

*Dependent (Disabled Child) Signature *** *Date*

Various health plan providers offer services to EUTF members. Some of these services are at no charge to either the EUTF or the State of Hawaii. These services which are offered at no charge are not a part of the health benefits package provided to you by the State of Hawaii and its municipalities by virtue of your employment or membership in the EUTF. These services offered at no charge are listed in the EUTF reference guides, [and] are provided only as [a] pilot programs and are subject to modification or termination at any time by the service provider, EUTF, and/or the State of Hawaii at their sole discretion. The State and EUTF expressly do not promise, do not warrant, do not guarantee, and make no representation that these services offered at no charge will be available to EUTF active or retired employees or their beneficiaries at any time in the future or in any form or manner.

***** Note:*** *Dependent Signature(s) and Date(s) are required if the dependent is enrolling or disenrolling in/from the Humana, Kaiser HMO Coverage or CVS/SilverScript plans. Failure for both the retiree and dependent(s) to sign when applicable, may result in continued Medicare enrollment with Humana, Kaiser Permanente, or CVS/SilverScript.*

Please submit your signed EC-2 form to:
EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

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

Hawaii Employer-Union Health Benefits Trust Fund

HSTA VB RETIREES
EC-2H HEALTH BENEFITS ENROLLMENT FORM

RETIREE DATA

Complete each section thoroughly. Please print clearly

	Retirement	Qualifying Event	Open Enrollment
Enrollment Type (Must check one box):	☐	☐	☐

Retirement or Qualifying Event Date: _____ **Qualifying Event Description:** _____

Full Name: _____ Social Security No.: _____
Last Name, First Name, Middle Initial

Mailing Address: _____
Street Name Apt No.
_____
City, State Zip Code

Residence Address: _____
Street Name Apt No.
_____
City, State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner Gender: ☐ Male ☐ Female ☐ Gender X

Marriage Date: _____ Birthdate: _____

Former Employer Department/Division: _____ Bargaining Unit: _____

Home Phone: _____ Cell Phone: _____ Email: _____

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

Note: If you will be adding your spouse/partner to your health plans, you must also indicate this information under the "Dependent Information" section.

Optional Race and Ethnicity Disclosure

Are you of Hispanic, Latino/a, or Spanish origin? _____ What is your race? _____

COVERAGE START DATE

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

☐ Coverage starts day of the event and premium contributions start 1st day of the pay period in which the effective date of coverage occurs. **(if no selection is made, this option will be used.)**

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

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

PLAN SELECTION

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

Medical, Prescription Drug, Vision, and Chiro (select one)				
HMSA PPO 90/10 Medical ** and Chiro (CVS Prescription Drug **, VSP Vision)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Kaiser HMO Medical ** and Chiro (Kaiser Prescription Drug, VSP Vision)	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Dental				
Hawaii Dental Service	☐ Cancel/Waive	☐ Self	☐ Two-Party	☐ Family
Life				
Securian Life Insurance	☐ Cancel/Waive	☐ Self		

NOTE: *The enrollment of HSTA VEBA members into the health and other benefit plans created as a result of the decision in the Gail Kono lawsuit is being solely done to comply with that decision and not to create any constitutional or contractual right to the benefits provided by those plans. Please note that the State does not agree with the decision and reserves the right to move HSTA VEBA members into regular EUTF plans if that decision is overturned or modified.*

***** NOTE:*** *If you are currently enrolled in the Kaiser HMO Medical Plan and have assigned your Medicare Benefits to KP and either select the "Cancel/Waive" box or enroll in either the HMSA PPO 90/10 Medical Plan or the CVS Caremark Prescription Drug Plan, you are also confirming your intent to disenroll from the Kaiser Permanente Senior Advantage Plan as well.*

EXHIBIT C

Retiree's Name: _____

***State and County Contributions**: No person may be enrolled in any EUTF benefit plan as both a retiree/active employee and dependent, nor may children be enrolled by more than one retiree/active employee (dual enrollment). In situations where you and your spouse/partner are both retiree/active employees, the employer's contribution cannot exceed a family plan contribution in accordance with Chapter 87A-33-36, Hawaii Revised Statutes. However, both retirees/active employees are able to select EUTF Self-Only plans. Lastly, if dependents are ages 19 to 24, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. (Detailed eligibility information is available at eutf.hawaii.gov)*

DEPENDENT INFORMATION

Complete dependent information (including spouse/partner/disabled child) and indicate plan selection if adding/removing dependents

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

Optional Race and Ethnicity Disclosure (Dependents)

- Are any of your dependents of Hispanic, Latino/a, or Spanish origin?_____
- What is your dependent's race? _____

MEDICARE

Are you and/or any of your dependents eligible for Medicare Part A & B? ☐ Yes (complete section below) ☐ No

Name	Medicare Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date

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

Kaiser Members: Kaiser Permanente is a Medicare Advantage plan. Medicare eligible members residing in the Hawaii Senior Advantage Service Area are required to enroll in the EUTF Senior Advantage Plan. I understand that my signature confirms enrollment in the EUTF Senior Advantage Plan and this will automatically end my enrollment in another Medicare plan.

OTHER INSURANCE INFORMATION

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

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

RETIREE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans elected.

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

_____ _____

Retiree Signature *Date*

_____ _____

*Dependent (Spouse/Partner) Signature ** * *Date*

*** **Note:** Dependent Signature(s) and Date(s) are required if the dependent is enrolling or disenrolling in/from the Humana, Kaiser HMO Coverage or CVS/SilverScript plans. Failure for both the retiree and dependent(s) to sign when applicable, may result in continued Medicare enrollment with Kaiser Permanente, or CVS/SilverScript.*

Please submit your signed EC-2H form to:
EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

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

Instructions for ACH Deduction Authorization Agreement

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

If you retire and/or become a survivor-beneficiary on or after **October 1, 2020** and are responsible to pay for a portion of your monthly health benefits premium, you are required to enroll in a recurring electronic premium deduction option **(Act 62, SLH2020)**. Please refer to EUTF Administrative Rule 4.14 for details**.**

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

Section A – Account Information

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

Section B – Agreement of All Account Holders

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

Section C – Signatures of All Account Holders

By signing the ACH Deduction Authorization Agreement, the signer certifies the information is accurate and confirms that they understand and agree to the agreement in Section B.

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

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

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

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

EUTF website: eutf.hawaii.gov

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

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

ACH Deduction Authorization Agreement

Automated Electronic Payment of Health Benefit Premiums

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

Member Information *[Please Print]*:

Member Name: _____ Last 4 digits of SSN or EUTF ID Number: _____

Mailing Address: _____

Home Phone Number: _____ Mobile Phone Number: _____

Work Phone Number: _____ E-mail Address: _____

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

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

***Please attach a VOIDED check**

SECTION B – Authorization

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

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

SECTION C – Signatures of All Account Holders

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

Please send form back to EUTF.

Instructions for Employees' Retirement System (ERS) Pension Deduction Authorization Agreement

All portions of the Employees' Retirement System (ERS) Pension Deduction Authorization Agreement must be completed, except where optional, for the form to be valid. In addition, if there is any alteration of this form, a new form must be completed.

If you retire on or after **October 1, 2020** and are responsible to pay for a portion of your monthly health benefits premium, you are required to enroll in a recurring electronic premium deduction option **(Act 62, SLH2020)**. Please refer to EUTF Administrative Rule 4.14 for details.

Notice to New Retirees:

If you submitted your ERS Pension Deduction Authorization Agreement prior to your retirement date, the earliest your health benefit premium deduction will begin will be the second month following your retirement date or your first pension payment, whichever is later. Please pay your health benefit premium payments by check or by other payment options until your deduction begins.

Notice to New and Current Retirees:

You will receive a confirmation notice by mail after the EUTF processes your ERS Pension Deduction Authorization Agreement form. The effective date of the pension deduction is specified on the confirmation notice. Any health benefit premium payments prior to the effective date of the deduction must be paid by check or by other payment options.

NOTE: Health benefit premium deduction from your pension is NOT available to retirees receiving a pension on a semi-monthly basis and surviving spouses receiving a pension.

Retiree Information Section
This section is required. Fill in required information.

Section A – Authorization
This section contains the agreement of the Hawaii Employer-Union Health Benefits Trust Fund (EUTF).

Section B – Signature of Retiree
By signing the ERS Pension Deduction Authorization Agreement, the signer certifies the information is accurate and confirms that they understand and agree to the authorization in Section A.

If you are representing the retiree, please ensure that you have all authorizing document(s) attached to the ERS Pension Deduction Authorization Agreement.

If you have any questions, please contact the EUTF at (808) 586-7390 or toll free at 800-295-0089. You can also visit our website at eutf.hawaii.gov.

Mail completed forms to:

EUTF
201 Merchant Street, Suite 1700
Honolulu, HI 96813

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

ERS Pension Deduction Authorization Agreement Form

I request automatic deduction from my ERS Pension for EUTF Health Benefit Premiums.

I am currently receiving ERS Pension payments (Y or N) _____

Retirement Date: _____ (if not currently receiving an ERS pension)

Retiree Information *[Please Print]*

Retiree Name: _____

Last 4 digits of SSN or EUTF ID Number: _____

Mailing Address: _____

Home Phone Number: _____ Mobile Phone Number: _____

E-mail Address: _____

SECTION A – Authorization

By signing in Section B, I hereby:

- Certify that I am capable and authorized to attest to the following;
- Certify that all information is accurate, and I authorize the EUTF to make payment of my EUTF health benefit premiums by deductions, adjustments or cancellations from my ERS Pension. This authorization will remain in full force until the EUTF receives written notification from me of its termination in such time and in such manner as to afford the EUTF and the ERS a reasonable opportunity to act on it.
- Consent to the disclosure by the ERS to the EUTF of any information that the EUTF requests to effectuate, administer, or enforce the transactions authorized in this EUTF ERS Pension Deduction Authorization Agreement form.
- Consent to the disclosure by the EUTF to the ERS of any information that the ERS requests to effectuate, administer, or enforce the transactions authorized in this EUTF ERS Pension Deduction Authorization Agreement form.
- Agree not to hold the EUTF, nor the ERS, responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me, the EUTF, or the ERS, or due to an error on the part of the EUTF or ERS in deducting funds from the ERS Pension.
- Understand that any existing Automated Clearing House (ACH) withdrawal agreement for EUTF health benefit premiums will be replaced with this EUTF ERS Pension Deduction Authorization Agreement form. The EUTF will, to the extent possible, coordinate termination of the electronic deductions from my bank account with the start of the ERS pension deduction so any break in payments will be limited.
- Understand that EUTF may terminate this EUTF ERS Pension Deduction Authorization Agreement form for any reason.

SECTION B – Signature of Retiree

Retiree Signature:	Date:

EXHIBIT C

State of Hawaii

Department of Budget and Finance
Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
201 Merchant Street, Suite 1700
Honolulu, HI 96813

EXHIBIT D

CHAPTER 87A, HRS

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (THE EUTF)

CHAPTER 87A
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

Part I. General Provisions

Section

Part 11. Board of Trustees

Part Ill. Board Powers and Duties

Part IV. Trust Fund

Note

Applicability of the following to health benefits plans under this chapter:

(1) Coverage for annual screenings of sexually transmitted diseases, including screenings for human immunodeficiency virus and acquired immunodeficiency syndrome, required by L 2016, c 204. L 2016, c 204, §6;

(2) Nondiscrimination provisions required by L 2016, c 135. L 2016, c 135, §5;

(3) Reimbursement for prescription contraceptive supplies required by L 2016, c 205. L 2016, c 205, §4; and

(4) Requirement for reimbursement for telehealth services by L 2016, c 226. L 2016, c 226, §13.

Cross References

Hawaii health authority, see chapter 322H.

Health and dental insurance data; mandatory reporting for certain insurers, see §323D-18.5.

Prescription drug benefits, see chapter 431R.

Case Notes

This chapter's use of general trust language does not impose upon the trustees all of the common law fiduciary duties; although this chapter does not use "discretion" in requiring the board to decide upon the structure of the health benefits plan, the legislature clearly intended that the board have broad discretion in its design; where trustees expressed concern regarding the impact a change to a three- or four-tier structure would have on the collective bargaining process, and also determined that the two-tiered structure would have a negative impact on the smallest percentage of plan participants, trustees did not abuse their discretion. 115 H. 126, 165 P.3d 1027.

The words "similarly situated beneficiary not eligible for medicare", as those words are used in §87A-23(1), or "similarly situated employee-beneficiary not eligible for medicare", as those words are used in §87A-23(3), invoke a comparison between medicare eligible retirees and retirees who do not qualify for medicare; thus, this chapter does not require the board of the employer-union health benefits trust fund to provide health benefits plans to retirees whose benefits "reasonably approximate" those benefits provided to active employees. 122 H. 402, 228 P.3d 282.

PART I. GENERAL PROVISIONS

§87A-1 Definitions. As used in this chapter:

"Board" means the board of trustees of the Hawaii employer-union health benefits trust fund described in section 87A-5.

"Carrier" means a voluntary association, corporation, partnership, or organization engaged in providing, paying for, arranging for, or reimbursing the cost of, health benefits or long-term care benefits under group insurance contracts.

"Contribution" means money payments made to the fund by the State, the counties, an employee-beneficiary, or a qualified-beneficiary.

"County" means the counties of Hawaii, Honolulu, Kauai, and Maui, including their respective boards of water supply and other quasi-independent boards, commissions, and agencies.

"Credited service" means service as an officer or employee paid by the State or county, service during the period of leave of absence or exchange if the individual is paid by the State or county during the leave of absence or exchange, and service during the period of unpaid leave of absence or exchange if the individual is engaged in the performance of a governmental function or if the unpaid leave of absence is an approved leave of absence for professional improvement.

"Dependent-beneficiary" means an employee-beneficiary's:

(1) Spouse;

(2) Child deemed eligible by the board, including a legally adopted child, stepchild, foster child, or recognized natural child, but excluding a child born or legally adopted more than ten months after the date of the death of:

(A) An active employee killed in the performance of duty;

(B) An active employee who was eligible to retire on the date of death; or

(C) A retired employee-beneficiary; and

(3) Unmarried child regardless of age who is incapable of self-support because of a mental or physical incapacity, which existed prior to the unmarried child's reaching the age of nineteen years.

"Employee" means an employee or officer of the State, county, or legislature,

(1) Including:

(A) An elective officer;

(B) An officer or employee under an authorized leave of absence;

(C) An employee of the Hawaii national guard although paid from federal funds;

(D) A retired member of the employees' retirement system; the county pension system; or the police, firefighters, or bandsmen pension system of the State or county;

(E) A salaried and full-time member of a board, commission, or agency appointed by the governor or the mayor of a county; and

(F) A person employed by contract for a period not exceeding one year, where the director of human resources development, personnel services, or civil service has certified that the service is essential or needed in the public interest and that, because of circumstances surrounding its fulfillment, personnel to perform the service cannot be obtained through normal civil service recruitment procedures,

(2) But excluding:

(A) A designated beneficiary of a retired member of the employees' retirement system; the county pension system; or the police, firefighters, or bandsmen pension system of the State or county;

(8) Except as allowed under paragraph (1)(F), a person employed temporarily on a fee or contract basis; and

(C) A part-time, temporary, and seasonal or casual employee.

"Employee-beneficiary" means:

(1) An employee;

(2) The beneficiary of an employee who is killed in the performance of the employee's duty, including:

(A) The surviving child, if there is no surviving parent who is eligible to be an employee-beneficiary and the child is unmarried and under the limiting age as defined by the board; and

(8) The surviving spouse, if the surviving spouse does not subsequently remarry;

(3) An employee who retired prior to 1961; and

(4) The beneficiary of a retired member of the employees' retirement system; a county pension system; or a police, firefighters, or bandsmen pension system of the State or a county, upon the death of the retired member, including:

(A) The surviving child, if there is no surviving parent who is eligible to be an employee-beneficiary and the child is

unmarried and under the limiting age as defined by the board; and

(B) The surviving spouse, if the surviving spouse does not subsequently remarry;

provided that the employee, the employee's beneficiary, or the beneficiary of the deceased retired employee is deemed eligible by the board to participate in a health benefits plan or long-term care benefits plan under this chapter.

"Fund" means the Hawaii employer-union health benefits trust fund established in section 87A-30.

"Health benefits plan" means:

(1) A group insurance contract or service agreement that may include medical, hospital, surgical, prescribed drugs, vision, and dental services, in which a carrier agrees to provide, pay for, arrange for, or reimburse the cost of the services as determined by the board; or

(2) A similar schedule of benefits established by the board and provided through the fund on a self-insured basis.

"Long-term care benefits plan" means:

(1) A group insurance contract or service agreement in which a carrier agrees to provide, pay for, arrange for, or reimburse the cost of long-term care benefits as determined by the board; or

(2) A similar schedule of benefits established by the board and provided through the fund on a self-insured basis.

"Part-time, temporary, and seasonal or casual employee" means a person employed for fewer than three months or whose employment is less than one-half of a full-time equivalent position.

"Periodic charge" means the periodic payment by the board to a carrier for any health benefits plan or long-term care benefits plan.

"Qualified-beneficiary" means, for purposes of the long-term care benefits plan, a former employee or an employee who is not eligible for benefits due to a reduction in work hours, including the spouse, divorced spouse, parents, grandparents, in-law parents, and in-law grandparents of an employee or retiree; provided that the beneficiary was enrolled in the plan before the employee or former employee became ineligible for benefits.

"State agency" includes the office of Hawaiian affairs.

"Trustee" means a trustee of the board of trustees of the Hawaii employer-union health benefits trust fund, as described in section 87A-5. [L 2001, c 88, pt of §1; am L 2003, c 152, §1; am L 2012, c 36, §1; am L **2019, c 51, §2]**

PART II. BOARD OF TRUSTEES

§87A-5 Composition of board. *[See explanatory note below.]* The board of trustees of the employer-union health benefits trust fund shall consist of ten trustees appointed by the governor in accordance with the following procedure:

(1) Five trustees, one of whom shall represent retirees, to represent employee-beneficiaries and to be selected as follows:

(A) Three trustees shall be appointed from a list of two nominees per trustee selected by each of the three exclusive representative organizations that have the largest number of employee-beneficiaries;

(B) One trustee shall be appointed from a list of two nominees selected by mutual agreement of the remaining exclusive employee representative organizations; and

(C) One trustee representing retirees shall be appointed from a list of two nominees selected by mutual agreement of all eligible exclusive representatives; and

(2) Five trustees to represent public employers.

Section 26-34 shall not apply to board member selection and terms. Notwithstanding any other provision of this section, no exclusive representative of a bargaining unit that sponsors or participates in a voluntary employee beneficiary association shall be eligible to select nominees or to be represented by a trustee on the board.

As used in this section, the term "exclusive representative" shall have the same meaning as in section 89-2. [L 2001, c 88, pt of §1; am L 2005, c250, §1]

Explanatory Note

L 2005, c 250 amendment. The legislature concluded that the governor's proclamation indicating the governor's intent to return H.B. No. 1548 was constitutionally defective and that said measure became law. On July 13, 2005, the legislature assigned Act 250 to H.B. No. 1548. The attorney general has taken the position that H.B. No. 1548 did not become law.

§87A-6 Term of a trustee; vacancy. *[See explanatory note below.]* The term of office of each trustee shall be four years; provided that a trustee may be reappointed for one additional consecutive four-year term.

A vacancy on the board shall be filled in the same manner as the trustee who vacated that position was nominated or appointed; provided that the criteria used for nominating or appointing the successor shall be the same criteria used for nominating or appointing the person's predecessor; provided further that vacancies on the board for each trustee position representing retirees and employee-beneficiaries appointed under section 87A-5(1)(A) and (B) shall be filled by appointment of the governor as follows:

(1) If a vacancy occurs in one of the trustee positions described in section 87A-5(1)(A), then the vacancy shall be appointed from a list of two nominees submitted by the exclusive employee representative from among the three largest exclusive employee representatives that does not have a trustee among the three trustee positions;

(2) If a vacancy occurs in a trustee position described in section 87A-5(1)(B), then the vacancy shall be appointed from a list of two nominees submitted by mutual agreement of the exclusive employee representatives described in section 87A-5(1)(B); and

(3) If a vacancy occurs in the retiree position described in section 87A-5(1)(C), then the vacancy shall be appointed from a list of two nominees submitted by mutual agreement of all eligible exclusive employee representatives.

If by the end of a trustee's term the trustee is not reappointed or the trustee's successor is not appointed, the trustee shall serve until the trustee's successor is appointed. [L 2001, c 88, pt of §1; am L 2005, c 250, §2]

Explanatory Note

L 2005, c 250 amendment. The legislature concluded that the governor's proclamation indicating the governor's intent to return H.B. No. 1548 was constitutionally defective and that said measure became law. On July 13, 2005, the legislature

assigned Act 250 to H.B. No. 1548. The attorney general has taken the position that H.B. No. 1548 did not become law.

[§87A-7] Chair, vice-chair, and secretary-treasurer. The trustees shall elect from among the members a chair, a vice-chair, and a secretary-treasurer. [L 2001, c 88, pt of§ 1]

[§87A-8] Compensation and expenses. Each trustee shall serve without compensation, but the trustees may be reimbursed from the fund for any reasonable expenses incurred in carrying out the purposes of the fund. [L 2001, c 88, pt of §1]

[§87A-9] Legal adviser. The attorney general shall serve as legal adviser to the board and shall provide legal representation for the Hawaii employer-union health benefits trust fund. [L 2001, c 88, pt of §1]

[§87A-10] Meetings; notice. Meetings may be scheduled, and notice of meetings shall be provided as follows:

(1) The chairperson may call a meeting of the board at any time by giving at least six calendar days' written notice of the time and place of the meeting to all trustees; and

(2) A majority of the trustees may call a meeting of the board by giving at least ten calendar days' written notice of the time and place to all other trustees. [L 2001, c 88, pt of §1]

[§87A-11] Quorum; board actions; voting. (a) Six trustees, three of whom represent the public employer and three of whom represent employee-beneficiaries, shall constitute a quorum for the transaction of business.

(b) Trustees representing the public employers shall collectively have one vote. Trustees representing the employee-beneficiaries shall collectively have one vote.

For any vote of the trustees representing the public employers to be valid, three of these trustees must concur to cast such a vote. In the absence of such concurrence, the trustees representing the public employers shall be deemed to have abstained from voting.

For any vote of the trustees representing the employee-beneficiaries to be valid, three of these trustees must concur to cast such a vote. In the absence of such concurrence, the trustees representing the employee-beneficiaries shall be deemed to have abstained from voting.

An abstention shall not be counted as either a vote in favor or against a matter before the board.

(c) Any action taken by the board shall be by the concurrence of at least two votes. In the event of a tie vote on any motion, the motion shall fail. Upon the concurrence of six trustees, the board shall participate in dispute resolution. [L 2001, c 88, pt of §1]

[§87A-12] Records and minutes. The board shall keep records and minutes of all meetings of the board. [L 2001, c 88, **pt of §1]**

PART III. BOARD POWERS AND DUTIES

[§87A-15] Administration of the fund. The board shall administer and carry out the purpose of the fund. Health and other benefit plans shall be provided at a cost affordable to both the public employers and the public employees. [L 2001, c 88, pt of §1]

[§87A-16] Health benefits plan; carriers. (a) The board shall establish the health benefits plan or plans, which shall be exempt from the minimum group requirements of chapter 431.

(b) The board may contract for health benefits plans or provide health benefits through a noninsured schedule of benefits. [L 2001, c 88, pt of §1]

[§87A-16.3] Prescription drugs; mail order opt out option. A Hawaii employer-union health benefits trust fund health benefits plan shall permit each beneficiary to fill any covered prescription in accordance with chapter 431R. [L 2013, c 226, §3]

[§87A-17] Group life insurance benefits or group life insurance program. The board may provide benefits under a group life insurance benefits program or group life insurance program to employees. [L 2001, c 88, pt of §1]

§87A-18 Long-term care benefits plan; carrier or third-party administrator. (a) The board may establish a long-term care benefits plan or plans for employee-beneficiaries; the spouses, parents, grandparents, in-law parents, and in-law grandparents of employee-beneficiaries; and qualified-beneficiaries. The plan or plans shall be at no cost to employers and shall comply with article 1OH of chapter 431.

(b) Notwithstanding any other law to the contrary, long-term care benefits shall be available only to:

(1) Employee-beneficiaries and their spouses, parents, and grandparents;

(2) Employee-beneficiary in-law parents and grandparents; and

(3) Qualified-beneficiaries who enroll between the ages of twenty and eighty-five,

who comply with the plan's age, enrollment, medical underwriting, and contribution requirements.

(c) The board may contract with a carrier to provide fully insured benefits or with a third-party administrator to administer self-insured benefits. [L2001, c88, ptof§1; am L2004, c216, §14]

[§87A-19] Plans for part-time, temporary, and seasonal or casual employees. (a) The board may offer medical, hospital, or surgical benefits plans to part-time, temporary, and seasonal or casual employees at no cost to the employers. The board may determine eligibility for part-time, temporary, and seasonal or casual employees by rules exempt from chapter 91 as provided in section 87A-26.

(b) The board shall establish the medical, hospital, or surgical benefits plan or plans, which shall be exempt from the minimum group requirements of article 10A of chapter 431. The medical, hospital, or surgical benefits plan or plans shall provide, pay for, arrange for, or reimburse the cost of medical, hospital, or surgical services, and may include prescribed hospital in-patient and out-patient service and medical benefits.

(c) The board may contract for the medical, hospital, or surgical benefits plan or plans. Each part-time, temporary, and seasonal or casual employee enrolled for medical, hospital, or surgical benefits shall pay monthly contributions directly to the board's designated carriers. The monthly contributions may include the carrier's administrative costs. [L 2001, c 88, pt of §1]

§87A-20 REPEALED. L 2004, c 216, §45.

[§87A-21] Eligibility. (a) The board shall establish eligibility criteria to determine who can qualify as an employee-beneficiary, dependent-beneficiary, or qualified-beneficiary, consistent with the provisions of this chapter.

(b) A retired member of the employees' retirement system; a county pension system; or a police, firefighters, and bandsmen pension system of the State or county, shall be eligible to qualify as an employee-beneficiary:

(1) Regardless of whether the retired member was actively employed by the State or county at the time of the retired employee's retirement; and

(2) Without regard to the date of the retired member's retirement.

(c) A dependent of a retired member shall be eligible to qualify as an employee-beneficiary or dependent-beneficiary:

(1) Regardless of whether the retired member was actively employed by the State or county at the time of the retired employee's retirement; and

(2) Without regard to the date of the retired member's retirement. [L 2001, c 88, pt of §1]

Case Notes

A retired employee's health benefits that are included in a health benefits plan falls within the constitutional protection contemplated by article XVI, §2 of the Hawaii constitution inasmuch as subsection (b) clearly and unambiguously conditions a retired state or county government employee's eligibility for health benefits on, inter alia, being a retired member of the employees' retirement system. 122 H. 402, 228 P.3d 282.

[§87A-22] Benefits plan information and enrollment. (a) The board shall make information summarizing approved benefits plans available to each employee-beneficiary. The information shall, to the extent reasonably possible, be distributed to each employee-beneficiary at the same time and in the same manner.

(b) The board shall establish conditions and procedures for benefits plan enrollment. [L 2001, c 88, pt of §1]

§87A-23 Health benefits plan supplemental to medicare. The board shall establish a health benefits plan, which takes into account benefits available to an employee-beneficiary and spouse under medicare, subject to the following conditions:

(1) There shall be no duplication of benefits payable under medicare. The plan under this section, which shall be secondary to medicare, when combined with medicare and any other plan to which the health benefits plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall provide benefits that approximate those provided to a similarly situated beneficiary not eligible for medicare;

(2) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a contribution equal to an amount not less than the medicare part B premium, excluding medicare income-related monthly adjustment amounts for a retired employee hired after June 30, 2023, and their spouse, for each of the following who are enrolled in the medicare part B medical insurance plan: (A) an employee-beneficiary who is a retired employee, (B) a spouse of an employee-beneficiary hired prior to July 1, 2023, while the employee-beneficiary is living, and (C) an employee-beneficiary's spouse, after the death of the employee-beneficiary, if the spouse qualifies as an employee-beneficiary. If the amount reimbursed by the fund under this section is less than the actual cost of the medicare part B medical insurance plan, excluding medicare income-related monthly adjustment amounts for a retired employee hired after June 30, 2023, and their spouse, due to an increase in the medicare part B medical insurance plan rate, the fund shall reimburse each employee-beneficiary and spouse of an employee-beneficiary hired prior to July 1, 2023, for the cost increase within thirty days of the rate change. Each employee-beneficiary and employee-beneficiary's spouse who becomes entitled to reimbursement from the fund for medicare part B premiums after July 1, 2006, shall designate a financial institution account into which the fund shall be authorized to deposit reimbursements. This method of payment may be waived by the fund if another

method is determined to be more appropriate. For purposes of this section, a "retired employee" means retired members of the employees' retirement system; county pension system; or a police, firefighters, or bandsmen pension system of the State or a county as set forth in chapter 88;

(3) The benefits available under this plan, when combined with benefits available under medicare or any other coverage or plan to which this plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall approximate the benefits that would be provided to a similarly situated employee-beneficiary not eligible for medicare;

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

(5) The board shall determine which of the employee-beneficiaries and dependent-beneficiaries, who are not enrolled in the medicare part B medical insurance plan, may participate in the plans offered by the fund. **[L** 2001, c 88, pt of §1; am **L** 2003, c 111, §1; am **L** 2006, c 39, §1; am L 2023, c 40, §2 and c 41, §2]

Case Notes

The words "similarly situated beneficiary not eligible for medicare", as those words are used in paragraph (1), or "similarly situated employee-beneficiary not eligible for medicare", as those words are used in paragraph (3), invoke a comparison between medicare eligible retirees and retirees who do not qualify for medicare; thus, this chapter does not require the board of the employer-union health benefits trust fund to provide health benefits plans to retirees whose benefits "reasonably approximate" those benefits provided to active employees. 122 H. 402, 228 P.3d 282.

§87A-24 Other powers. In addition to the power to administer the fund, the board may:

(1) Collect, receive, deposit, and withdraw money on behalf of the fund;

(2) Invest moneys in the same manner specified in section 88-119;

(3) Hold, purchase, sell, assign, transfer, or dispose of any securities or other investments of the fund, as well as the proceeds of those investments and any money belonging to the fund;

(4) Appoint, and at pleasure dismiss, an administrator and other fund staff. The administrator shall be exempt from chapter 76. Other fund staff may be exempt from chapter 76 as determined by the board. The administrator and staff who are exempt from chapter 76 shall serve under and at the pleasure of the board; provided that civil service exempt positions under this section that are created after July 1, 2014, shall be exempt from section 76-16(b)(17)(A); provided further that the salaries of the administrator and chief investment officer shall be set by the board;

(5) Make payments of periodic charges and pay for reasonable expenses incurred in carrying out the purposes of the fund;

(6) Contract for the performance of financial audits of the fund and claims audits of its insurance carriers;

(7) Retain auditors, actuaries, investment firms and managers, benefit plan consultants, or other professional advisors to carry out the purposes of this chapter, including the retaining of an actuary to determine the annual required public employer contribution for the separate trust fund established under section 87A-42;

(8) Establish health benefits plan and long-term care benefits plan rates that include administrative and other expenses necessary to effectuate the purposes of the fund; and

(9) Require any department, agency, or employee of the State or counties to furnish information to the board to carry out the purposes of this chapter. [L 2001, c 88, pt of §1; am L 2004, c 216, §15; am L 2013, c 268, §7; am L 2016, c 30, §2; am L 2017, c 145, §2; am L 2021, c 229, §§2, 9; am L 2023, c 38, §2]

[§87A-25] Other duties. The board shall:

(1) Authorize charges and payments from the fund only upon vouchers countersigned by the chairperson and any other person designated by the board;

(2) Maintain accurate records and accounts of all financial transactions of the fund that shall be audited annually and summarized in an annual report to the governor and legislature;

(3) Maintain suitable and adequate records and provide information requested by State and county employers as necessary to carry out the purpose of the fund;

(4) Procure fiduciary liability insurance and error and omissions coverage for all trustees; and

(5) Procure a fidelity bond of a reasonable amount for the chairperson and any other person authorized to handle fund moneys. [L 2001, c 88, pt of §1]

[§87A-26] Rules; policies, standards, and procedures. (a) The board may adopt rules for the purposes of this chapter. Rules shall be adopted without regard to chapter 91. Rulemaking procedures shall be adopted by the board and shall minimally provide for:

(1) Consultation with employers and affected employee organizations with regard to proposed rules;

(2) Adoption of rules at open meetings that permit the attendance of any interested persons;

(3) Approval of rules by the governor; and

(4) Filing of rules with the lieutenant governor.

(b) The board may also issue policies, standards, and procedures consistent with its rules.

(c) The board may adopt rules, without regard to chapter 91, governing dispute resolution procedures in the event of impasse in decision-making; provided that the rules shall be adopted with the concurrence of six trustees. [L 2001, c 88, pt of§ 1]

[§87A-27] Actuarial investigation; valuations. Beginning on July 1, 2017, the actuary retained by the board pursuant to section 87A-42 shall make an annual valuation of the assets and liabilities of the fund based on tables and other factors adopted by the board annually. The annual valuation shall include an update of assumptions specific to the fund that are not updated pursuant to section 88-105, as deemed necessary by the actuary, at least once in each three-year period. [L **2017, c 93, §2]**

PART IV. TRUST FUND

§87A-30 Hawaii employer-union health benefits trust fund; establishment. There is established outside the state treasury, a trust fund to be known as the "Hawaii Employer-Union Health Benefits Trust Fund". The fund shall consist of contributions, interest, income, dividends, refunds, rate credits, and other returns. It is hereby declared that any and all sums contributed or paid from any source to the fund created by this part, and all assets of the fund including any and all interest and earnings on the same, are and shall be held in trust by the board for the exclusive use and benefit of the employee-beneficiaries and dependent-beneficiaries and shall not be subject to appropriation for any other purpose whatsoever. The fund shall be under the control of the board and placed under the department of budget and finance for administrative purposes. [L 2001, c 88, pt of §1; am L 2006, c 57, §3]

§87A-31 Trust fund; purpose; disclosure of information. (a) The fund shall be used to provide employee-beneficiaries and dependent-beneficiaries with health and other benefit plans, and to pay administrative and other expenses of the fund. All assets of the fund are and shall be dedicated to providing health and other benefits plans to the employee-beneficiaries and dependent-beneficiaries in accordance with the terms of those plans and to pay administrative and other expenses of the fund, and shall be used for no other purposes except for those set forth in this section.

(b) The fund, including any earnings on investments, and rate credits or reimbursements from any carrier or self-insured plan and any earning or interest derived therefrom, may be used to stabilize health and other benefit plan rates; provided that the approval of the governor and the legislature shall be necessary to fund administrative and other expenses necessary to effectuate these purposes.

(c) The fund may be used to provide group life insurance benefits to employees to the extent that contributions are provided for group life insurance benefits in sections 87A-32 and 87A-37.

(d) The fund may assist the State and the counties to implement and administer cafeteria plans authorized under title 26 United States Code section 125, the Internal Revenue Code of 1986, as amended, and section 78-30.

(e) At the discretion of the board, some or all of the fund may be used as a reserve against or to pay the fund's future costs of providing health and other benefits plans established under sections 87A-23 and 87A-37 and any other benefits plans the board establishes for retired employees and their beneficiaries. The board may create separate funds within the fund for this purpose. Each separate fund shall be subject to all provisions of this chapter.

(f) If after commencing the reimbursement of medicare part B premiums in section 87A-23, or any other debt payable under this chapter, the fund cannot locate the employee-beneficiary or other person or entity entitled to payment, further payment shall be forfeited to the fund if the total amount is less than $500 and shall not escheat under the laws of any state; provided that the forfeited payment shall be restored if the employee-beneficiary, or other person or entity entitled to the forfeited payment makes a proper application to the fund for restoration of the benefit no later than ten years following the last valid reimbursement or payment. All applications for restoration of a forfeited benefit or payment shall be in a form satisfactory to the fund. For forfeited benefits or payments in existence on June 30, 2017, the ten-

year time limitation on claiming the benefits or payments shall commence on July 1, 2017.

(g) The exemptions from disclosure of information pursuant to chapter 92F set forth in section 88-103.5(c) through (e) shall apply to the disclosure of information relating to the fund's alternative investments; provided that references to the "system" in section 88-103.5(c) and (e) shall be replaced with the "fund" for purposes of the fund's alternative investments. [L 2001, c 88, pt of §1; am L 2006, c 57, §4; am L 2017, c 144, §2; am L 2022, c 75, §2]

Revision Note

In subsection (d), reference to "section 78-30" substituted for "part II of chapter 78".

[§87A-31.1] Public employers; defined. For the purposes of this part, "public employer" means a governmental entity whose employees', beneficiaries', and retirees' health benefits coverage is provided through the fund. [L 2013, c 268, pt of §6]

[§87A-31.5] Employer contributions irrevocable. Notwithstanding any law to the contrary, all of the monthly contributions that the State and counties make to the fund under sections 87A-32, 87A-33, 87A-34, 87A-35, 87A-36, and 87A-37, and all other contributions that the State and counties may make to the fund, shall be irrevocable; provided that this shall not preclude the fund from returning contributions or payments made by the State or any county under a mistake of fact within one year after the payment of the contributions or payments. [L 2006, c 57, §2]

§87A-32 State and county contributions; active employees. (a) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a monthly contribution equal to the amount established under chapter 89C or specified in the applicable public sector collective bargaining agreements, whichever is appropriate, for each of their respective employee-beneficiaries and employee-beneficiaries with dependent-beneficiaries, which shall be used toward the payment of costs of a health benefits plan; provided that:

(1) The monthly contribution shall be a specified dollar amount;

(2) The monthly contribution shall not exceed the actual cost of a health benefits plan;

(3) If two employee-beneficiaries are married or in a civil union, the total contribution by the State or the county shall not exceed the monthly contribution for a family plan; and

(4) If the State or any of the counties establish cafeteria plans in accordance with Title 26, United States Code section 125, the Internal Revenue Code of 1986, as amended, and section 78-30, the monthly contribution for those employee-beneficiaries who participate in a cafeteria plan shall be made through the cafeteria plan, and the payments made by the State or counties shall include their respective contributions to the fund and their employee-beneficiary's share of the cost of the employee-beneficiary's health benefits plan.

(b) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a monthly contribution equal to the amount established under chapter 89C or specified in the applicable public sector collective bargaining agreement, whichever is applicable, for each of their respective employees, to be used toward the payment of group life insurance benefits for each employee. [L 2001, c 88, pt of §1; am L **2019, c 51, §3]**

Revision Note

In subsection (a)(4), reference to "section 78-30" substituted for "part II of chapter 78".

§87A-33 State and county contributions; retired employees. (a) Notwithstanding any law to the contrary, this section shall apply to state and county contributions to the fund for:

(1) The dependent-beneficiary of an employee who is killed in the performance of duty;

(2) A dependent-beneficiary, upon the death of the employee-beneficiary, except as provided in section 87A-36;

(3) An employee-beneficiary who retired after June 30, 1984, due to a disability falling within sections 88-79 and 88-285;

(4) An employee-beneficiary who retired before July 1, 1984;

(5) An employee-beneficiary who:

(A) Was hired before July 1, 1996;

(B) Retired after June 30, 1984; and

(C) Who has ten years or more of credited service, excluding sick leave;

(6) An employee-beneficiary who:

(A) Was hired after June 30, 1996; and

(B) Retired with twenty-five or more years of credited service, excluding sick leave, except as provided in section 87A-36; and

(7) Employees who retired prior to 1961 and their dependent-beneficiaries.

(b) Effective January 1, 2014, there is established a base monthly contribution for health benefit plans that the State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund, up to the following:

(1) $524.73 for each employee-beneficiary enrolled in supplemental medicare self plans;

(2) $1,051.70 for each employee-beneficiary enrolled in supplemental medicare two-party plans;

(3) $1,531.78 for each employee-beneficiary enrolled in supplemental medicare family plans;

(4) $736.60 for each employee-beneficiary enrolled in non-medicare self plans;

(5) $1,484.72 for each employee-beneficiary enrolled in non-medicare two-party plans; and

(6) $2,173.06 for each employee-beneficiary enrolled in non-medicare family plans.

The monthly contribution by the State or county shall not exceed the actual cost of the health benefit plan or plans and shall not be required

to cover increased benefits above those initially contracted for by the fund for plan year 2004-2005. If two employee-beneficiaries are married or in a civil union, the total contribution by the State or county shall not exceed the monthly contribution for a supplemental medicare family or non-medicare family plan, as appropriate.

(c) The base composite monthly contribution shall be adjusted annually, beginning January 1, 2015. The adjusted base composite monthly contribution for each new plan year (January 1 until December 31) shall be calculated by increasing or decreasing the base composite monthly contribution in effect through the end of the previous plan year by the percentage increase or decrease in the medicare part B premium rate for those years, which percentage shall be calculated by dividing the medicare part B premium rate in effect at the beginning of the new plan year by the rate in effect at the beginning of the previous plan year.

As used in this subsection, "medicare part B premium rate" means the rate published in the Federal Register each year on November 1 or on the business day closest to November 1 of each year after the medicare part B premium rate has been established by the United States Secretary of Health and Human Services and approved by the United States Congress.

(d) If the board adopts a rate structure that provides for other than self and family rates for the health benefit plans, the base monthly contribution for the rate structure adopted by the board shall be adjusted to provide the equivalent underwriting cost as the base monthly contribution that is provided for in this section. [L 2001, c 88, pt of §1; am L 2003, c 111, §2; am L 2007, c 26, §1; am L 2012, c 38, §1; am L 2013, c 282, §1; am L 2019, c 51, §4]

[§87A-33.5] State and county contribution; reimbursement for retired employees. Effective July 1, 2007, an employee-beneficiary who retires and relocates outside of the State shall be reimbursed for the premiums paid by the employee-beneficiary for a personal health insurance policy; provided that the board shall determine which employee-beneficiaries and what types of personal health insurance policies shall be eligible for reimbursement and may set other conditions that shall be met for the employee-beneficiary to receive the reimbursements provided under this section.

The reimbursement shall be the lesser of:

(1) The actual cost of the personal health insurance policy; or

(2) The amount of the state or county contribution for the most comparable health benefits plan.

Reimbursements shall be paid by the fund on a quarterly basis upon the presentation of documentation that the premiums for the personal health insurance policy have been paid by the employee-beneficiary. This section shall apply to all employee-beneficiaries who retire and relocate outside of the State, regardless of their date of retirement. [L **2006, c 167,** §1)

§87A-34 State and county contributions; retired employees with fewer than ten years of service. (a) This section shall apply to state and county contributions to the fund for employees specified in paragraph (1)(D) of the definition of "employee" in section 87A-1 who:

(1) Were hired on or before June 30, 1996; and

(2) Retired after June 30, 1984, with fewer than ten years of credited service, excluding sick leave.

(b) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a monthly contribution equal to one-half of the base monthly contribution set forth under section 87A-33(b) for retired employees enrolled in medicare or non-medicare health benefits plans. If two employee-beneficiaries are married or in a civil union, the total contribution by the State or county shall not exceed the monthly contribution for supplemental medicare family or non-medicare family plan, as appropriate. [L 2001, c 88, pt of §1; am L 2017, c 12, §5; am L **2019,** c **51, §5]**

§87A-35 State and county contributions; employees hired after June 30, 1996, but before July 1, 2001, and retired with fewer than twenty-five years of service. (a) This section shall apply to state and county contributions to the fund for employees who were hired after June 30, 1996, but before July 1, 2001, and who retire with fewer than twenty-five years of credited service, excluding sick leave; provided that this section shall not apply to the following employees, for whom state and county contributions shall be made as provided by section 87A-33:

(1) An employee hired prior to July 1, 1996, who transfers employment after June 30, 1996, and who cumulatively accrues at least ten years of credited service; and

(2) An employee hired prior to July 1, 1996, who has at least ten years of credited service prior to a break in service.

For the purposes of this section:

"Break in service" means to leave state or county employment for more than ninety calendar days before returning to state or county employment.

"Transfer" means to leave state or county employment and return to state or county employment within ninety calendar days.

(b) For purposes of this section, if an employee leaves state or county employment and returns to state or county employment after June 30, 1996, upon retirement, the employee's years of service shall be computed in the same manner as set forth in chapter 88.

(c) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund:

(1) For retired employees enrolled in medicare or non-medicare health benefit plans with ten or more years but fewer than fifteen years of service, a monthly contribution equal to one-half of the base monthly contribution set forth under section 87A-33(b); and

(2) For retired employees enrolled in medicare or non-medicare health benefit plans with at least fifteen but fewer than twenty-five years of service, a monthly contribution of seventy-five per cent of the base monthly contribution set forth under section 87A-33(b).

If two employee-beneficiaries are married or in a civil union, the total contribution by the State or county shall not exceed the monthly contribution for a supplemental medicare family or non-medicare family plan, as appropriate. [L 2001, c 88, pt of §1; am L 2004, c 184, §1; am L **2019, c 51, §6]**

§87A-36 State and county contributions; employees hired after June 30, 2001, and retired. (a) This section shall apply to state and county contributions to the fund for employees hired after June 30, 2001, and who retired, except that this section shall not apply to the following employees, for whom state and county contributions shall be made as provided by section 87A-35:

(1) An employee hired after June 30, 1996, and prior to July 1, 2001, who transfers employment after June 30, 2001, and who cumulatively accrues at least ten years of credited service; and

(2) An employee hired after June 30, 1996, and prior to July 1, 2001, who has at least ten years of credited service prior to a break in service.

For purposes of this section:

"Break in service" means to leave state or county employment for more than ninety calendar days before returning to state or county employment.

"Transfer" means to leave state or county employment and return to state or county employment within ninety calendar days.

(b) For purposes of this section, if an employee leaves state or county employment and returns to state or county employment after July 1, 2001, upon retirement, the employee's years of service shall be computed in the same manner as set forth in chapter 88.

(c) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund:

(1) For retired employees based on the self plan with ten or more years but fewer than fifteen years of service, a monthly contribution equal to one-half of the base medicare or non-medicare monthly contribution set forth under section 87A-33(b);

(2) For retired employees based on the self plan with at least fifteen but fewer than twenty-five years of service, a monthly contribution equal to seventy-five per cent of the base medicare or non-medicare monthly contribution set forth under section 87A-33(b);

(3) For retired employees based on the self plan with twenty-five or more years of service, a monthly contribution equal to one hundred per cent of the base medicare or non-medicare monthly contribution set forth under section 87A-33(b); and

(4) One-half of the monthly contributions for the employee-beneficiary or employee-beneficiary with dependent-beneficiaries upon the death of the employee, as defined in paragraph (1)(D) of the definition of "employee" in section 87A-1[.]

If two employee-beneficiaries are married or in a civil union, the total contribution by the State or county shall not exceed the monthly contribution for two supplemental medicare self or non-medicare self plans, as appropriate. [L 2001, c 88, pt of §1; am L 2004, c 184, §2; am L 2017, c 12, §6; am L 2019, c 51, §7]

[§87A-37] Group life insurance benefits plans for retired employees; contributions. (a) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a base monthly contribution as set forth in subsection (b) for each retired employee enrolled in the fund's group life insurance benefits plan under section 87A-34, 87A-35, and 87A-36.

(b) Effective July 1, 2003, there is established a base monthly contribution of $4.16 for each retired employee enrolled in a group life insurance plan; provided that the monthly contribution shall not exceed the actual cost of the group life insurance benefits plan. The base composite monthly contribution shall be adjusted annually beginning July 1, 2004. The adjusted base composite monthly contribution for each new plan year shall be calculated by increasing or decreasing the base composite monthly contribution in effect through the end of the previous plan year by the percentage increase or decrease in the medicare part B premium rate for those years. The percentage shall be calculated by dividing the medicare part B premium rate in effect at the beginning of the new plan year by the rate in effect through the end of the previous plan year.

As used in this subsection, "medicare part B premium rate" means the rate published in the Federal Register each year on November 1 or on the business day closest to November 1 of each year after the medicare part B premium rate has been established by the Secretary of Health and Human Services and approved by the United States Congress. [L 2001, c 88, pt of §1]

[§87A-38] State and county contributions not considered wages or salary. Contributions made by the State or the counties under this part shall not be considered wages or salary of an employee-beneficiary. No employee-beneficiary shall have any vested right in or be entitled to receive any part of any contribution made to the fund. [L 2001, c 88, pt of §1]

[§87A-39] Reimbursement for state contributions. (a) All state agencies having control of funds other than the general fund shall reimburse the State for contributions made by the State pursuant to sections 87A-32, 87A-33, 87A-34, 87A-35, 87A-36, and 87A-37 on account of agency employees whose compensation is paid in whole or part from funds other than the general fund.

(b) All state and county agencies receiving federal funds, which may be expended for the purpose of replacing the contributions payable by the State to the fund, shall set aside a portion of the federal funds sufficient to reimburse the State for contributions made by the State pursuant to sections 87A-32, 87A-33, 87A-34, 87A-35, 87A-36, and 87A-37, on account of the employees in the agencies whose compensation is paid in whole or part from federal funds. [L 2001, c 88, pt of §1]

§87A-40 Employee-beneficiary contributions; health benefit plans. (a) Each employee-beneficiary shall make a monthly contribution to the fund amounting to the difference between the monthly charge of the health benefits plan selected by the employee-beneficiary and the contribution made by the State or county for the employee-beneficiary to the fund. Nothing in this section shall prohibit any employee-beneficiary from participating in a cafeteria plan authorized under Title 26 United States Code section 125, Internal Revenue Code of 1986, as amended, and section 78-30.

(b) Except as provided in subsection (c), during the period the health benefits plan selected by an employee-beneficiary is in effect, the employee-beneficiary, if allowed by law, shall authorize the employee-beneficiary's contribution to be withheld and transmitted to the fund monthly by the comptroller, employees' retirement system, or finance officer who disburses the employee-beneficiary's compensation, pension, or retirement pay. If an employee-beneficiary's contribution to the fund is not withheld and transmitted to the fund, the employee-beneficiary shall pay the monthly contribution directly to the fund by the first day of each month.

(c) Each employee-beneficiary who retires after June 30, 2020, and each surviving spouse or surviving child who enrolls in a health plan offered by the fund as an employee-beneficiary after June 30, 2020, shall authorize their contribution to the fund to be electronically withheld or deducted and transmitted to the fund monthly by the employees' retirement system or the financial institution of the retirant or retirant's surviving beneficiary. This method may be waived by the fund if another method is determined to be more appropriate. If the contribution by the retirant or the retirant's surviving beneficiary is not electronically withheld, deducted, or transmitted to the fund, the retirant or the retirant's surviving beneficiary shall pay their monthly contribution directly to the fund by the first day of each month.

(d) Notwithstanding subsection (a), an employee-beneficiary's monthly contribution to the fund shall include the amount that would have been the employee-beneficiary's contribution if the employee-beneficiary had not elected to participate in the cafeteria plan. [L 2001, c 88, pt of §1; am L 2020, c 62, §2]

[§87A-41] Employee-beneficiary or qualified-beneficiary contributions; long-term care benefits plan. (a) During the period the long-term care benefits plan is in effect, the employee-beneficiary, if allowed by law, shall authorize the employee-beneficiary's contribution to be withheld and transmitted to the fund monthly by the comptroller, employees' retirement system, or finance officer who disburses the employee-beneficiary's compensation, pension, or retirement pay. If an employee-beneficiary's monthly contribution to the fund is not withheld and transmitted to the fund, the employee-beneficiary shall pay the monthly contribution directly to the board's designated carrier or third-party administrator as specified by the board.

(b) Qualified-beneficiaries shall pay monthly contributions directly to the board's designated carrier or third-party administrator as specified by the board. [L 2001, c 88, pt of §1]

§87A-42 Other post-employment benefits trust. (a) Notwithstanding sections 87A-31 and 87A-31.5, the board, upon terms and conditions set by the board, shall establish and administer a separate trust fund for the purpose of receiving employer contributions that will prefund other post-employment health and other benefit plan costs for retirees and their beneficiaries. The separate trust fund shall meet the requirements of the Governmental Accounting Standards Board regarding other post-employment benefits trusts. The board shall establish and maintain a separate account for each public employer within the separate trust fund to accept and account for each public employer's contributions. Employer contributions to the separate trust fund shall be irrevocable, all assets of the fund shall be dedicated exclusively to providing health and other benefits to retirees and their beneficiaries, and assets of the fund shall not be subject to appropriation for any other purpose and shall not be subject to claims by creditors of the employers or the board or plan administrator. The board's powers under section 87A-24 shall also apply to the fund established pursuant to this section.

(b) Public employer contributions shall be paid into the fund in each fiscal year, and commencing with the 2018-2019 fiscal year, the amount of the annual public employer contribution shall be equal to the amount of the annual required contribution, as determined by an actuary retained by the board.

(c) In any fiscal year subsequent to the 2017-2018 fiscal year in which the state public employer's contributions into the fund are less than the amount of the annual required contribution, the amount that represents the excess of the annual required contribution over the state public employer's contributions shall be deposited into the appropriate account of the separate trust fund from a portion of all general excise tax revenues collected by the department of taxation under section 237-31.

If any general excise tax revenues are deposited into the separate trust fund in any fiscal year as a result of this subsection, the director of finance shall notify the legislature and governor whether the general fund expenditure ceiling for that fiscal year would have been exceeded if those revenues had been legislatively appropriated instead of deposited without appropriation into the trust fund. The notification shall be submitted within thirty days following the end of the applicable fiscal year.

(d) In any fiscal year subsequent to fiscal year 2017-2018 in which a public employer's contributions into the fund are less than the amount of the annual required contribution, the public employer's contributions

shall be deposited into the fund from portions of any other revenues collected on behalf of the public employer or held by the State. The director of finance shall deduct the amount necessary to meet the public employer's annual required contribution from any revenues collected on behalf of the public employer held by the State, except the tax revenues deposited into the mass transit special fund pursuant to section 237D-2(e)(1), and transfer the amount to the board for deposit into the appropriate account of the separate trust fund.

(e) For the purposes of this section, "annual required contribution" means a public employer's required contribution to the trust fund established in this section that is sufficient to cover:

(1) The normal cost, which is the cost of other post-employment benefits attributable to the current year of service; and

(2) An amortization payment, which is a catch-up payment for past service costs to fund the unfunded actuarial accrued liability over the next thirty years. If the State issues general obligation bonds to pay or prepay all or any portion of the State's unfunded actuarial accrued liability and contributes the proceeds to the trust fund, the outstanding balance of the general obligation bonds shall be considered part of the State's unfunded actuarial accrued liability for the purpose of determining the preliminary annual required contribution. The annual required contribution would be the greater of:

(A) The preliminary annual required contribution less the related general obligation bond payment; or

(B) The amount calculated under this paragraph without any special consideration given to the outstanding balance of the general obligation bonds or any related general obligation bond payments. **[L** 2012, c 304, §1; am **L** 2013, c 268, §8; am **L** 2015, c 121, §4; am **L** 2020, c 70, §2; am L 2021, c 229, §§3, 9; am L Sp 2021, c I, §8; am **L** 2022, c 247, §2]

Note

Authorization to create fund requires Government Accounting Standards Board requirements. L 2012, c 304, §2.

Public employer contributions into trust fund (fiscal period 2014-2019). **L 2013, c 268, §11.**

[§87A-43] Payment of public employer contributions to the other post-employment benefits trust. (a) Commencing with fiscal year 2018-2019, each of the counties and all other public employers shall make annual required contributions in accordance with section 87A-42 for the benefit of their retirees and beneficiaries.

(b) The board shall determine the annual required contribution owed by each public employer under this part for each fiscal year, beginning with fiscal year 2018-2019. [L 2013, c 268, pt of §6; am L 2021, c 229, §§7, 9]

EXHIBIT E

EUTF ADMINISTRATIVE RULES

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (THE EUTF)

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

ADMINISTRATIVE RULES

CONTENTS

1.00 GENERAL PROVISIONS

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.

"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 of a retired employee hired prior to July 1, 2024, 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

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.

"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.

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. The Fund may charge a minimum of twenty-five cents per page, or an amount to be approved by the board, for each copy of a document that it reproduces under Section 92-21, HRS, pursuant to a public record request under chapter 92F, HRS, and shall include, but not be limited to, the labor, material, electricity, equipment, certification, and other related costs for reproduction.

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.

(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 ttustee group.

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

(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 hoard. 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 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 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.

(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

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,

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:

(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

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

(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

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 (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

(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 defimition 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 HSTA VB Health Benefits Offered by the Fund

(a) Eligibility. Employee-beneficiaries who were enrolled in the HSTA VB health benefit plan(s) effective January 1, 2011 upon the dissolution of the HSTA Voluntary Employees Beneficiary Association Trust and their dependent-beneficiaries who meet the eligibility requirements detailed in Rule 3.01.

(b) An employee-beneficiary who voluntarily enrolls in a non-HSTA VB plan offered by the Fund shall permanently forfeit their eligibility in the HSTA VB health benefit plans. This shall include a bargaining unit change even if the employee-beneficiary subsequently returns to bargaining unit 05. This shall not apply to an employee-beneficiary who enrolls as a dependent-beneficiary in a non-HSTA VB plan offered by the Fund provided the employee-beneficiary remains enrolled in the HSTA VB life insurance.

3.03 Group Life Insurance

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

4.00 ENROLLMENT PROCEDURES

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.

(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 partially or fully 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.

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

4.03 Dual and Split Enrollment

(a) 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.

(b) Employee-beneficiaries who are married or in a domestic partnership and have an enrolled dependent-beneficiary are limited to employer contributions for a family plan. If the employee-beneficiaries elect to enroll in a self and two-party or self and family coverage, the employee-beneficiaries shall be responsible for health benefit premium in excess of the maximum employer contribution for a family plan. The additional premium must be paid directly to the Fund within the month for which coverage was provided. Failure to make a timely payment in full shall be treated as a shortage as defined in Rule 4.10.

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; (4) cancellation of enrollment in a Fund benefit plan upon acquiring coverage from a non-Fund plan must be filed within ninety (90) 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.

(c) An application will not be processed if it does not include a Social Security (SSN) for an employee-beneficiary and/or a SSN or Individual Taxpayer Identification Number (ITIN) for a dependent-beneficiary for whom enrollment is being requested. The employee-beneficiary and/or dependent-beneficiary shall be added retroactive to the effective date of the event upon the Fund's receipt of the employee-beneficiary and/or dependent-beneficiary's SSN or ITIN.

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.

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.

4.10.7 Overdraft or Non-Sufficient Funds Fees

Employee-Beneficiaries may be required to reimburse the Fund for any amounts relating to overdraft or non-sufficient funds fees.

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 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 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 ninety (90) 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.

5.00 HEALTH AND OTHER BENEFIT PLANS

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) tbe 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

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, sixty (60) days when the termination is from a Medicaid plan. The employee-beneficiary may only enroll during the next open enrollment period when the enrollment application is received more than forty five (45) days, sixty (60) days for Medicaid, 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 tbe second pay period following the event, except for a qualified medical cbild 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 an eligible foster child the date indicated on the State of Hawaii Department of Human Services Form, Admission to Foster Home;
(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; and
(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 an eligible 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 an eligible foster child, the event date shall be the date indicated on the State of Hawaii Department of Human Services Form, 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, sixty (60) days when the termination is from a Medicaid plan. Coverage for a dependent-beneficiary may be added at the next open enrollment period when enrollment applications are received after forty five (45) days, sixty (60) days for Medicaid, 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).

(6) The employee-beneficiary is enrolled in HSTA VB health benefit plans and changes to a bargaining unit (BU) other than 05, may enroll in a non-HSTA VB health benefit plan offered by the Fund. An enrollment application shall be filed within forty five (45) days of the effective date of the BU change. Non-HSTA VB benefit plan options shall be limited to the benefit plan(s) lost under the HSTA VB health benefit plans. If an enrollment application is not received within forty five (45) days of the effective date of the BU change, the employee-beneficiary shall be enrolled in the comparable non-HSTA VB health benefit plan offered by the Fund. The effective date of the change shall be the effective date of the bargaining unit change.

(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 sball 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.

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(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 hired prior to July 1, 2023 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. Retired employee-beneficiaries hired on or after July 1, 2023 shall be reimbursed quarterly the cost of their Medicare Part B premiums, less IRMAA premiums and penalties, for the retired employee-beneficiary only. 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 hy 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-heneficiaries 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 Datc of Cancellation

(a) If a retired employee-beneficiary's federal Medicare Part B medical insurance plan is not in effect when he/she is eligihle to enroll, the retired employee-beneficiary's enrollment in the medical and/or prescription drug plans offered or sponsored hy the Fund and the medical and/or

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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.

(h) 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, September 29, 2020, April 27, 2021, and August 29, 2023. The rules shall take effect on the first day after filing with the Lieutenant Governor's Office.

Jacqueline Ferguson-Miyamoto,
Chairperson
Hawaii Employer-Union Health
Benefits Trust Fund

APPROVED

Josh Green, M.D.
Governor
State of Hawaii

DEC - 1 2023

Date Filed, Office of the Lieutenant Governor

APPROVED AS TO FORM:

Deputy Attorney General

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LIEUTENANT GOVERNOR'S OFFICE

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EXHIBIT F

THE EUTF OPEB ACTUARIAL VALUATION STUDY, JULY 1, 2023

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (THE EUTF)

EXHIBIT F

Hawaii Employer-Union Health Benefits Trust Fund Retiree Health Care Plan

Actuarial Valuation Report
as of July 1, 2023

P: 469.524.0000 | [illegible]consulting.com

January 18, 2024

Mr. Derek Mizuno
EUTF Administrator
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant St.; Suite 1700
Honolulu, Hawaii 96813

Dear Mr. Mizuno:

Submitted in this report are the results of an actuarial valuation for the EUTF of the liabilities associated with the employer financed retiree health benefits provided through the Hawaii Employer-Union Health Benefits Trust Fund (EUTF). The date of the valuation was July 1, 2023. The annual required contribution has been calculated for the fiscal year ending June 30, 2026. The actuarial calculations were prepared to determine the annual required employer contribution to satisfy the requirements of ACT 268, SLH 2013 ("ACT 268"). Determinations of the liability associated with the benefits described in this report for purposes other than satisfying the funding requirements of ACT 268 may produce significantly different results. This report may be provided to parties other than the EUTF only in its entirety and only with the permission of the EUTF.

The valuation was based upon information, furnished by the EUTF and the Employees' Retirement System of the State of Hawaii (ERS), concerning retiree health benefits, members' census and financial data. Data was checked for internal consistency but was not otherwise audited. Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements; and changes in plan provisions or applicable law.

This report was prepared using our proprietary valuation model and related software which in our professional judgment has the capability to provide results that are consistent with the purposes of the valuation and has no material limitations or known weaknesses. We performed tests to ensure that the model reasonably represents that which is intended to be modeled.

The signing actuaries are independent of the plan sponsor. To the best of our knowledge, this report is complete and accurate and was made in accordance with generally recognized actuarial methods. Joseph Newton and Blake Orth are members of the American Academy of Actuaries and meet the Qualification Standards of the Academy of Actuaries to render the actuarial opinion herein.

Respectfully submitted,

Joseph P. Newton, FSA, FCA, EA, MAAA
Pension Market Leader

Lewis Ward
Consultant

Blake Orth, FSA, EA, MAAA
Consultant

Table of Contents

SECTION A

OVERVIEW

The following table summarizes the key results of the July 1, 2023 Other Post-Employment Benefits (OPEB) valuation for the EUTF.

Executive Summary		
	July 1, 2023	**July 1, 2022**
Membership		
Number of		
-Retirees	53,667	52,534
-Deferred Inactives	8,967	9,014
-Active Employees	64,066	64,083
Covered Payroll*	$ 4,792,453,000	$ 4,574,213,000
Actuarial Summary		
Discount Rate	7.0%	7.0%
Amortization Growth Rate	2.5%	2.5%
Present Value of Benefits	$ 18,263,810,000	$ 17,503,668,000
Actuarial Accrued Liability	15,576,527,000	14,906,454,000
Market Value of Assets	6,728,824,000	5,896,309,000
Actuarial Value of Assets (AVA)	6,881,966,000	5,944,797,000
Unfunded Actuarial Accrued Liability	8,694,561,000	8,961,657,000
Funded Ratio, AVA	44.2%	39.9%
ARC as % of Payroll	22.3%	23.2%
Fiscal Year Ending	June 30, 2026	June 30, 2025
ACT 268 Minimum Contribution Summary		
Fiscal Year Ending	June 30, 2026	June 30, 2025
Annual Required Contribution (ARC)	$ 1,146,312,000	$ 1,135,330,000

*The covered payroll is equal to the projected payroll for the fiscal year beginning on the valuation date.

This report provides the minimum OPEB trust contribution required to satisfy the funding requirements of ACT 268. The Annual Required Contribution (ARC) developed in this report is for the fiscal year ending June 30, 2026. The contribution determined by each valuation will be applicable for the fiscal year which begins two years after the valuation date. The two-year lag between the valuation date and the applicable fiscal year allows appropriate time for budgeting and management of the appropriations.

Section C provides a multi-year projection of liability and contribution information which should be useful to management for the operation of the OPEB program.

Agent Multiple-Employer Plans

The EUTF OPEB plan operates as an **agent multiple-employer plan.** For agent multiple employer plans, separate asset accounts are maintained for each employer so that the employer's contributions provide benefits only for the employees of that employer. A separate actuarial valuation is performed for each individual employer's plan to determine the employer's periodic contribution rate and other information for the individual plan.

In a cost-sharing arrangement, such as the Employees' Retirement System of the State of Hawaii (ERS), the plan's assets can be used to pay the benefits for the retirees of any participating employer. By contrast, the assets of the participating government employers in an *agent multiple-employer plan* are pooled for investment purposes but separate accounts are maintained for each individual employer. As such, the EUTF's assets at EUTF can only be used to pay benefits for the EUTF's retirees. The EUTF's unfunded actuarial accrued liability and the annual required contribution for retiree health benefits will be determined based solely on the EUTF's membership and assets.

ACT 304, SLH 2012 and ACT 268, SLH 2013

ACT 304, SLH 2012 (ACT 304), authorized the board of trustees of the EUTF to create a separate trust fund (The OPEB Trust). The OPEB Trust was established effective June 30, 2013, specifically for pre-funding the participating employers OPEB benefits. Previous pre-funding contributions and related net investment earnings were transferred to each employer's respective OPEB Trust account. As required by ACT 304, contributions to the OPEB Trust shall be irrevocable and the assets of the fund shall be dedicated exclusively to providing health and other benefits to retirees and their eligible dependents. The assets in the OPEB Trust shall not be subject to appropriation for any other purpose and shall not be subject to claims by creditors of the employers or the board or plan administrator.

ACT 268, SLH 2013 (ACT 268) established an "annual required contribution" (ARC) equal to (a) the normal cost, plus (b) an amortization payment to fund the unfunded actuarial accrued liability over a period of no more than thirty years. Moreover, employers were required to contribute 100% of the ARC starting in fiscal year ending June 30, 2019. ACT 268 established mechanisms for funding the ARC if the employer fails to do so.

ACT 268 established a funding policy which ensures the ARC will be consistently met. As a result, the liabilities in this valuation have been calculated using a 7.0% long-term investment return assumption on the OPEB Trust's assets. The 7.0% return assumption is based on the OPEB Trust's investment policy and we believe the assumption is consistent with the target asset allocation.

Actuarial Assumptions and Methods

In any long-term actuarial valuation (such as for Pensions and OPEB), certain demographic, economic and behavioral assumptions are made concerning the population, the investment return rates and the benefits provided. These Actuarial Assumptions form the basis for the actuarial model which is used to project the future population, the future benefits provided, and the future contributions collected. Then the investment return rate (discount rate) assumption is used to discount those projected net OPEB benefits to a present value. This and other related present values are used to calculate the Annual Required Contribution.

This actuarial valuation of the EUTF's OPEB is similar to the actuarial valuations performed for the State's pension plans. The demographic assumptions used in this OPEB Valuation were identical to those used in the June 30, 2023 ERS valuation. Because the assumptions were based upon the most recent actuarial experience study adopted by the Trustees of ERS, they were deemed reasonable for this OPEB Valuation and were employed in this report.

There are some economic and behavioral assumptions which are unique to health benefits. It would be instructive to review the Section of this Report titled, "Actuarial Assumptions and Methods" for a detailed discussion and disclosure of all the relevant actuarial assumptions used in this valuation. The Individual Entry Age Normal Cost Method was used in this valuation. This is both an acceptable and reasonable cost method. Furthermore, the Normal Costs and the amortization of any Unfunded Actuarial Accrued Liabilities were calculated using a level percent of pay.

There were no assumption or method changes since the previous valuation as of July 1, 2022.

Summary of Changes

The funded ratio of the plan increased from 39.9% to 44.2%. The unfunded actuarial accrued liability decreased from $8.96 billion to $8.69 billion. The liabilities and contribution amounts developed in this July 1, 2023 valuation closely resemble what was expected from the previous valuation. The actuarial accrued liability increased from $14.91 billion to $15.58 billion, and the liability was expected to increase to $15.61 billion.

The actuarial value of assets (AVA) increased from $5.94 billion to $6.88 billion. The AVA is almost identical to the $6.89 billion expected from the previous valuation. The July 1, 2023 valuation provides the Annual Required Contribution (ARC) for fiscal year ending June 30, 2026. The FYE26 ARC of $1,146,312,000 nearly matches the projected FYE26 ARC of $1,146,679,000 from the previous valuation.

There were two bills passed since the previous valuation: Act 040, SLH 2023 (Act 040) and Act 041, SLH 2023 (Act 041). Act 040 eliminated the Medicare Part B reimbursements for spouses of those hired after June 30, 2023. Act 041 removed the income-related monthly adjustment amounts (IRMAA) portion of the Medicare part B reimbursements for participants hired after June 30, 2023. These changes did not affect the financial condition of the plan as of the July 1, 2023 valuation date, but they did have an impact on the projected financial condition of the plan, shown in section C of this report.

ARC with 2% Corridor Smoothing

A funding policy mechanism was introduced in the July 1, 2021 valuation to manage contribution volatility. The combination of the level percentage of payroll UAAL amortization methodology (assumed to grow at 2.5% annually) and the entry-age normal actuarial cost method (which should grow about 3.5% to 4.25% annually) produce a combined ARC that is expected to increase by roughly 3.00% per year. The corridor will target this 3.00% and limit the dollar amount of the ARC so that it is within 2% of the prior year's ARC increased by the 3.00%. Another way to describe the corridor is to say that it limits the dollar amount of the ARC to between 101% and 105% of the prior year's ARC. The ARC for fiscal year 2026 is developed on page 12. The "ARC without Limitation" is the ARC developed without corridor smoothing. As shown on page 12, the actual FYE26 ARC is held higher as a result of the corridor because results since implementation of the smoothing corridor have overall been better than expected. The corridor will not only limit contribution increases in years when there is adverse experience, but it will also limit contribution decreases in years when there is favorable experience. The current position of the ARC to the corridor is expected to produce significant stability in the State contributions for many years into the future.

It should also be noted that the corridor is adjusted downward when employers contribute more than the ARC. This adjustment makes it so that employers can still lower their future ARCs by contributing more than the minimum required.

SECTION B

VALUATION RESULTS

Results by Employer

($ Thousands)	State of Hawaii	City & County of Honolulu	HART	County of Hawaii	County of Maui	County of Kauai	Kauai - Department of Water	Board of Water Supply - Honolulu	Hawaii Department of Water Supply	Total
Discount Rate	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
Amortization Growth Rate	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Present Value of Benefits	$13,354,963	$2,872,597	$ 8,331	$ 720,010	$ 722,687	$ 343,036	$ 23,183	$ 176,997	$ 42,006	$18,263,810
Actuarial Accrued Liability	11,390,407	2,471,737	7,459	599,686	608,261	288,970	19,552	154,622	35,833	15,576,527
Actuarial Value of Assets	4,478,522	1,224,344	5,460	327,910	463,771	214,312	15,640	123,580	28,427	6,881,966
Unfunded Actuarial Accrued Liability	6,911,885	1,247,393	1,999	271,776	144,490	74,658	3,912	31,042	7,406	8,694,561
Funded Ratio	39.3%	49.5%	73.2%	54.7%	76.2%	74.2%	80.0%	79.9%	79.3%	44.2%
ARC for FYE 2026	$ 838,506	$ 194,748	$ 401	$ 45,023	$ 38,095	$ 17,906	$ 1,096	$ 8,470	$ 2,067	$ 1,146,312
ARC as % of Payroll for FYE 2026	22.3%	26.0%	9.5%	21.6%	18.7%	19.0%	17.0%	19.8%	18.9%	22.5%

*Honolulu Authority for Rapid Transportation

The ARC for FYE 2026 reflects the smoothing corridor for all employers.

Liabilities

The liabilities shown in the following exhibit were calculated as of July 1, 2023.

	Medical/ Prescription Drug/ Dental/Vision/Life	Medicare Part B	Total
Present Value of Benefits (PVB)			
Retirees	$ 6,750,202,000	$ 2,013,822,000	$ 8,764,024,000
Deferred Inactives	799,190,000	402,588,000	1,201,778,000
Actives	6,213,529,000	2,084,479,000	8,298,008,000
Total PVB	$ 13,762,921,000	$ 4,500,889,000	$ 18,263,810,000
Actuarial Accrued Liability (AAL)			
Retirees	$ 6,750,202,000	$ 2,013,822,000	$ 8,764,024,000
Deferred Inactives	799,190,000	402,588,000	1,201,778,000
Actives	4,282,618,000	1,328,107,000	5,610,725,000
Total AAL	$ 11,832,010,000	$ 3,744,517,000	$ 15,576,527,000
Normal Cost	$ 218,582,000	$ 88,782,000	$ 307,364,000

Projected Benefits

The table below provides the EUTF's estimated benefit payments (pay-as-you-go) for the 15 years following the valuation date.

Projected Benefit Payments			
Year Ending June 30,	Medical/ Prescription Drug/ Dental/Vision/Life	Medicare Part B	Total
2024	$ 528,263,000	$ 135,413,000	$ 663,676,000
2025	564,676,000	147,064,000	711,740,000
2026	602,679,000	158,290,000	760,969,000
2027	641,965,000	170,075,000	812,040,000
2028	681,994,000	182,652,000	864,646,000
2029	722,416,000	195,820,000	918,236,000
2030	761,765,000	209,787,000	971,552,000
2031	801,634,000	224,472,000	1,026,106,000
2032	843,021,000	239,469,000	1,082,490,000
2033	885,241,000	254,837,000	1,140,078,000
2034	926,929,000	270,635,000	1,197,564,000
2035	965,815,000	287,230,000	1,253,045,000
2036	1,002,560,000	304,709,000	1,307,269,000
2037	1,040,272,000	322,410,000	1,362,682,000
2038	1,078,807,000	339,965,000	1,418,772,000

Plan Assets

Statement of Changes in Plan Net Assets		
	Year Ended June 30, 2023	Year Ended June 30, 2022
Assets available at beginning of year	$ 5,896,307,989	$ 5,745,484,824
Contributions	1,141,075,001	845,569,135
Transfer from retiree agency fund	10,500,000	0
Investment income	89,335,203	83,265,529
Appreciation / (depreciation)	194,376,104	(182,562,811)
Benefit payments	(592,607,644)	(583,594,327)
Investment fees	(9,753,014)	(11,353,224)
Administrative fees	(410,838)	(501,138)
Increase in net assets	832,514,812	150,823,164
Assets available at end of year	$ 6,728,822,800	$ 5,896,307,989
Investment return, net of expenses	4.44%	-1.88%

Investment returns were calculated based on the dollar-weighted methodology with the assumption that contributions and benefit payments were made mid-year.

Development of Actuarial Value of Assets

		Year Ending June 30, 2023
1.	Actuarial value of assets, beginning of year	$ 5,944,797,000
2.	Net new investments	
a.	Contributions	$ 1,140,413,000
b.	Benefit payments	(591,945,000)
c.	Transfer from retiree agency fund	10,501,000
d.	Administrative expenses	(411,000)
e.	Subtotal	$ 558,558,000
3.	Market value of assets at end of year	6,728,824,000
4.	Expected return on actuarial value of assets	435,356,000
5.	Expected actuarial value of assets, end of year	6,938,711,000
6.	Excess/(shortfall) return (Item 3 - Item 5)	(209,887,000)
7.	Development of amounts to be recognized as of June 30, 2023:	

Fiscal Year End	Remaining Deferrals of Excess / (Shortfall) of Investment Income	Offsetting of Gains/(Losses)	Net Deferrals Remaining	Years Remaining	Recognized for this valuation	Remaining after this valuation
	(1)	(2)	(3) = (1) + (2)	(4)	(5) = (3) / (4)	(6) = (3) - (5)
2022	$ (48,488,000)	$ 0	$ (48,488,000)	3	$ (16,162,667)	$ (32,325,333)
2023	(161,399,000)	0	(161,399,000)	4	(40,582,333)	(120,816,667)
Total	$ (209,887,000)	$ 0	$ (209,887,000)		$ (56,745,000)	$ (153,142,000)

8.	Actuarial value of assets as of June 30, 2023 (Item 3 - Item 7)	$ 6,881,966,000
9.	Ratio of actuarial value to market value	102.3%
10.	Asset gain / (loss) for year (Item 8 - Item 5)	$ (56,745,000)

Determination of the ARC

Annual Required Contribution without Limitation

	FYE 6/30/2026
Discount Rate	7.0%
Amortization Growth Rate	2.5%
Normal Cost*	$ 326,534,000
Amortization of UAAL	700,829,000
ARC without Limitation	$ 1,027,363,000

*Includes plan administration fees.

The Annual Required Contribution without limitation is equal to the Normal Cost (the present value of benefits earned by the current employees in the respective fiscal year), plus projected plan administrative costs, plus an amortization payment to fund the liability attributable to past service. The ARC without limitation is determined in the same method as prior years.

After the 2% corridor smoothing is applied, the total ARC for all employers is $1,146,312,000.

It is important to keep in mind that each participating employer is responsible for the amount that they contribute towards their own ARC.

Total Experience Gain or Loss

A. Calculation of total actuarial gain or loss

1.	Unfunded actuarial accrued liability (UAAL), as of July 1, 2022	$	8,961,657,000
2.	Normal cost for the year, including administrative expenses		297,659,000
3.	Less: ACT 268 minimum required contribution		(1,138,075,000)
4.	Interest at 7.00%		
	a. On UAAL		627,317,000
	b. On normal cost		10,242,000
	c. On contribution		(39,157,000)
	d. Total	$	598,402,000
5.	Expected UAAL as of July 1, 2023 (Sum of Items 1 - 4)		8,719,643,000
6.	Actual UAAL as of July 1, 2023		8,694,561,000
7.	Total (gain)/loss for the year (Item 6 - Item 5)		(25,082,000)

B. Source of gains and losses

8.	Asset (gain)/loss for the year (AVA Table)	$	56,745,000
9.	(Gain)/loss due to contribution*		(12,919,000)
10.	Other liability (gain)/loss		(68,908,000)
11.	Change in assumptions		-
12.	Change in benefit provisions		-
13.	Total (gain)/loss for the year	$	(25,082,000)

** Impact of employer contributions.*

Schedule of Funding Progress

Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded AAL (b) - (a)	Funded Ratio (a)/(b)	Covered Payroll (c)	Unfunded AAL as a % of Covered Payroll (b - a)/(c)
July 1, 2007	$ 0	$ 9,194,300,000	$ 9,194,300,000	0.0%	$ 2,789,000,000	329.7%
July 1, 2009	115,500,000	14,662,100,000	14,546,600,000	0.8%	2,758,000,000	527.4%
July 1, 2011	178,200,000	16,458,800,000	16,280,600,000	1.1%	3,743,000,000	435.0%
July 1, 2013	296,124,000	11,477,633,000	11,181,509,000	2.6%	3,881,223,000	288.1%
July 1, 2015	843,520,000	12,615,528,000	11,772,008,000	6.7%	4,161,386,000	282.9%
July 1, 2017	1,777,674,000	13,923,637,000	12,145,963,000	12.8%	4,278,034,000	283.9%
July 1, 2018	2,363,352,000	14,640,923,000	12,277,571,000	16.1%	4,399,147,000	279.1%
July 1, 2019	3,133,111,000	15,569,500,000	12,436,389,000	20.1%	4,546,823,000	273.5%
July 1, 2020	3,898,479,000	15,412,329,000	11,513,850,000	25.3%	4,663,329,000	246.9%
July 1, 2021	5,317,784,000	15,834,920,000	10,517,136,000	33.6%	4,671,099,000	225.2%
July 1, 2022	5,944,797,000	14,906,454,000	8,961,657,000	39.9%	4,574,213,000	195.9%
July 1, 2023	6,881,966,000	15,576,527,000	8,694,561,000	44.2%	4,792,453,000	181.4%

As a result of ACT 268's funding requirements, the discount rate was changed from 4.00% to 7.00% in the July 1, 2013 valuation for the State of Hawaii. The discount rate remained at 7.00% for the other participating employers.
New demographic and healthcare assumptions were adopted in the July 1, 2017 valuation. The most significant assumption change was to reflect longer life expectancy.
Asset smoothing was first introduced in the July 1, 2018 valuation.
Minor updates to the demographic and healthcare assumptions were adopted in the July 1, 2019 valuation.
The healthcare trend assumption was updated in the July 1, 2020 valuation to reflect the repeal of the "Cadillac Tax".
New demographic and healthcare trend assumptions were adopted in the July 1, 2022 valuation. The most significant change was the healthcare trend assumption.

Actuarial Methods and Assumptions

Inflation rate	2.50%
Investment rate of return	7.00%
Actuarial Cost method	Individual Entry Age Normal
Amortization method*	Level percent, closed
Amortization Growth Rate	2.50%
Wage Inflation	3.00%
Asset Method	Smoothed
Mortality	System-specific mortality tables utilizing ultimate scale MP2021 to project generational mortality improvement
Participation Rates	
	98% healthcare participation assumption for retirees that receive 100% of the Base Monthly Contribution (BMC). Healthcare participation rates of 25%, 65%, and 90% for retirees that receive 0%, 50%, or 75% of the base monthly contribution, respectively. 100% for Life Insurance and 98% for Medicare Part B
Healthcare cost trend rate	
PPO**	Initial rate of 6.30%, declining to a rate of 4.25% after 21 years
HMO**	Initial rate of 6.30%, declining to a rate of 4.25% after 21 years
Part B & Base Monthly Contribution	Initial rate of 5.00%, declining to a rate of 4.25% after 21 years
Dental	4.00%
Vision	2.50%
Life Insurance	0.00%

* Closed bases are established at each valuation for new unfunded liabilities.
** Includes prescription drug assumptions.

Trend Sensitivity

Actuarial valuations are based on the cost of benefits to be paid in the future. The payments considered will range from one month in the future to decades from the valuation date. When the benefits being valued are health benefits, a key factor is the future cost of the health benefits being promised. The future benefits are projected using the current cost of the health care benefits and assumed future health care cost increases. The final cost of providing retiree health care benefits will depend upon how the charges for health care services actually increase in the future.

In order to demonstrate how the cost of these benefits can vary depending upon future health care cost increases, we have performed additional valuations based upon alternative health care cost increase assumptions. The following table shows the impact of a 1.0% increase or decrease in the assumed healthcare trend rates.

	-1% Trend	Baseline	+1% Trend
Present Value of Benefits (PVB)	$ 15,547,075,000	$ 18,263,810,000	$ 21,831,956,000
Funded Status			
Actuarial Accrued Liability	$ 13,523,504,000	$ 15,576,527,000	$ 18,204,116,000
Actuarial Value of Assets	6,881,966,000	6,881,966,000	6,881,966,000
Unfunded AAL	6,641,538,000	8,694,561,000	11,322,150,000
ARC without limitation for FYE26	$ 772,092,000	$ 1,027,363,000	$ 1,335,001,000

SECTION C

PROJECTIONS

Summary of Funding Projections

The projections in this section provide estimated future liabilities, assets, contributions and benefit payments based on the census data used for the July 1, 2023 valuation and the actuarial assumptions/methods described in Section G of this report. The projections provide insight into how the employer's contributions and the financial condition of the plan are assumed to change over time. Key items from the projections are:

- Prefunding the OPEB liability will require a significant commitment. However, the long-term savings will also be significant. Once the plan is well funded, the percentage of the benefits paid for by investment earnings is typically over 50%.
- The Annual Required Contribution (ARC) is developed using a level percentage of payroll amortization.
- The ARC is expected to remain fairly level, as a percentage of payroll, until the initial amortization base is paid off. However, the ARC is expected to trend upwards because the normal cost is expected to slowly grow over time as a percentage of payroll.
- Projection assumes the employer will contribute the full ARC, as required by ACT 268.
- The employer's annual cost for financing the retiree health benefit becomes less than what it would have been under a pay-as-you-go approach starting in FYE2034.
- As participants separate from employment, it is assumed they are replaced with an average new hire so that the total number of active employees remains level. The average new hire is assumed to have similar entry age and entry pay as recently hired employees. The projection includes liabilities for these new employees as the projection steps forward in time and they accrue benefits.

Please bear in mind that, depending on plan experience, actual results could deviate significantly from the actuarial projections. The key assumptions in the projections are:

1. the assumed 7.00% rate of investment return
2. future health care inflation
3. that the benefits and cost sharing provisions will remain the same as they currently are

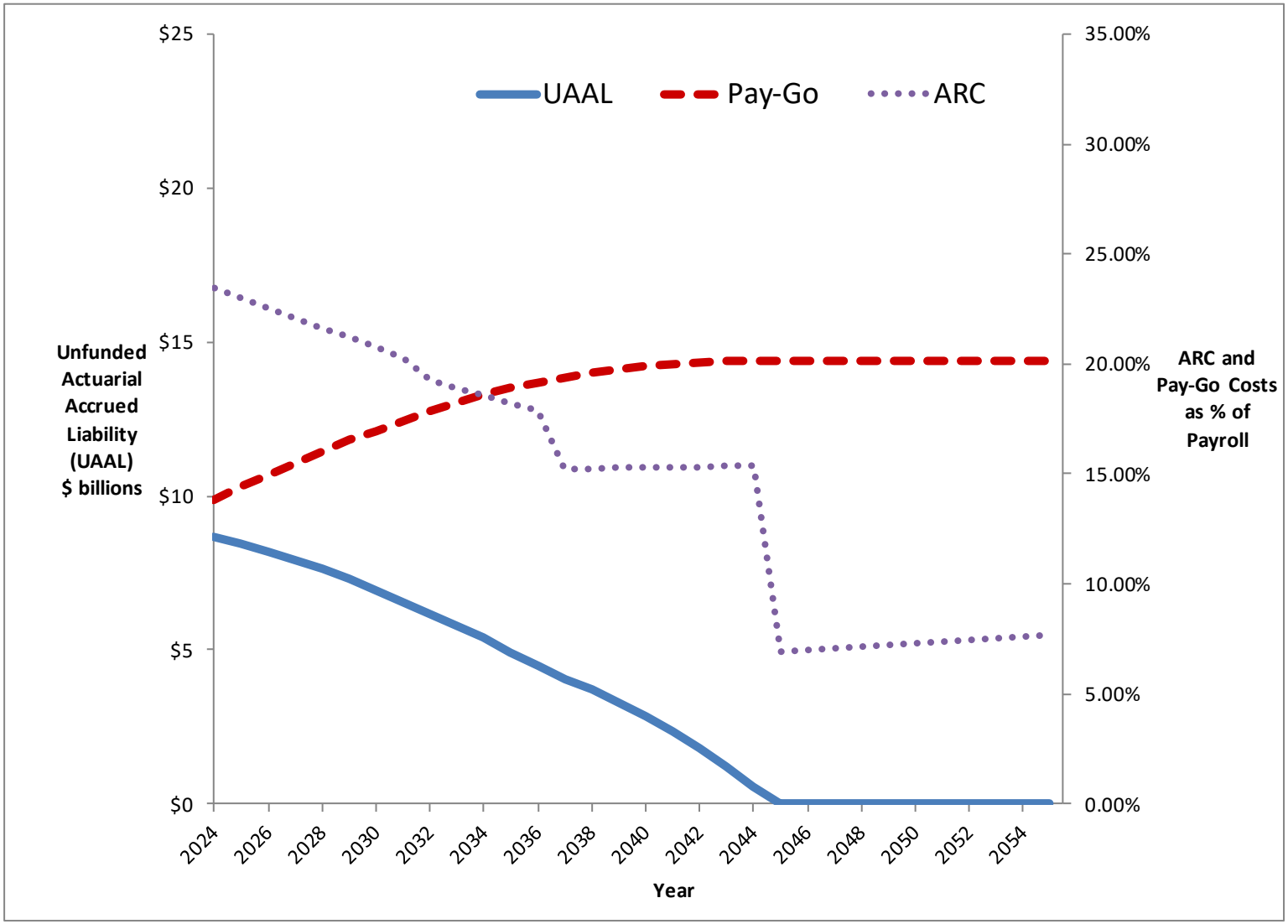
Projection of Funding Progress

Over the next 34 years, the sum of the ARCs equals $34 billion while the trust will payout $51 billion in benefits.

Fiscal Year Ending	Payroll	Actuarial Accrued Liability (AAL)	Actuarial Value of Assets (AVA)	Unfunded AAL (UAAL)	Funded Ratio	Annual Required Contribution	Actual Contribution	Contribution as % of Payroll	Benefit Payment Total	Benefits as % of Payroll	ARC minus Benefit Payments
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)
2024	$ 4,792,453,000	$ 15,576,527,000	$ 6,881,966,000	$ 8,694,561,000	44.2%	$ 1,124,824,000	$ 1,124,824,000	23.5%	$ 663,676,000	13.8%	$ 461,148,000
2025	4,936,226,000	16,298,311,000	7,840,283,000	8,458,028,000	48.1%	1,135,330,000	1,135,330,000	23.0%	711,740,000	14.4%	423,590,000
2026	5,084,311,000	17,030,442,000	8,826,817,000	8,203,625,000	51.8%	1,146,312,000	1,146,312,000	22.5%	760,969,000	15.0%	385,343,000
2027	5,236,841,000	17,772,727,000	9,842,831,000	7,929,896,000	55.4%	1,157,404,000	1,157,404,000	22.1%	812,040,000	15.5%	345,364,000
2028	5,393,947,000	18,513,716,000	10,888,600,000	7,625,116,000	58.8%	1,168,608,000	1,168,608,000	21.7%	864,646,000	16.0%	303,962,000
2029	5,555,767,000	19,260,966,000	11,964,730,000	7,296,236,000	62.1%	1,179,923,000	1,179,923,000	21.2%	918,236,000	16.5%	261,687,000
2030	5,722,438,000	20,014,855,000	13,072,445,000	6,942,410,000	65.3%	1,191,349,000	1,191,349,000	20.8%	971,552,000	17.0%	219,797,000
2031	5,894,113,000	20,779,729,000	14,214,353,000	6,565,376,000	68.4%	1,195,650,000	1,195,650,000	20.3%	1,026,106,000	17.4%	169,544,000
2032	6,070,935,000	21,565,414,000	15,384,198,000	6,181,216,000	71.3%	1,170,660,000	1,170,660,000	19.3%	1,082,490,000	17.8%	88,170,000
2033	6,253,063,000	22,345,082,000	16,551,739,000	5,793,343,000	74.1%	1,182,912,000	1,182,912,000	18.9%	1,140,078,000	18.2%	42,834,000
2034	6,440,656,000	23,133,153,000	17,754,099,000	5,379,054,000	76.7%	1,195,342,000	1,195,342,000	18.6%	1,197,564,000	18.6%	(2,222,000)
2035	6,633,874,000	23,931,223,000	18,993,998,000	4,937,225,000	79.4%	1,207,944,000	1,207,944,000	18.2%	1,253,045,000	18.9%	(45,101,000)
2036	6,832,891,000	24,743,120,000	20,276,320,000	4,466,800,000	81.9%	1,223,682,000	1,223,682,000	17.9%	1,307,269,000	19.1%	(83,587,000)
2037	7,037,879,000	25,667,602,000	21,608,576,000	4,059,026,000	84.2%	1,073,877,000	1,073,877,000	15.3%	1,362,682,000	19.4%	(288,805,000)
2038	7,249,016,000	26,521,410,000	22,821,790,000	3,699,620,000	86.1%	1,105,630,000	1,105,630,000	15.3%	1,418,772,000	19.6%	(313,142,000)
2039	7,466,486,000	27,395,329,000	24,094,737,000	3,300,592,000	88.0%	1,140,166,000	1,140,166,000	15.3%	1,474,684,000	19.8%	(334,518,000)
2040	7,690,479,000	28,291,841,000	25,434,658,000	2,857,183,000	89.9%	1,175,974,000	1,175,974,000	15.3%	1,529,697,000	19.9%	(353,723,000)
2041	7,921,193,000	29,214,360,000	26,848,487,000	2,365,873,000	91.9%	1,213,072,000	1,213,072,000	15.3%	1,584,761,000	20.0%	(371,689,000)
2042	8,158,830,000	30,165,568,000	28,342,680,000	1,822,888,000	94.0%	1,251,500,000	1,251,500,000	15.3%	1,638,567,000	20.1%	(387,067,000)
2043	8,403,594,000	31,149,718,000	29,925,537,000	1,224,181,000	96.1%	1,291,275,000	1,291,275,000	15.4%	1,692,046,000	20.1%	(400,771,000)
2044	8,655,702,000	32,170,400,000	31,604,996,000	565,404,000	98.2%	1,332,345,000	1,332,345,000	15.4%	1,745,406,000	20.2%	(413,061,000)
2045	8,915,373,000	33,389,279,000	33,389,279,000	0	100.0%	618,629,000	618,629,000	6.9%	1,798,547,000	20.2%	(1,179,918,000)
2046	9,182,834,000	34,505,199,000	34,505,199,000	0	100.0%	643,526,000	643,526,000	7.0%	1,852,024,000	20.2%	(1,208,498,000)
2047	9,458,319,000	35,669,641,000	35,669,641,000	0	100.0%	669,449,000	669,449,000	7.1%	1,905,980,000	20.2%	(1,236,531,000)
2048	9,742,069,000	36,886,578,000	36,886,578,000	0	100.0%	696,482,000	696,482,000	7.1%	1,961,606,000	20.1%	(1,265,124,000)
2049	10,034,331,000	38,159,094,000	38,159,094,000	0	100.0%	724,651,000	724,651,000	7.2%	2,019,243,000	20.1%	(1,294,592,000)
2050	10,335,360,000	39,490,179,000	39,490,179,000	0	100.0%	754,038,000	754,038,000	7.3%	2,078,778,000	20.1%	(1,324,740,000)
2051	10,645,422,000	40,883,224,000	40,883,224,000	0	100.0%	784,736,000	784,736,000	7.4%	2,141,523,000	20.1%	(1,356,787,000)
2052	10,964,786,000	42,340,607,000	42,340,607,000	0	100.0%	816,822,000	816,822,000	7.4%	2,206,784,000	20.1%	(1,389,962,000)
2053	11,293,729,000	43,865,661,000	43,865,661,000	0	100.0%	850,297,000	850,297,000	7.5%	2,274,380,000	20.1%	(1,424,083,000)
2054	11,632,540,000	45,462,143,000	45,462,143,000	0	100.0%	885,101,000	885,101,000	7.6%	2,344,798,000	20.2%	(1,459,697,000)
2055	11,981,516,000	47,133,508,000	47,133,508,000	0	100.0%	921,494,000	921,494,000	7.7%	2,417,702,000	20.2%	(1,496,208,000)
2056	12,340,961,000	48,884,068,000	48,884,068,000	0	100.0%	959,505,000	959,505,000	7.8%	2,493,240,000	20.2%	(1,533,735,000)

The projection assumes a constant workforce.

Projection of Funding
Trust contributions are projected to be less than benefits paid starting in FYE 2034



SECTION D

DEVELOPMENT OF BASELINE COSTS

Development of Baseline Costs

The underlying retiree claims costs were estimated using the plan premiums effective January 1, 2024, and are used for both current and future retirees. An inherent assumption in this methodology is that the projected future retirees will have a similar distribution by plan type as the current retirees (82% PPO and 18% HMO). The fully-insured retiree plans are separate from the active plans and are underwritten using the claims experience of the retired members only. The contracts for the retiree plans do not allow for any cross subsidization of premiums or rates. The prescription drug benefit for the PPO plan is self-insured. Based on conversations with EUTF's health care consultant (Segal), we did not believe it was necessary to independently verify the premiums for the PPO prescription drug benefit. The estimated age-adjusted claims shown below include administrative expenses and are net of prescription drug rebates.

Age-graded and sex-distinct premiums are utilized by this valuation. These costs are appropriate for the unique age and sex distribution currently existing. Over the future years covered by this valuation, the age and sex distribution will most likely change. Therefore, our process "distributes" the average premium over all age/sex combinations and assigns a unique premium for each combination. The age/sex specific costs more accurately reflect the health care utilization and cost at that age.

Baseline Costs for Retirees and Spouses (Medical and Prescription Drug) (Expected Monthly Per Capita Costs for 2024)				
	HMSA		Kaiser	
Age	Male	Female	Male	Female
50	$504.68	$621.72	$449.87	$554.20
55	664.10	725.10	591.98	646.36
60	857.72	844.56	764.58	752.85
65	436.30	411.51	397.81	375.22
70	475.28	459.91	433.36	419.34
75	510.46	498.10	465.44	454.16
80	535.89	526.52	488.62	480.07

Dental and vision benefits are not included in the benefits shown above. The underlying claims for the dental and vision benefits were not age-rated. Premiums for all medical, prescription drug, dental, and vision plans are shown in Section E.

SECTION E

SUMMARY OF BENEFIT PROVISIONS

Summary of the Substantive Plan Provisions

Plan Participants

Plan participants are retired members of the employees' retirement system; the County pension system; or the police, firefighters, or bandsmen pension system of the State or County.

Base Monthly Contribution Amount

January 1, 2024 - Base Monthly Contribution			
	Self	Two-Party	Family
Non-Medicare	$1,224.52	$2,468.20	$3,612.50
Medicare	872.30	1,748.34	2,546.42

The Base Monthly Contribution (BMC) determines the maximum amount provided by the employer to cover premiums for medical, prescription drug, dental and vision care. The BMC is adjusted annually based on the change in the Medicare Part B premium. The employer's costs for providing the Medicare Part B premium reimbursement and the life insurance benefit are in addition to the contribution related to the BMC.

Deferred Retirement

Employees who terminate employment are eligible for retiree health care benefits upon commencing a retirement or pension allowance.

Disability Retirement

Employees who terminate due to disability are eligible for retiree health care benefits upon commencing a retirement or pension allowance.

Non-Duty Death in Service Retirement

If an active employee dies while in service and is eligible to retire at the time of death, the ERS will retire the employee and the surviving spouse, domestic or civil union partner and eligible dependents are eligible for retiree health care benefits. If the member was not eligible for retirement at the time of death, the surviving spouse, domestic or civil union partner and eligible dependents are eligible for COBRA benefits only.

Duty Death in Service Retirement

The surviving spouse, domestic or civil union partner and eligible dependents of an employee who is killed in the performance of the employee's duty are eligible for retiree health care benefits. Regardless of the employee's date of hire or years of service, the employer will pay up to the BMC for a spouse, domestic or civil union partner and eligible dependents of an employee who is killed in the performance of duty. Coverage ends when the surviving spouse or domestic or civil union partner remarries or enters into another domestic or civil union partnership or when the surviving child reaches age 19 or 24 if the child is a full-time student.

Surviving Spouses of Retired Employees

The employer's contribution percentage for a surviving spouse, domestic or civil union partner and eligible dependent of a retiree who was hired prior to July 1, 2001 will remain the same as the deceased retiree. For a surviving spouse, domestic or civil union partner and eligible dependent of a retiree who was hired after June 30, 2001, the employer's contribution percentage will be half of the deceased retirees' employer contribution percentage.

Life Insurance

Retiree life insurance benefit is $1,487, and is provided at no cost to the retiree.

Medicare Part B Reimbursement

Retirees and spouses/domestic and civil union partners are required to enroll in Medicare Part B coverage when they become eligible and enroll in a medical and/or prescription drug plan. The employer reimburses the Part B premium for both retiree and, for participants hired before July 1, 2023, spouse/domestic or civil union partner at 100%. Surviving spouses/domestic or civil union partners, regardless of hire date, continue to receive the Part B reimbursement. The 2023 Medicare Part B premiums vary for current retirees due to the hold harmless provisions. The 2024 Part B premium is $174.70 per month for retirees enrolling in Part B for the first time or not enrolled in Social Security. For participants hired before July 1, 2023, EUTF will reimburse the entire Part B premium for retirees who pay income adjusted Part B premiums if they submit proof.

Employer's Contribution

The Employer's percentage of the BMC for the year determines the maximum employer contribution payable. Any difference between the maximum employer contribution and the total premium for plans selected (medical, prescription drug, dental and vision) will be paid by the retiree.

Hire Date	Year of Service	% of BMC*
Before 7/1/1996	< 10	50%
	10+	100%
Post 7/1/1996	< 10	0%
	10-14	50%
	15-24	75%
	25+	100%

* Employees hired after 6/30/2001 only receive the % of the "Self" BMC.

EUTF Monthly Retiree Rates
Effective January 1, 2024 through December 31, 2024

Benefit Plan	Type of Enrollment	Total Contribution Required
MEDICAL AND PRESCRIPTION DRUG PLANS – MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$251.52
	Two-Party	490.10
	Family	726.60
Humana Medicare Advantage PPO Medical Plan	Self	$51.88
	Two-Party (both Medicare)	103.76
	Three-Party (all Medicare; maximum of 3 enrollees)	155.64
SilverScript Prescription Drug Plan	Self	$235.34
	Two-Party	458.24
	Family	679.44
Kaiser Senior Advantage Medical and Prescription Drug Plan	Self	$462.50
	Two-Party	901.84
	Family	1,336.60
MEDICAL AND PRESCRIPTION DRUG PLANS - NON-MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$581.96
	Two-Party	1,133.96
	Family	1,681.08
CVS Caremark Prescription Drug Plan	Self	$244.24
	Two-Party	475.68
	Family	705.26
Kaiser HMO Comprehensive Medical and Prescription Drug Plan	Self	$763.08
	Two-Party	1,541.42
	Family	2,273.98
DENTAL PLAN		
HDS Dental	Self	$43.78
	Two-Party	85.38
	Family	104.62
VISION PLAN		
VSP Vision	Self	$3.54
	Two-Party	7.10
	Family	9.52
LIFE INSURANCE		
Securian Life Insurance (Retiree only)	Self	$4.12

HSTA VB Monthly Retiree Rates
Effective January 1, 2023 through December 31, 2023

Benefit Plan	Type of Enrollment	Total Contribution Required
MEDICAL AND PRESCRIPTION DRUG PLANS – MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, SilverScript Prescription Drug, and VSP Vision Plans	Self	$541.24
	Two-Party	1,054.72
	Family	1,560.86
Kaiser Senior Advantage Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$473.54
	Two-Party	923.60
	Family	1,367.82
MEDICAL AND PRESCRIPTION DRUG PLANS - NON-MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, CVS Caremark Prescription Drug, and VSP Vision Plans	Self	$795.52
	Two-Party	1,550.10
	Family	2,295.34
Kaiser HMO Comprehensive Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$752.22
	Two-Party	1,519.46
	Family	2,240.64
DENTAL PLAN		
HDS Dental	Self	$51.80
	Two-Party	101.02
	Family	123.82
VISION PLAN		
VSP Vision	Self	$3.54
	Two-Party	7.10
	Family	9.52
LIFE INSURANCE		
Securian Life Insurance (Retiree only)	Self	$4.12

Medical Plan Benefits - EUTF
Non-Medicare Retirees

Medical	HMSA 90/10 PPO		Kaiser HMO
	In-Network	Out-of-Network	HMO Network
Calendar Year Deductible	$100 per person $300 per family		None
Calendar Year Maximum Out-of-Pocket Limit	$2,500 per person $7,500 per family		$2,000 per person $6,000 per family
Lifetime Benefit Maximum	None		None
Physician Office Visit	10%*	30%	$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge*	Not covered	No charge
Urgent Care Visit	10%*	30%	$15 (in service area) 20% (out of service area)
Emergency Room	10%*	10%*	$50 (in service area) 20% (out of service area)
Ambulance Air	20%	20%	20%
Ambulance Ground	20%	30%	20%
Inpatient Hospital Services	10%*	30%	No charge
Outpatient Surgery	10%*	30%	$15
Outpatient Testing, Lab and X-ray Services	20%*	30%	$15
Annual Physical Exam	No charge*	30%*	No charge
Preventative Screening	20%*	30%	No charge
Inpatient Mental Health	10%*	30%	No charge
Outpatient Mental Health	10%*	30%	$15
Chiropractic Services	Not covered	Not covered	Not covered

* Not subject to the deductible

Medical Plan Benefits – HSTA VB
Non-Medicare Retirees

Medical	HMSA 90/10 PPO		Kaiser HMO
	In-Network	Out-of-Network	HMO Network
Calendar Year Deductible	None	$100 per person $300 per family	None
Calendar Year Maximum Out-of-Pocket Limit	$2,000 per person $6,000 per family		$2,000 per person $6,000 per family
Lifetime Benefit Maximum	$2,000,000 for all individuals combined; $25,000/ calendar year thereafter		None
Physician Office Visit	10%	30%	$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge	Not covered	No charge
Urgent Care Visit	10%	30%	$15 (in service area) 20% (out of service area)
Emergency Room	10%	10%*	$50 (in service area) 20% (out of service area)
Ambulance Air	10%	10%*	20%
Ambulance Ground	10%	30%	20%
Inpatient Hospital Services	10%	30%	No charge
Outpatient Surgery	10%	30%	$15
Outpatient Testing, Lab and X-ray Services	10%	30%	$15
Annual Physical Exam	No charge (limits apply)	No charge* (limits apply)	No charge
Preventative Screening	10%	30%	No charge
Inpatient Mental Health	10%	30%	No charge
Outpatient Mental Health	10%	30%	$15
Chiropractic Services (administered through American Specialty Health, Inc.)	$12 (20 visits/year)	Not covered	$12 (20 visits/year)

* Not subject to the deductible

Prescription Drug Plan Benefits – EUTF
Non-Medicare Retirees

Prescription Drug	CVS PPO Drug Plan*			Kaiser HMO Plan+	
	In-Network	Out-of-Network**	Retail 90/Mail Order	HMO Network	Mail Order
Day Supply	30/60/90			30/60/90	
Generic	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10	$15/$30/$45	$15/$30/$30
Preferred Brand	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30		
Non-Preferred Brand	$30/$60/$90	$30/$60/$90 + 20%	$30/$60/$60		
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10	$15/$30/$45	Not covered
Other Insulin	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30		
Preferred Diabetic Supplies	No charge	20%	No charge	$15/$30/$45	$15/$30/$30
Other Diabetic Supplies	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30		
Specialty Drugs/ Injectables	20% (up to a 30-day supply) Up to $250 per fill; $2,000 maximum out-of-pocket per calendar year; $30 copay for oral oncology specialty medications Mail Pharmacy: Not covered			$15 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

* This plan is the prescription drug coverage for the HMSA PPO medical plan option and is administered by CVS Caremark. Note: Maintenance medications can be filled at any retail network pharmacy or through mail order but must be filled in a 90-day supply after the first three 30-day initial fills.

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

+ The Kaiser prescription drug coverage is included under the Kaiser HMO medical plan.

Prescription Drug Plan Benefits – HSTA VB
Non-Medicare Retirees

Prescription Drug	CVS PPO Drug Plan*		Kaiser HMO Plan+	
	In-Network / Mail Order	Out-of-Network**	HMO Network	Mail Order
Day Supply	30/60/90		30/60/90	
Generic	$5/$9/$9	$5/$9/$9 + 30%	$10/$20/$30	$10/$20/$20
Brand	$15/$27/$27	$15/$27/$27 + 30%		
Insulin	$5/$9/$9	$5/$9/$9 + 30%	$10/$20/$30	Not covered
Diabetic Supplies	No charge	No charge	50%	50%
Specialty Drugs/ Injectables	Generic/brand copays apply Mail Pharmacy: Not covered		$10 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

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

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

+ The Kaiser prescription drug coverage is included under the Kaiser HMO medical plan.

Medical Plan Benefits – EUTF
Medicare Retirees

Medical	HMSA 90/10 PPO Plan (Supplemental Plan to Medicare)		Humana Medicare Advantage Plan	Kaiser Senior Advantage Plan
	In-Network	Out-of-Network	In-Network/ Out-of-Network	HMO Network
Calendar Year Deductible	$100 per person $300 per family		$100 per person	None
Calendar Year Maximum Out-of-Pocket Limit	$2,500 per person $7,500 per family		$2,500 per person	$2,000 per person $6,000 per family
Lifetime Benefit Maximum	None		None	None
Physician Office Visit	10%*	30%	10%*	$15
Online Care (through hmsaonlinecare.com, myhumana.com, or kp.org)	No charge*	Not covered	Primary Care: No charge Specialist: 10% Behavioral Health and Substance Abuse: No charge	No charge
Urgent Care Visit	10%*	30%	10%*	$20
Emergency Room	10%*	10%*	10%* (waived if admitted within 24 hours)	$50
Ambulance Air	20%	20%	10%	20%
Ambulance Ground	20%	30%	10%	20%
Inpatient Hospital Services	10%*	30%	10%	No charge
Outpatient Surgery	10%*	30%	10%	$15
Outpatient Testing, Lab, and X-ray Services	20%*	30%	10%	No charge
Annual Physical Exam	No charge*	30%*	No charge*	No charge
Preventative Screening	20%*	30%	No charge*	No charge
Inpatient Mental Health	10%*	30%	10%	No charge
Outpatient Mental Health	10%*	30%	Facility: 10% Physician visit: 10%*	$15
Chiropractic Services	Not covered	Not covered	10%* For Medicare-covered services only (manual manipulation of the spine to correct subluxation)	$15 For Medicare-covered services only (manual manipulation of the spine to correct subluxation)

* Not subject to the deductible

Medical Plan Benefits – HSTA VB
Medicare Retirees

Medical	HMSA 90/10 PPO Plan		Kaiser Senior Advantage Plan
	In-Network	Out-of-Network	HMO Network
Calendar Year Deductible	None	$100 per person $300 per family	None
Calendar Year Maximum Out-of-Pocket Limit	$2,000 per person $6,000 per family		$2,000 per person $6,000 per family
Lifetime Benefit Maximum	$2,000,000 for all individuals combined; $25,000/ calendar year thereafter		None
Physician Office Visit	10%	30%	$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge	Not covered	No charge
Urgent Care Visit	10%	30%	$20
Emergency Room	10%	10%*	$50
Ambulance Air	10%	10%*	20%
Ambulance Ground	10%	30%	20%
Inpatient Hospital Services	10%	30%	No charge
Outpatient Surgery	10%	30%	$15
Outpatient Testing, Lab, and X-ray Services	10%	30%	No charge
Annual Physical Exam	No charge (limits apply)	No charge* (limits apply)	No charge
Preventative Screening	10%	30%	No charge
Inpatient Mental Health	10%	30%	No charge
Outpatient Mental Health	10%	30%	$15
Chiropractic Treatment (administered through American Specialty Health, Inc.)	$12 (20 visits per year)	Not covered	$12 (20 visits per year)

* Not subject to the deductible

Prescription Drug Plan Benefits – EUTF Medicare Retirees

Prescription Drug	SilverScript (SSI) Medicare Part D PPO Drug Plan*		Kaiser Senior Advantage Plan+	
	In-Network/ Mail Order	Out-of-Network**	HMO Network	Mail Order
Day Supply	30/60/90		30/60/90	
Generic	$5/$10/$10	$5/$10/$10 + 20%	$15/$30/$45	$15/$30/$30
Preferred Brand	$15/$30/$30	$15/$30/$30 + 20%		
Non-Preferred Brand	$30/$60/$60	$30/$60/$60 + 20%		
Insulin	$5/$10/$10	$5/$10/$10 + 20%	$15/$30/$45	Not covered
Diabetic Supplies	No charge Meters: Covered by Medicare Part B and the HMSA and Humana medical plans	20% Meters: Covered by Medicare Part B and the HMSA and Humana medical plans	Lancets, strips & meters: 20% Syringes/ needles: $15/$30/$45	Lancets, strips & meters: 20% Syringes/ needles: $15/$30/$30
Specialty Drugs (including high-cost drugs as defined by CMS) and Injectables	20% (up to a 30-day supply) Up to $250 per fill; $2,000 In-Network maximum out-of-pocket per calendar year; $30 copay for oral oncology specialty medications Mail Pharmacy: Not covered	50% $30 copay (up to a 30-day supply) + 20% for oral oncology specialty medications	$15 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

* The EUTF's Medicare Part D prescription drug plan is administered by SilverScript (SSI), the Medicare Part D administrator for CVS Caremark. This plan is the prescription drug coverage for Medicare retirees enrolled in the HMSA and Humana PPO medical plan options and for stand-alone drug coverage.

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

+The Kaiser Medicare Part D prescription drug coverage is included under the Kaiser Permanente Senior Advantage medical plan.

Prescription Drug Plan Benefits – HSTA VB Medicare Retirees

Prescription Drug	SilverScript (SSI) Medicare Part D PPO Drug Plan*		Kaiser Senior Advantage Plan+	
	In-Network/Mail Order	Out-of-Network**	HMO Network	Mail Order
Day Supply	30/60/90		30/60/90	
Generic	$3/$9/$9	$3/$9/$9 + 30%	$10/$20/$30	$10/$20/$20
Brand	$9/$27/$27	$9/$27/$27 + 30%		
Insulin	$3/$9/$9	$3/$9/$9 + 30%	$10/$20/$30	Not covered
Diabetic Supplies	No charge Meters: Covered by Medicare Part B and the HMSA PPO medical plan	30% Meters: Covered by Medicare Part B and the HMSA PPO medical plan	20%	20%
Specialty Drugs/ Injectables	Generic/brand copays apply Mail Pharmacy: Not covered		$10 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

* The HSTA VB's Medicare Part D prescription drug plan is administered by SilverScript (SSI), the Medicare Part D administrator for CVS Caremark. This plan is the prescription drug coverage for Medicare retirees enrolled in the HMSA PPO medical plan option.

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

+The Kaiser Medicare Part D prescription drug coverage is included under the Kaiser Permanente Senior Advantage medical plan.

Dental Plan Benefits (Hawaii Dental Service [HDS]) – EUTF & HSTA VB

DENTAL BENEFIT	PLAN COVERS
Plan Maximum per calendar year per member (Jan 1 - Dec 31)	$2,000
DIAGNOSTIC	
Examinations – 2 per calendar year	100%
Bitewing X-rays – 2 per calendar year through age 14; 1 per calendar year ages 15 and older	100%
Other X-rays – full mouth X-rays limited to 1 every 5 years	100%
PREVENTIVE	
Cleanings — 2 per calendar year, additional cleanings or gum maintenance covered for expectant mothers and members with a history of cancer treatment (chemotherapy or radiation), diabetes, Sjögren's syndrome, stroke, heart attack, congestive heart failure, kidney failure, or organ transplant	100%
Fluoride – 2 per calendar year through age 19, additional fluoride treatments for members with a history of certain cancers, Sjögren's syndrome, or at medical risk for cavities	100%
Silver Diamine Fluoride	100%
Space Maintainers – through age 17	100%
Sealants – through age 18 (one treatment per tooth per lifetime to permanent molars with no prior fillings on biting surfaces)	100%
BASIC CARE	
Fillings – silver fillings; white-colored fillings limited to front teeth	60%
Root Canals	60%
Gum Surgeries & Maintenance – cleaning (maintenance) for gum disease limited to 2 per calendar year after qualifying gum treatment where qualifying gum treatment is one or more of the following: • Root Planing and Scaling – 1 every 2 years per quadrant • Gum/Bone Surgeries – 1 every 3 years per quadrant	60%
Oral Surgeries	60%
MAJOR CARE	
Crowns – 1 every 5 years when teeth cannot be restored with silver or white fillings; white crowns limited to front teeth and bicuspids	60%
Fixed Bridges & Dentures – 1 every 5 years; age 16 and older	60%
Implants	60%
OTHER SERVICES	
Emergency Treatments of Dental Pain	100%

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

Vision Exam & Eye Wear Benefits: Members can have an eye exam and choose between a pair of lenses or contact lenses every calendar year. Frames are covered every other calendar year.

Vision Benefit	Frequency	In-Network	Out-of-Network Plan Pays
Exam	Every calendar year	$10 copay	Up to $45
Prescription Glasses		$25 copay	
Prescription Glasses Frame	Every other calendar year	$150 allowance plus 20% off out-of-pocket cost	Up to $47
Prescription Glasses Lenses:	Every calendar year		
- Single vision lenses		- Included in $25 copay	- Up to $45
- Lined bifocal lenses		- Included in $25 copay	- Up to $65
- Lined trifocal lenses		- Included in $25 copay	- Up to $85
- Impact-resistant lenses for dependent children up to age 18		- Included in $25 copay	- Not covered
- Standard progressive lenses		- Included in $25 copay	- Up to $85
- Premium progressive lenses		- $80-$90 copay	- Up to $85
- Custom progressive lenses		- $120-$160 copay	- Up to $85
- Lenticular lenses		- No charge	- Up to $125
- UV protection		- No charge	- Not covered
Contact Lenses	Every calendar year		
- Contact lenses (elective)		- $130 allowance	- Up to $105
- Contact lenses (medically necessary)		- No charge	- Up to $210
- Contact lenses fitting and evaluation		- $60 copay max	- Not covered

Extra Discounts and Savings from VSP Providers

Glasses & Sunglasses

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

Retinal Screening

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

Contact Lenses

- VSP partners with leading contact lens manufacturers to provide VSP members exclusive offers. Check out www.vsp.com for details

Laser Vision Correction

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

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

Summary of Benefit Eligibility
(For Members Hired Prior to 7/1/2012)

	Noncontributory Plan	Contributory Plan	Hybrid Plan
Normal Retirement	Age 62 and 10 years credited service; or age 55 and 30 years credited service	Age 55 and 5 years credited service	Age 62 and 5 years credited service; or age 55 and 30 years credited service
Early Retirement	Age 55 and 20 years credited service	Any age and 25 years credited service	Age 55 with 20 years credited service
Deferred Vesting	10 years credited service	5 years credited service and contributions left in the ERS	5 years credited service and contributions left in the ERS
Ordinary Disability	10 years credited service	10 years credited service	10 years credited service
Service-Connected Disability	Any age or credited service	Any age or credited service	Any age or credited service
Ordinary Death	Active employee at time of death with at least 10 years of credited service	Active employee at time of death with at least 1 year of service	Active employee at time of death with at least 5 years of service
Service-Connected Death	Any age or service	Any age or service	Any age or service

The benefit eligibilities summarized above apply to teachers and most State and County employees. Special provisions applicable to other groups of employees are outlined below:

Police officers, firefighters, investigators of the Department of the Prosecuting Attorney and the Attorney General, narcotic enforcement investigators, and public safety investigators may retire at age 55 with 5 years of credited service or at any age with 25 years of credited service.

Judges, elected officials, and legislative officers may retire at age 55 with at least 5 years of credited service, or at any age with at least 10 years of credited service. Judges hired after June 30, 1999 require 25 years of credited service in order to retire before age 55.

Sewer workers in specified classifications, water safety officers, and emergency medical technicians (EMTs) may retire at any age if they are credited with 25 years of such service with the last 5 or more years in these occupations. (The 25-year feature is phased in through 7/1/2008 for EMTs.)

Sewer workers in specified classifications, water safety officers, and emergency medical technicians (EMTs) that transfer to the Hybrid Plan may retire at age 62 with 5 years of credited service or at any age if they are credited with 25 years of such service with the last 5 or more years in these occupations.

Summary of Benefit Eligibility
(For Members Hired After 6/30/2012)

	Contributory Plan (for Police/Fire)	Contributory Plan (for Judges/Elected Officers)	Hybrid Plan
Normal Retirement	Age 60 and 10 years credited service	Age 60 and 10 years credited service	Age 65 and 10 years credited service; or age 60 and 30 years credited service Sewer workers, water safety officers, and EMTs may retire with 25 years credited service at age 55
Early Retirement	Age 55 and 25 years credited service	Age 55 and 25 years credited service any age with 10 years for elected officers	Age 55 with 20 years credited service Sewer workers, water safety officers, and emergency medical technicians (EMTs) may retire with 25 years credited service
Deferred Vesting	10 years credited service and contributions left in the ERS	10 years credited service and contributions left in the ERS	10 years credited service and contributions left in the ERS
Ordinary Disability	10 years credited service	10 years credited service	10 years credited service
Service-Connected Disability	Any age or credited service	Any age or credited service	Any age or credited service
Ordinary Death	Active employee at time of death with at least 1 year of credited service	Active employee at time of death with at least 1 year of credited service	Active employee at time of death with at least 10 years of service
Service-Connected Death	Any age or service	Any age or service	Any age or service

SECTION F

SUMMARY OF PARTICIPANT DATA

Active Employee Age/Service Distribution

Attained Age	Years of Credited Service												
	0	1	2	3	4	5-9	10-14	15-19	20-24	25-29	30-34	35 & Over	Total
Under 25	554	270	62	29	16	5	-	-	-	-	-	-	936
25-29	821	909	601	535	417	425	-	-	-	-	-	-	3,708
30-34	668	686	459	569	590	2,407	270	-	-	-	-	-	5,649
35-39	508	534	364	499	558	2,373	1,695	325	-	-	-	-	6,856
40-44	454	485	334	416	462	2,050	1,716	1,971	277	-	-	-	8,165
45-49	372	392	264	349	372	1,652	1,396	1,969	1,782	156	3	-	8,707
50-54	316	317	208	296	302	1,356	1,140	1,652	1,949	1,539	313	-	9,388
55-59	229	255	166	230	232	1,137	898	1,359	1,312	1,255	1,308	152	8,533
60-64	133	166	116	189	203	934	791	1,073	1,045	784	976	564	6,974
65 & Over	85	83	73	107	133	694	657	740	746	497	590	745	5,150
Total	4,140	4,097	2,647	3,219	3,285	13,033	8,563	9,089	7,111	4,231	3,190	1,461	64,066

Inactive Age Distribution

Age	Deferred Inactives	Retirees	Total
<35	56	20	76
35-39	621	4	625
40-44	1,194	22	1,216
45-49	1,418	62	1,480
50-54	1,726	429	2,155
55-59	1,809	1,826	3,635
60-64	1,471	4,532	6,003
65-69	490	9,038	9,528
70-74	157	11,352	11,509
75-79	17	10,634	10,651
80-84	5	6,824	6,829
85-89	3	4,540	4,543
90-94	0	2,981	2,981
95+	0	1,403	1,403
Total	8,967	53,667	62,634

Hawaii Employee-Union Trust Fund
Distribution by Health Plan and Coverage Type

Actives

	Single	Two-Party	Family	Waived	Total
PPO	19,584	5,848	9,263	N/A	34,695
HMO	8,191	2,423	3,398	N/A	14,012
Others	153	131	311	N/A	595
Waived				14,764	14,764
Total Medical					**64,066**
Dental	27,440	11,341	13,323	11,962	**64,066**
Vision	27,076	10,501	12,354	14,135	**64,066**

Retirees

	Single	Two-Party	Family	Total
PPO	24,488	15,617	1,459	41,564
HMO	5,229	2,755	231	8,215
Medicare Adv	44	10	-	54
Others	124	62	3	189
Total Medical				**50,022**
Dental	29,858	19,281	1,696	**50,835**
Vision	29,824	19,258	1,723	**50,805**
Life				**47,632**

SECTION G

ACTUARIAL ASSUMPTIONS AND METHODS

Summary of Actuarial Assumptions and Methods

The actuarial assumptions used in the valuation are shown in this Section. Assumptions that are specific to certain groups (i.e. General Employees, Teachers, Police and Firefighters) are discussed under the first subsection that follows. Assumptions that are common to all types of members and unique to this valuation are then shown on the following pages.

Demographic and Certain Economic Assumptions

This actuarial valuation of the OPEB is similar to the actuarial valuations performed for ERS. All of the demographic assumptions and most of the economic assumptions used in this OPEB Valuation were identical to those used in the June 30, 2023 retirement system valuations performed by Gabriel, Roeder, Smith and Company. The assumptions which are common to the pension and OPEB valuations are described in Appendix A of this report.

Healthcare and Other Economic Assumptions

General Inflation was assumed to be 2.50% per year.

The rate of investment return was assumed to be 7.00% a year, compounded annually net after investment expenses. The assumed real return is the rate of return in excess of price inflation. Considering other assumptions used in the valuation, the nominal rate translates to a net real return of 4.50% a year.

Health Cost and Premium Increases – *See table below*

Year	*HMSA (PPO)*	*Kaiser (HMO)*	*Dental*	*Vision*	*Part B Premiums*
2025	6.30%	6.30%	4.00%	2.50%	5.00%
2026	6.20%	6.20%	4.00%	2.50%	5.00%
2027	6.10%	6.10%	4.00%	2.50%	5.00%
2028	6.00%	6.00%	4.00%	2.50%	5.00%
2029	5.90%	5.90%	4.00%	2.50%	5.00%
2030	5.80%	5.80%	4.00%	2.50%	5.00%
2031	5.70%	5.70%	4.00%	2.50%	5.00%
2032	5.60%	5.60%	4.00%	2.50%	5.00%
2033	5.50%	5.50%	4.00%	2.50%	5.00%
2034	5.40%	5.40%	4.00%	2.50%	5.00%
2035	5.30%	5.30%	4.00%	2.50%	5.00%
2036	5.20%	5.20%	4.00%	2.50%	5.00%
2037	5.10%	5.10%	4.00%	2.50%	5.00%
2038	5.00%	5.00%	4.00%	2.50%	5.00%
2039	4.90%	4.90%	4.00%	2.50%	4.90%
2040	4.80%	4.80%	4.00%	2.50%	4.80%
2041	4.70%	4.70%	4.00%	2.50%	4.70%
2042	4.60%	4.60%	4.00%	2.50%	4.60%
2043	4.50%	4.50%	4.00%	2.50%	4.50%
2044	4.40%	4.40%	4.00%	2.50%	4.40%
2045	4.30%	4.30%	4.00%	2.50%	4.30%
2046	4.25%	4.25%	4.00%	2.50%	4.25%

The premiums for 2024 were known at the time of the valuation. The first trend rate shown above is assumed to occur at 1/1/2025. Future increases are also assumed to occur on 1/1. The HMSA and Kaiser trend rates are blended rates used to project both medical and prescription drug costs.

The trend rates shown above for the Part B premiums apply to the BMC and the Part B premiums.

The 4.25% ultimate trend assumption for the HMSA and Kaiser plans is comprised of 2.50% long-term price inflation + 1.75% real GDP growth.

Healthcare and Other Economic Assumptions (Continued)

Plan Participation

The plan participation rates were assumed to vary based on the employer contribution percentage, as follows:

Employer Contribution	Rates of Participation		
	Medical, Prescription Drug, Dental and Vision	Life Insurance	Medicare Part B
0%	25%	100%	98%
50%	65%	100%	98%
75%	90%	100%	98%
100%	98%	100%	98%

The same assumptions were used for terminated participants with vested pension benefits. However, current active employees who terminate service prior to the age of 35 are not assumed to ever participate in the retiree health plan.

For current retirees, the actual family coverage election is used. For future retirees, the family coverage assumptions are 35% single / 50% two-party / 15% family prior to age 65 and 50% single / 50% two-party after the age of 65. It was assumed 45% of eligible future retirees would receive Medicare Part-B reimbursements for a spouse. For those that elect two-party or family coverage, it was assumed that coverage would continue to the spouse upon death of the retiree.

Plan Elections

For current retirees, plan elections were based on the plan in which they are currently enrolled. For future retirees, plan participation was assumed to be 82% HMSA / 18% Kaiser.

Administration Fees

The following table provides the 2024 monthly administration fees. The EUTF Board approved to pay third party administration fees through December 31, 2028, using the Agency Fund assets. As a result, it was assumed that the administration fees would be in addition to the premiums shown in Section E for years after 2028.

Monthly Fee	Single Party	Two-Party	Family
Medical and Drug	$5.42	$10.84	$16.26
Dental	0.36	0.72	1.08
Vision	0.04	0.08	0.12
Life	0.04	0.04	0.04

Healthcare and Other Economic Assumptions (Continued)

Aging Factors: In any given year, the cost of medical and prescription drug benefits vary by age. As the ages of retirees in the covered population increase so does the cost of benefits. Morbidity tables are employed to develop Per Capita Costs at every relevant age. The following table represents the percent by which the cost of medical and prescription drug benefits at one age is higher than the cost for the previous age. For example, according to the following table, the cost of benefits for a male age 55 is 5.50% higher than for one age 54. These percentages below are separate from the annual Medical Trend, which operates to increase costs independent of and in addition to the Aging Factors shown below.

Sample Ages	Cost Increases by Age	
	Male	Female
45	4.66%	1.88%
50	5.83%	3.53%
55	5.50%	2.85%
60	5.06%	3.45%
65	3.34%	3.28%
70	1.77%	2.02%
75	1.15%	1.32%
80	0.82%	1.05%
85	-0.27%	0.49%
90	-0.32%	0.03%

Actuarial Methods

The individual entry age actuarial cost method was used in determining liabilities and normal cost. Differences between assumed experience and actual experience ("actuarial gains and/or losses") become part of actuarial accrued liabilities.

Unfunded actuarial accrued liabilities are amortized to produce payments (principal & interest) which are a level percent of payroll. Closed bases will be established at each valuation for new unfunded liabilities. If experience produces a loss, the new base will be amortized over a period of 20 years. Experience gains will be amortized over the same period as the initial liability base, until the initial liability base is fully amortized.

Miscellaneous and Technical Assumptions

Actuarial Value of Assets	The actuarial value of assets is based on the market value of assets with a four-year phase-in of actual investment return in excess of (less than) expected investment income. Offsetting unrecognized gains and losses are immediately recognized, with the shortest remaining bases recognized first and the net remaining bases continue to be recognized on their original timeframe. The expected actuarial value of assets is calculated net of investment expenses, and the expected investment return is equal to the assumed investment return rate multiplied by the prior year's actuarial value of assets, adjusted for contributions, benefits paid, and refunds.
Claims Utilization	To model the impact of aging on the underlying health care costs, the valuation relied on the Society of Actuaries' 2013 Study "Health Care Costs – From Birth to Death". Chart 1 (2010 Aggregate Commercial Costs) was used to model the impact of aging for ages less than 65 and Table 4 (Development of Plan Specific Medicare Age Curve) was used to model the impact of aging for ages 65 and over.
Marriage Assumption	100% of males and females are assumed to be married for purposes of death-in-service benefits. For future retirees, husbands are assumed to be four years older than wives.
Pay Increase Timing	Beginning of (fiscal) year. This is equivalent to assuming that reported pays represent amounts paid to members during the year ended on the valuation date.
Decrement Timing	Except for teachers, decrements of all types are assumed to occur mid-year. For teachers, the normal retirement, early retirement and termination decrements are assumed to occur at the beginning of the year.
Eligibility Testing	Eligibility for benefits is determined based upon the age nearest birthday and service nearest whole year on the date the decrement is assumed to occur.
Decrement Operation	Disability and mortality decrements are added to the termination decrements during the first 5 years. Disability is added to the retirement decrement during retirement eligibility.

Miscellaneous and Technical Assumptions (continued)

Deferred Age	Terminated employees with vested pension benefits are assumed to commence their benefit at age 62 or their current age if they are older than 62 as of the valuation date.
Timing of ARC Contributions	The ARC is assumed to be received at the middle of the year.
Administrative Expenses	Third party administrative expenses related to providing benefits are included in the age-rated costs. The administrative costs related to operating the trust are included in the normal cost.
Reliance on Other Actuaries	We have relied on the premiums developed by Segal Consulting for the self-insured prescription drug benefit.
Assumption, Method And Plan Changes	There were no assumption changes this year.

APPENDIX A

DEMOGRAPHIC AND CERTAIN ECONOMIC ASSUMPTIONS

Demographic and Certain Economic Assumptions

A. Economic Assumptions

1. Wage inflation: 3.00% per annum

2. Salary increase rate: As shown below

	General Employees		Teachers	
Years of Service	Service-related Component	Total Rate Including 2.50% Inflation Component and 1.25% Productivity Component	Service-related Component	Total Rate Including 2.50% Inflation Component and 1.25% Productivity Component
1	3.00%	6.75%	3.00%	6.75%
2	3.00%	6.75%	3.00%	6.75%
3	2.00%	5.75%	2.00%	5.75%
4	1.50%	5.25%	1.50%	5.25%
5	1.50%	5.25%	1.50%	5.25%
6	1.25%	5.00%	1.25%	5.00%
7	1.25%	5.00%	1.25%	5.00%
8	1.00%	4.75%	1.00%	4.75%
9	1.00%	4.75%	1.00%	4.75%
10	1.00%	4.75%	1.00%	4.75%
11	0.75%	4.50%	0.75%	4.50%
12	0.75%	4.50%	0.75%	4.50%
13	0.50%	4.25%	0.50%	4.25%
14	0.50%	4.25%	0.50%	4.25%
15	0.50%	4.25%	0.50%	4.25%
16	0.50%	4.25%	0.50%	4.25%
17	0.50%	4.25%	0.50%	4.25%
18	0.50%	4.25%	0.50%	4.25%
19	0.50%	4.25%	0.50%	4.25%
20	0.25%	4.00%	0.25%	4.00%
21	0.25%	4.00%	0.25%	4.00%
22	0.25%	4.00%	0.25%	4.00%
23	0.25%	4.00%	0.25%	4.00%
24	0.25%	4.00%	0.25%	4.00%
25 or more	0.00%	3.75%	0.00%	3.75%

2. Salary increase rates (continued):

	Police & Firefighters	
Years of Service	Service-related Component	Total Annual Rate of Increase Including 2.50% Inflation Component and 2.50% General Increase Rate
1	1.00%	6.00%
2	1.00%	6.00%
3	1.00%	6.00%
4	1.00%	6.00%
5	1.00%	6.00%
6	1.00%	6.00%
7	1.00%	6.00%
8	1.00%	6.00%
9	1.00%	6.00%
10	1.00%	6.00%
11	1.00%	6.00%
12	1.00%	6.00%
13	1.00%	6.00%
14	1.00%	6.00%
15	1.00%	6.00%
16	0.75%	5.75%
17	0.75%	5.75%
18	0.75%	5.75%
19	0.50%	5.50%
20	0.50%	5.50%
21	0.50%	5.50%
22	0.25%	5.25%
23	0.25%	5.25%
24	0.25%	5.25%
25 or more	0.00%	5.00%

Salary increases are assumed to occur once a year, on July 1. Therefore the pay used for the period between the valuation date and the first anniversary of the valuation date is equal to the reported pay for the prior year, annualized if necessary, and then increased by the salary increase assumption. To adjust the pays received as of March 31st to the June 30th valuation date, the reported pay for each member is increased by 1%.

B. Demographic Assumptions

1. Mortality rates:

Active Members: Multiples of the Pub-2010, Employee Tables for active employees based on the occupation of the member as follows:

	General Employees	Teachers	Police and Fire
Type	Male & Female	Male & Female	Male & Female
Ordinary	94%	92%	80%
% of Ordinary Choosing Annuity	41%	52%	24%
Duty Related	6%	8%	20%

Healthy Retirees: The 2022 Public Retirees of Hawaii mortality tables. The rates are projected on a fully generational basis by the long-term rates of scale UMP from the year 2022 and with multipliers and setbacks based on plan and group experience. The following are sample rates of the base table with the corresponding multipliers:

Healthy Annuitant Mortality Rates Before Projection (Multiplier Applied)

	General Employees		Teachers		Police and Fire	
Age	Male	Female	Male	Female	Male	Female
50	0.2094%	0.1276%	0.1698%	0.0951%	0.2421%	0.1130%
55	0.3215%	0.1687%	0.2883%	0.1596%	0.3473%	0.1633%
60	0.5570%	0.3095%	0.4672%	0.2467%	0.6179%	0.2799%
65	0.8041%	0.4488%	0.7256%	0.4063%	0.8426%	0.4283%
70	1.2621%	0.7066%	1.0762%	0.6015%	1.4172%	0.6565%
75	2.0700%	1.0964%	1.7879%	0.9358%	2.3227%	1.0121%
80	3.5996%	2.1275%	3.0429%	1.6565%	4.1824%	1.8863%
85	6.5891%	4.1569%	5.5564%	3.2698%	7.6513%	3.6977%
90	11.9340%	8.3647%	10.1056%	6.5007%	13.6689%	7.3991%
Multiplier	102%	98%	97%	101%	93%	100%
Setback	0	-1	1	1	-2	0

The following table provides the life expectancy for individuals retiring in future years based on the assumption with full generational projection:

Life Expectancy for an Age 65 Retiree in Years

	Year of Retirement				
Gender	2025	2030	2035	2040	2045
	General Retirees				
Male	22.8	23.2	23.5	23.9	24.2
Female	26.3	26.6	26.9	27.2	27.5
	Teachers				
Male	24.1	24.5	24.9	25.2	25.5
Female	28.0	28.3	28.6	28.9	29.2
	Police and Fire				
Male	21.8	22.1	22.4	22.8	23.1
Female	27.1	27.4	27.7	28	28.3

Disabled retirees: Base Table for healthy retirees' occupation, set forward 3 years, generational projection using the UMP projection table from the year 2022. Minimum mortality rate of 3.5% for males and 2.5% for females.

2. Disability rates – The assumed total disability rates at select ages are multiples of the client specific table that follows:

Age	Male & Female
25	0.000%
30	0.001%
35	0.008%
40	0.026%
45	0.064%
50	0.146%
55	0.198%
60	0.217%

Note: The disability rates project the percentage of employees at each age that is assumed to become disabled before retiring. Multiples of the rates above are assumed to be ordinary disability or accidental disability, and varies by employee group as follows:

	General Employees	Teachers	Police and Fire
Type	Male & Female	Male & Female	Male & Female
Ordinary	200%	100%	50%
Accidental	60%	8%	120%

3. Termination Rates - Same male and female rates, based solely on the member's service. Rates reflect terminations for causes other than death, disability or retirement. Employees eligible for retirement are assumed to have no probability of termination. Sample rates are shown below:

	Expected Terminations per 1000 Lives (Male & Female)		
Years of Service	General Employees	Teachers	Police & Fire
0	177.2	0.0	140.0
1	142.2	197.9	52.4
2	114.2	165.2	41.3
3	92.0	134.8	34.8
4	74.8	108.2	30.2
5	61.7	86.3	26.6
6	51.9	69.4	23.7
7	44.7	57.3	21.3
8	39.6	49.4	19.1
9	35.8	44.5	17.2
10	32.8	41.0	15.6
11	30.3	35.8	10.6
12	27.9	32.4	10.0
13	22.6	29.1	9.4
14	19.8	26.1	8.8
15	17.7	23.2	8.2
16	16.1	20.6	7.6
17	14.8	18.1	7.0
18	13.7	15.8	6.4
19	12.8	13.6	5.8
20	11.9	11.7	5.2
21	11.1	10.0	4.6
22	10.2	8.4	4.0
23	9.3	7.0	3.4
24	8.3	5.8	2.8
25	7.1	4.8	0.0
26	6.0	4.0	0.0
27	4.7	3.3	0.0
28	3.5	2.8	0.0
29	2.4	2.6	0.0
30 and more	0.0	0.0	0.0

4. Retirement rates - Separate male and female rates, based on age. Sample rates are shown below:

Contributory Members

Expected Retirements per 100 Lives

	General Employees				Teachers				Police/Fire
	Unreduced Retirement		Reduced Retirement		Unreduced Retirement		Reduced Retirement		Unreduced Retirement
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male & Female
45	0	0	0	0	0	0	0	0	15.5
46	0	0	0	0	0	0	0	0	15.5
47	0	0	0	0	0	0	0	0	15.5
48	0	0	0	0	0	0	0	0	15.5
49	0	0	0	0	0	0	0	0	15.5
50	0	0	0	0	0	0	1	0	18.0
51	0	0	2	1	0	0	1	1	18.0
52	0	0	2	1	0	0	1	1	18.0
53	0	0	2	1	0	0	2	2	18.0
54	0	0	3	2	0	0	3	3	18.0
55	25	20			20	18			22.0
56	25	20			15	16			22.0
57	16	13			15	16			22.0
58	16	13			15	16			24.0
59	13	13			15	16			27.0
60	13	15			14	18			30.0
61	13	15			14	18			30.0
62	28	25			14	25			30.0
63	20	20			14	20			30.0
64	20	20			14	15			30.0
65	20	20			20	25			100.0
66	18	20			15	25			
67	18	20			15	20			
68	18	20			15	20			
69	18	20			15	20			
70	20	20			15	20			
71	20	20			15	20			
72	20	20			15	20			
73	20	20			15	20			
74	20	20			15	20			
75	100	100			100	100			

Noncontributory Members

	Expected Retirements per 100 Lives									
	General Employees						Teacher			
	Unreduced		25 & Out		Reduced		Unreduced		Reduced Retirement	
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
55	20	11	15	11	1	1	10	13	1	2
56	18	11	23	11	1	1	10	7	1	2
57	13	11	18	11	1	1	10	8	1	2
58	10	11	15	11	2	2	10	10	2	2
59	10	11	15	11	2	2	10	20	3	3
60	10	14	15	14	4	4	10	11	5	5
61	11	18	16	18	4	4	10	16	7	5
62	20	20	25	20			16	25		
63	20	20	25	20			12	20		
64	12	20	17	20			10	15		
65	14	20	19	20			20	25		
66	20	20	25	20			15	25		
67	20	20	25	20			15	25		
68	20	20	25	20			15	25		
69	20	20	25	20			15	25		
70	20	20	25	20			15	25		
71	20	20	25	20			15	25		
72	20	20	25	20			15	25		
73	20	20	25	20			15	25		
74	20	20	25	20			15	25		
75	100	100	100	100			100	100		

Note: Retirement rates for the 25&out group age 50-54 are 15% for male and 11% for female.

Hybrid Members

	Expected Retirements per 100 Lives							
	General Employees				Teachers			
	Unreduced		Reduced		Unreduced		Reduced	
Age	Male	Female	Male	Female	Male	Female	Male	Female
55	18	18	1	1	20	16	2	2
56	12	13	1	1	13	10	2	2
57	12	13	1	1	13	10	2	2
58	16	13	2	2	13	12	2	2
59	16	13	2	2	13	12	3	3
60	14	13	4	4	14	14	3	5
61	14	15	4	4	14	18	3	10
62	21	20			22	30		
63	18	20			14	20		
64	18	20			14	20		
65	21	20			20	25		
66	18	18			15	25		
67	18	18			15	25		
68	18	18			15	25		
69	18	18			15	25		
70	20	20			15	25		
71	20	20			15	25		
72	20	20			15	25		
73	20	20			15	25		
74	20	20			15	25		
75	100	100			100	100		

Note: For the 25&out group with membership dates before July 1, 2012, the retirement rates prior to age 55 are 6% for both male and female.

For members hired after June 30, 2012 the retirement rates for members once they reach unreduced retirement eligibility are increased 10% (multiplicative) for each year the member is beyond the age the member would have been eligible under the Hybrid provisions for members hired prior to June 30, 2012.

APPENDIX B

GLOSSARY

Glossary

Accrued Service. The service credited under the plan which was rendered before the date of the actuarial valuation.

Actuarial Accrued Liability. The difference between (i) the actuarial present value of future plan benefits, and (ii) the actuarial present value of future normal cost. Sometimes referred to as "accrued liability" or "past service liability."

Actuarial Assumptions. Estimates of future plan experience with respect to rates of mortality, disability, turnover, retirement, rate or rates of investment income and salary increases. Decrement assumptions (rates of mortality, disability, turnover and retirement) are generally based on past experience, often modified for projected changes in conditions. Economic assumptions (salary increases and investment income) consist of an underlying rate in an inflation-free environment plus a provision for a long-term average rate of inflation.

Actuarial Cost Method. A mathematical budgeting procedure for allocating the dollar amount of the "actuarial present value of future plan benefits" between the actuarial present value of future normal cost and the actuarial accrued liability. Sometimes referred to as the "actuarial funding method."

Actuarial Equivalent. A single amount or series of amounts of equal value to another single amount or series of amounts, computed on the basis of the rate(s) of interest and mortality tables used by the plan.

Actuarial Present Value. The amount of funds presently required to provide a payment or series of payments in the future. It is determined by discounting the future payments at a predetermined rate of interest, taking into account the probability of payment.

Amortization. Paying off an interest-bearing liability by means of periodic payments of interest and principal, as opposed to paying it off with a lump sum payment.

Annual Required Contribution (ARC). The ARC is the normal cost plus the portion of the unfunded actuarial accrued liability to be amortized in the current period. The ARC is an amount that is actuarially determined in accordance with the requirements so that, if paid on an ongoing basis, it would be expected to provide sufficient resources to fund both the normal cost for each year and the amortized unfunded liability.

Medical Trend Rate (Health Inflation). The increase in the plan's cost over time. Trend includes all elements that may influence a plan's cost, assuming that enrollments and the plan benefits do not change. Trend includes such elements as, pure price inflation, changes in utilization, advances in medical technology, and cost shifting.

Normal Cost. The annual cost assigned, under the actuarial funding method, to current and subsequent plan years. Sometimes referred to as "current service cost." Any payment toward the unfunded actuarial accrued liability is not part of the normal cost.

Other Post-Employment Employee Benefits (OPEB). OPEB are post-employment benefits other than pensions. OPEB generally takes the form of health insurance and dental, vision, prescription drugs or other healthcare benefits.

Reserve Account. An account used to indicate that funds have been set aside for a specific purpose and are not generally available for other uses.

Unfunded Actuarial Accrued Liability. The difference between the actuarial accrued liability and valuation assets. Sometimes referred to as "unfunded accrued liability."

Valuation Assets. The value of current plan assets recognized for valuation purposes.

State of Hawaii Retiree Health Care Plan

Actuarial Valuation Report
as of July 1, 2023

P: 469.524.0000 | [illegible]consulting.com

January 18, 2024

Luis Salaveria
Director of Budget and Finance
State of Hawaii – Department of Budget and Finance
250 South Hotel Street, Room 305
Honolulu, Hawaii 96813

Dear Mr. Salaveria:

Submitted in this report are the results of an actuarial valuation for the State of Hawaii of the liabilities associated with the employer financed retiree health benefits provided through the Hawaii Employer-Union Health Benefits Trust Fund (EUTF). The date of the valuation was July 1, 2023. The annual required contribution has been calculated for the fiscal year ending June 30, 2026. The actuarial calculations were prepared to determine the annual required employer contribution to satisfy the requirements of ACT 268, SLH 2013 ("ACT 268"). Determinations of the liability associated with the benefits described in this report for purposes other than satisfying the funding requirements of ACT 268 may produce significantly different results. This report may be provided to parties other than the State of Hawaii only in its entirety and only with the permission of the State of Hawaii.

The valuation was based upon information, furnished by the EUTF and the Employees' Retirement System of the State of Hawaii (ERS), concerning retiree health benefits, members' census and financial data. Data was checked for internal consistency but was not otherwise audited. Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements; and changes in plan provisions or applicable law.

This report was prepared using our proprietary valuation model and related software which in our professional judgment has the capability to provide results that are consistent with the purposes of the valuation and has no material limitations or known weaknesses. We performed tests to ensure that the model reasonably represents that which is intended to be modeled.

The signing actuaries are independent of the plan sponsor. To the best of our knowledge, this report is complete and accurate and was made in accordance with generally recognized actuarial methods. Joseph Newton and Blake Orth are members of the American Academy of Actuaries and meet the Qualification Standards of the Academy of Actuaries to render the actuarial opinion herein.

Respectfully submitted,

Joseph P. Newton, FSA, FCA, EA, MAAA
Pension Market Leader

Lewis Ward
Consultant

Blake Orth, FSA, EA, MAAA
Consultant

Table of Contents

SECTION A

OVERVIEW

The following table summarizes the key results of the July 1, 2023 Other Post-Employment Benefits (OPEB) valuation for the State of Hawaii.

Executive Summary		
	July 1, 2023	**July 1, 2022**
Membership		
Number of		
-Retirees	40,136	39,326
-Deferred Inactives	7,520	7,564
-Active Employees	48,709	48,678
Covered Payroll*	$ 3,549,407,000	$ 3,373,712,000
Actuarial Summary		
Discount Rate	7.0%	7.0%
Amortization Growth Rate	2.5%	2.5%
Present Value of Benefits	$ 13,354,963,000	$ 12,805,146,000
Actuarial Accrued Liability	11,390,407,000	10,908,074,000
Market Value of Assets	4,365,370,000	3,774,693,000
Actuarial Value of Assets (AVA)	4,478,522,000	3,820,804,000
Unfunded Actuarial Accrued Liability	6,911,885,000	7,087,270,000
Funded Ratio, AVA	39.3%	35.0%
ARC as % of Payroll	22.3%	23.2%
Fiscal Year Ending	June 30, 2026	June 30, 2025
ACT 268 Minimum Contribution Summary		
Fiscal Year Ending	June 30, 2026	June 30, 2025
Annual Required Contribution (ARC)	$ 838,506,000	$ 830,204,000

* The covered payroll is equal to the projected payroll for the fiscal year beginning on the valuation date.

This report provides the minimum OPEB trust contribution required to satisfy the funding requirements of ACT 268. The Annual Required Contribution (ARC) developed in this report is for the fiscal year ending June 30, 2026. The contribution determined by each valuation will be applicable for the fiscal year which begins two years after the valuation date. The two-year lag between the valuation date and the applicable fiscal year allows appropriate time for budgeting and management of the appropriations.

Section C provides a multi-year projection of liability and contribution information which should be useful to management for the operation of the OPEB program.

Agent Multiple-Employer Plans

The EUTF OPEB plan operates as an **agent multiple-employer plan.** For agent multiple employer plans, separate asset accounts are maintained for each employer so that the employer's contributions provide benefits only for the employees of that employer. A separate actuarial valuation is performed for each individual employer's plan to determine the employer's periodic contribution rate and other information for the individual plan.

In a cost-sharing arrangement, such as the Employees' Retirement System of the State of Hawaii (ERS), the plan's assets can be used to pay the benefits for the retirees of any participating employer. By contrast, the assets of the participating government employers in an *agent multiple-employer plan* are pooled for investment purposes but separate accounts are maintained for each individual employer. As such, the State of Hawaii's assets at EUTF can only be used to pay benefits for the State of Hawaii's retirees. The State of Hawaii's unfunded actuarial accrued liability and the annual required contribution for retiree health benefits will be determined based solely on the State of Hawaii's membership and assets.

ACT 304, SLH 2012 and ACT 268, SLH 2013

ACT 304, SLH 2012 (ACT 304), authorized the board of trustees of the EUTF to create a separate trust fund (The OPEB Trust). The OPEB Trust was established effective June 30, 2013, specifically for pre-funding the participating employers OPEB benefits. Previous pre-funding contributions and related net investment earnings were transferred to each employer's respective OPEB Trust account. As required by ACT 304, contributions to the OPEB Trust shall be irrevocable and the assets of the fund shall be dedicated exclusively to providing health and other benefits to retirees and their eligible dependents. The assets in the OPEB Trust shall not be subject to appropriation for any other purpose and shall not be subject to claims by creditors of the employers or the board or plan administrator.

ACT 268, SLH 2013 (ACT 268) established an "annual required contribution" (ARC) equal to (a) the normal cost, plus (b) an amortization payment to fund the unfunded actuarial accrued liability over a period of no more than thirty years. Moreover, employers were required to contribute 100% of the ARC starting in fiscal year ending June 30, 2019. ACT 268 established mechanisms for funding the ARC if the employer fails to do so.

ACT 268 established a funding policy which ensures the ARC will be consistently met. As a result, the liabilities in this valuation have been calculated using a 7.0% long-term investment return assumption on the OPEB Trust's assets. The 7.0% return assumption is based on the OPEB Trust's investment policy and we believe the assumption is consistent with the target asset allocation.

Actuarial Assumptions and Methods

In any long-term actuarial valuation (such as for Pensions and OPEB), certain demographic, economic and behavioral assumptions are made concerning the population, the investment return rates and the benefits provided. These Actuarial Assumptions form the basis for the actuarial model which is used to project the future population, the future benefits provided, and the future contributions collected. Then the investment return rate (discount rate) assumption is used to discount those projected net OPEB benefits to a present value. This and other related present values are used to calculate the Annual Required Contribution.

This actuarial valuation of the State of Hawaii's OPEB is similar to the actuarial valuations performed for the State's pension plans. The demographic assumptions used in this OPEB Valuation were identical to those used in the June 30, 2023 ERS valuation. Because the assumptions were based upon the most recent actuarial experience study adopted by the Trustees of ERS, they were deemed reasonable for this OPEB Valuation and were employed in this report.

There are some economic and behavioral assumptions which are unique to health benefits. It would be instructive to review the Section of this Report titled, "Actuarial Assumptions and Methods" for a detailed discussion and disclosure of all the relevant actuarial assumptions used in this valuation. The Individual Entry Age Normal Cost Method was used in this valuation. This is both an acceptable and reasonable cost method. Furthermore, the Normal Costs and the amortization of any Unfunded Actuarial Accrued Liabilities were calculated using a level percent of pay.

There were no assumption or method changes since the previous valuation as of July 1, 2022.

Summary of Changes

The funded ratio of the plan increased from 35.0% to 39.3% and the unfunded actuarial accrued liability decreased from $7.09 billion to $6.91 billion. The liabilities and contribution amounts developed in this July 1, 2023 valuation closely resemble what was expected from the previous valuation. The actuarial accrued liability increased from $10.91 billion to $11.39 billion, while the liability was expected to increase to $11.42 billion.

The actuarial value of assets (AVA) increased from $3.82 billion to $4.48 billion. The AVA closely resembles the $4.48 billion expected from the previous valuation. The FYE23 investment return was 4.32%. The July 1, 2023 valuation provides the Annual Required Contribution (ARC) for fiscal year ending June 30, 2026. The FYE26 ARC of $838,506,000 matches the projected FYE26 ARC from the previous valuation.

There were two bills passed since the previous valuation: Act 040, SLH 2023 (Act 040) and Act 041, SLH 2023 (Act 041). Act 040 eliminated the Medicare Part B reimbursements for spouses of those hired after June 30, 2023. Act 041 removed the income-related monthly adjustment amounts (IRMAA) portion of the Medicare part B reimbursements for participants hired after June 30, 2023. These changes did not affect the financial condition of the plan as of the July 1, 2023 valuation date, but they did have an impact on the projected financial condition of the plan, shown in section C of this report.

ARC with 2% Corridor Smoothing

A funding policy mechanism was introduced in the July 1, 2021 valuation to manage contribution volatility. The combination of the level percentage of payroll UAAL amortization methodology (assumed to grow at 2.5% annually) and the entry-age normal actuarial cost method (which should grow about 3.5% to 4.25% annually) produce a combined ARC that is expected to increase by roughly 3.00% per year. The corridor will target this 3.00% and limit the dollar amount of the ARC so that it is within 2% of the prior year's ARC increased by the 3.00%. Another way to describe the corridor is to say that it limits the dollar amount of the ARC to between 101% and 105% of the prior year's ARC. The ARC for fiscal year 2023 is developed on page 12. The "ARC without Limitation" is the ARC developed without corridor smoothing. As shown on page 12, the actual FYE26 ARC is held higher as a result of the corridor because results since implementation of the smoothing corridor have overall been better than expected. The corridor will not only limit contribution increases in years when there is adverse experience, but it will also limit contribution decreases in years when there is favorable experience. The current position of the ARC to the corridor is expected to produce significant stability in the State contributions for many years into the future.

It should also be noted that the corridor is adjusted downward when employers contribute more than the ARC. This adjustment makes it so that employers can still lower their future ARCs by contributing more than the minimum required.

SECTION B

VALUATION RESULTS

Liabilities

The liabilities shown in the following exhibit were calculated as of July 1, 2023.

	Medical/ Prescription Drug/ Dental/Vision/Life	Medicare Part B	Total
Present Value of Benefits (PVB)			
Retirees	$ 4,699,898,000	$ 1,461,403,000	$ 6,161,301,000
Deferred Inactives	655,663,000	338,478,000	994,141,000
Actives	4,599,939,000	1,599,582,000	6,199,521,000
Total PVB	$ 9,955,500,000	$ 3,399,463,000	$ 13,354,963,000
Actuarial Accrued Liability (AAL)			
Retirees	$ 4,699,898,000	$ 1,461,403,000	$ 6,161,301,000
Deferred Inactives	655,663,000	338,478,000	994,141,000
Actives	3,202,427,000	1,032,538,000	4,234,965,000
Total AAL	$ 8,557,988,000	$ 2,832,419,000	$ 11,390,407,000
Normal Cost	$ 160,531,000	$ 67,696,000	$ 228,227,000

Projected Benefits

The table below provides the State of Hawaii's estimated benefit payments (pay-as-you-go) for the 15 years following the valuation date.

Projected Benefit Payments			
Year Ending June 30,	Medical/ Prescription Drug/ Dental/Vision/Life	Medicare Part B	Total
2024	$ 378,836,000	$ 104,917,000	$ 483,753,000
2025	405,570,000	113,663,000	519,233,000
2026	433,349,000	122,020,000	555,369,000
2027	461,607,000	130,834,000	592,441,000
2028	490,754,000	140,237,000	630,991,000
2029	519,936,000	150,157,000	670,093,000
2030	548,453,000	160,658,000	709,111,000
2031	577,685,000	171,605,000	749,290,000
2032	608,150,000	182,695,000	790,845,000
2033	639,444,000	194,143,000	833,587,000
2034	670,301,000	205,908,000	876,209,000
2035	699,733,000	218,090,000	917,823,000
2036	727,503,000	231,044,000	958,547,000
2037	755,965,000	244,170,000	1,000,135,000
2038	784,770,000	257,256,000	1,042,026,000

Plan Assets

Statement of Changes in Plan Net Assets		
	Year Ended June 30, 2023	Year Ended June 30, 2022
Assets available at beginning of year	$ 3,774,693,203	$ 3,732,999,638
Contributions	839,445,000	533,579,292
Transfer from retiree agency fund	7,693,319	0
Investment income	56,385,076	53,216,883
Appreciation / (depreciation)	121,731,828	(116,025,393)
Benefit payments	(428,181,899)	(421,467,799)
Investment fees	(6,136,714)	(7,289,900)
Administrative fees	(259,870)	(319,517)
Increase in net assets	590,676,740	41,693,565
Assets available at end of year	$ 4,365,369,943	$ 3,774,693,203
Investment return, net of expenses	4.32%	-1.85%

Investment returns were calculated based on the dollar-weighted methodology with the assumption that contributions and benefit payments were made mid-year.

Development of Actuarial Value of Assets

	Year Ending June 30, 2023
1. Actuarial value of assets, beginning of year	$ 3,820,804,000
2. Net new investments	
a. Contributions	$ 839,445,000
b. Benefit payments	(428,182,000)
c. Transfer from retiree agency fund	7,693,000
d. Administrative expenses	(260,000)
e. Subtotal	$ 418,696,000
3. Market value of assets at end of year	4,365,370,000
4. Expected return on actuarial value of assets	281,863,000
5. Expected actuarial value of assets, end of year	4,521,363,000
6. Excess/(shortfall) return (Item 3 - Item 5)	(155,993,000)

7. Development of amounts to be recognized as of June 30, 2023:

Fiscal Year End	Remaining Deferrals of Excess / (Shortfall) of Investment Income	Offsetting of Gains/(Losses)	Net Deferrals Remaining	Years Remaining	Recognized for this valuation	Remaining after this valuation
	(1)	(2)	(3) = (1) + (2)	(4)	(5) = (3) / (4)	(6) = (3) - (5)
2022	$ (46,111,000)	$ 0	$ (46,111,000)	3	$ (15,370,000)	$ (30,741,000)
2023	(109,882,000)	0	(109,882,000)	4	(27,471,000)	(82,411,000)
Total	$ (155,993,000)	$ 0	$(155,993,000)		$ (42,841,000)	$ (113,152,000)

8. Actuarial value of assets as of June 30, 2023 (Item 3 - Item 7)	$ 4,478,522,000
9. Ratio of actuarial value to market value	102.6%
10. Asset gain / (loss) for year (Item 8 - Item 5)	$ (42,841,000)

Determination of the ARC

Amortization of the Unfunded Actuarial Accrued Liability (UAAL)

Date Established	UAAL Balance 7/1/2023	Projected UAAL Balance 7/1/2024	Projected UAAL Balance 7/1/2025	Period Remaining 7/1/2025	Amortization Payment FYE26
7/1/2013	9,843,141,000	9,786,918,000	9,708,129,000	19	756,926,000
7/1/2015	(217,334,000)	(216,093,000)	(214,353,000)	19	(16,713,000)
7/1/2017	28,263,000	28,101,000	27,875,000	19	2,173,000
7/1/2018	(5,105,000)	(5,075,000)	(5,034,000)	19	(392,000)
7/1/2019	57,530,000	57,201,000	56,741,000	19	4,424,000
7/1/2020	(834,194,000)	(829,430,000)	(822,753,000)	19	(64,149,000)
7/1/2021	(904,578,000)	(899,411,000)	(892,171,000)	19	(69,561,000)
7/1/2022	(1,039,699,000)	(1,112,478,000)	(1,103,522,000)	19	(86,040,000)
7/1/2023	(16,139,000)	(17,269,000)	(18,478,000)	19	(1,441,000)
Total	$ 6,911,885,000	$ 6,792,464,000	$ 6,736,434,000	19.0	$ 525,227,000

The unfunded liability is amortized using a layered amortization base approach. Closed amortization bases will be established at each valuation for new unfunded liabilities. If experience produces a loss, the new base will be amortized over a period of 20 years. If experience produces a gain, the new base will be netted against the initial liability base. For fiscal year ending June 30, 2026, the Equivalent Single Amortization Period equals 19.0.

Annual Required Contribution without Limitation

	FYE 6/30/2026
Discount Rate	7.0%
Amortization Growth Rate	2.5%
Normal Cost*	$ 242,410,000
Amortization of UAAL	525,227,000
ARC without Limitation	$ 767,637,000

*Includes plan administration fees.

The Annual Required Contribution without Limitation is equal to the Normal Cost (the present value of benefits earned by the current employees in the respective fiscal year), plus projected plan administrative costs, plus an amortization payment to fund the liability attributable to past service calculated on the previous page.

Annual Required Contribution for Fiscal year Ending June 30, 2026

The combination of the level percentage of payroll UAAL amortization methodology (assumed to grow at 2.5% annually) and the entry-age normal actuarial cost method (which should grow about 3.5% to 4.25% annually) produce a combined ARC that is expected to increase by roughly 3.00% per year. The corridor will target this 3.00% and limit the dollar amount of the ARC so that it is within 2% of the prior year's ARC increased by the 3.00%. Another way to describe the corridor is to say that it limits the dollar amount of the ARC to between 101% and 105% of the prior year's ARC. As shown in the table below, the actual FYE26 ARC is held higher as a result of the corridor. The current position of the ARC to the corridor is expected to produce significant stability in the State contributions for many years into the future.

FYE 2023 Contributions in Excess of ARC	$ -
(1) FYE 2025 ARC	$ 830,204,000
(2) Calculated FYE 2026 ARC without Limitation	767,637,000
(2a) Increase from prior year	-7.5%
(3) 2% Corridor Lower Bound: [(1) x 1.01]	$ 838,506,000
(4) 2% Corridor Upper Bound: [(1) x 1.05]	871,714,000
(5) FYE 2026 ARC under 2% Corridor Methodology, MAX [(2),(3)] or MIN ((2),(4)]	**$ 838,506,000**
(5a) Increase in ARC from prior year	1.0%

Total Experience Gain or Loss

A. Calculation of total actuarial gain or loss

1.	Unfunded actuarial accrued liability (UAAL), as of July 1, 2022	$	7,087,270,000
2.	Normal cost for the year, including administrative expense		220,970,000
3.	Less: ACT 268 minimum required contribution		(839,445,000)
4.	Interest at 7.00%		
	a. On UAAL		496,109,000
	b. On normal cost		7,603,000
	c. On contribution		(28,884,000)
	d. Total	$	474,828,000
5.	Expected UAAL as of July 1, 2023 (Sum of Items 1 - 4)		6,943,623,000
6.	Actual UAAL as of July 1, 2023		6,911,885,000
7.	Total (gain)/loss for the year (Item 6 - Item 5)		(31,738,000)

B. Source of gains and losses

8.	Asset (gain)/loss for the year (AVA Table)	$	42,841,000
9.	(Gain)/loss due to contributions*		(7,693,000)
10.	Other liability (gain)/loss		(66,886,000)
11.	Change in assumptions		-
12.	Change in benefit provisions		-
13.	Total (gain)/loss for the year	$	(31,738,000)

** Impact of employer contributions.*

Schedule of Funding Progress

Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded AAL (b) - (a)	Funded Ratio (a)/(b)	Covered Payroll (c)	Unfunded AAL as a % of Covered Payroll (b - a)/(c)
July 1, 2007	$ 0	$ 8,788,892,000	$ 8,788,892,000	0.0%	$ 2,633,810,000	333.7%
July 1, 2009	0	14,007,480,000	14,007,480,000	0.0%	2,610,348,000	536.6%
July 1, 2011	0	13,566,836,000	13,566,836,000	0.0%	2,592,961,000	523.2%
July 1, 2013	0	8,529,546,000	8,529,546,000	0.0%	2,926,092,000	291.5%
July 1, 2015	221,194,000	9,287,120,000	9,065,926,000	2.4%	3,093,493,000	293.1%
July 1, 2017	879,517,000	10,194,187,000	9,314,670,000	8.6%	3,152,515,000	295.5%
July 1, 2018	1,290,918,000	10,704,565,000	9,413,647,000	12.1%	3,253,853,000	289.3%
July 1, 2019	1,829,458,000	11,382,908,000	9,553,450,000	16.1%	3,352,511,000	285.0%
July 1, 2020	2,371,060,000	11,272,718,000	8,901,658,000	21.0%	3,441,830,000	258.6%
July 1, 2021	3,477,138,000	11,602,201,000	8,125,063,000	30.0%	3,449,439,000	235.5%
July 1, 2022	3,820,804,000	10,908,074,000	7,087,270,000	35.0%	3,373,712,000	210.1%
July 1, 2023	4,478,522,000	11,390,407,000	6,911,885,000	39.3%	3,549,407,000	194.7%

As a result of ACT 268's funding requirements, the discount rate was changed from 4.00% to 7.00% in the July 1, 2013 valuation.
New demographic and healthcare assumptions were adopted in the July 1, 2017 valuation. The most significant assumption change was to reflect longer life expectancy.

Asset smoothing was first introduced in the July 1, 2018 valuation.

Minor updates to the demographic and healthcare assumptions were adopted in the July 1, 2019 valuation.

The healthcare trend assumption was updated in the July 1, 2020 valuation to reflect the repeal of the "Cadillac Tax".

New demographic and healthcare trend assumptions were adopted in the July 1, 2022 valuation. The most significant change was the healthcare trend assumption.

Actuarial Methods and Assumptions

Inflation rate	2.50%
Investment rate of return	7.00%
Actuarial Cost method	Individual Entry Age Normal
Amortization method*	Level percent, closed
Amortization Period	19.0 year Equivalent Single Amortization Period for FYE26
Amortization Growth Rate	2.50%
Wage Inflation	3.00%
Asset Method	Smoothed
Mortality	System-specific mortality tables utilizing scale MP2021 with immediate convergence to project generational mortality improvement
Participation rate	98% healthcare participation assumption for retirees that receive 100% of the Base Monthly Contribution (BMC). Healthcare participation rates of 25%, 65%, and 90% for retirees that receive 0%, 50%, or 75% of the base monthly contribution, respectively. 100% for Life Insurance and 98% for Medicare Part B
Healthcare cost trend rate	
PPO**	Initial rate of 6.30%, declining to a rate of 4.25% after 21 years
HMO**	Initial rate of 6.30%, declining to a rate of 4.25% after 21 years
Part B & Base Monthly Contribution	Initial rate of 5.00%, declining to a rate of 4.25% after 21 years
Dental	4.00%
Vision	2.50%
Life Insurance	0.00%

* Closed bases are established at each valuation for new unfunded liabilities.

** Includes prescription drug assumptions.

Trend Sensitivity

Actuarial valuations are based on the cost of benefits to be paid in the future. The payments considered will range from one month in the future to decades from the valuation date. When the benefits being valued are health benefits, a key factor is the future cost of the health benefits being promised. The future benefits are projected using the current cost of the health care benefits and assumed future health care cost increases. The final cost of providing retiree health care benefits will depend upon how the charges for health care services actually increase in the future.

In order to demonstrate how the cost of these benefits can vary depending upon future health care cost increases, we have performed additional valuations based upon alternative health care cost increase assumptions. The following table shows the impact of a 1.0% increase or decrease in the assumed healthcare trend rates.

	-1% Trend	Baseline	+1% Trend
Present Value of Benefits (PVB)	$ 11,369,275,000	$ 13,354,963,000	$ 15,961,082,000
Funded Status			
Actuarial Accrued Liability	$ 9,886,158,000	$ 11,390,407,000	$ 13,315,792,000
Actuarial Value of Assets	4,478,522,000	4,478,522,000	4,478,522,000
Unfunded AAL	5,407,636,000	6,911,885,000	8,837,270,000
ARC without Limitation for FYE26	$ 591,592,000	$ 767,637,000	$ 993,744,000

SECTION C

PROJECTIONS

Summary of Funding Projections

The projection in this section provides estimated future liabilities, assets, contributions and benefit payments based on the census data used for the July 1, 2023 valuation and the actuarial assumptions/methods described in Section G of this report. The projection provides insight into how the employer's contributions and the financial condition of the plan are assumed to change over time. Key items from the projection are:

- Prefunding the OPEB liability requires a significant commitment. However, the long-term savings will also be significant. Once the plan is well funded, the percentage of the benefits paid for by investment earnings is typically over 50%, meaning the State will be saving hundreds of millions and eventually over a billion dollars a year.
- The Annual Required Contribution (ARC) is developed using a level percentage of payroll amortization.
- The ARC is expected to remain fairly level, as a percentage of payroll, until the initial amortization base is paid off. However, the ARC is expected to trend upwards because the normal cost is expected to slowly grow over time as a percentage of payroll.
- Projection assumes the employer will contribute the full ARC, as required by ACT 268.
- The employer's annual cost for financing the retiree health benefit becomes less than what it would have been under a pay-as-you-go approach starting in FYE2035.
- As participants separate from employment, it is assumed they are replaced with an average new hire so that the total number of active employees remains level. The average new hire is assumed to have similar entry age and entry pay as recently hired employees. The projection includes liabilities for these new employees as the projection steps forward in time and they accrue benefits.

Please bear in mind that, depending on plan experience, actual results could deviate significantly from the actuarial projections. The key assumptions in the projections are:

1. the assumed 7.00% rate of investment return
2. future health care inflation
3. that the benefits and cost sharing provisions will remain the same as they currently are

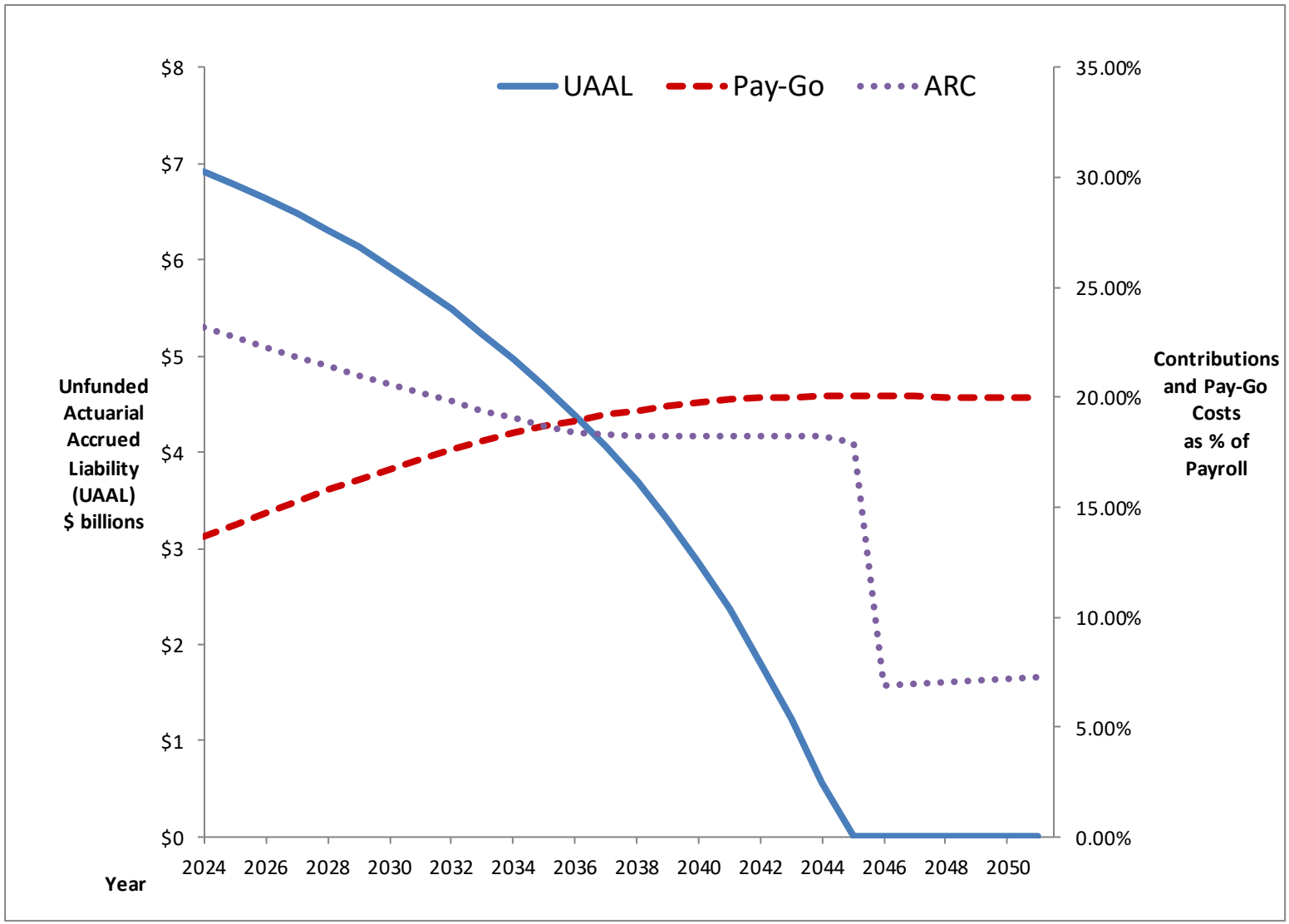
Projection of Funding Progress

Over the next 34 years, the sum of the ARCs equals $27.33 billion while the trust will payout $39.14 billion in benefits.

Fiscal Year Ending	Payroll	Actuarial Accrued Liability (AAL)	Actuarial Value of Assets (AVA)	Unfunded AAL (UAAL)	Funded Ratio	Annual Required Contribution	Actual Contribution	Contribution as % of Payroll	Benefit Payment Total	Benefits as % of Payroll	ARC minus Benefit Payments
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)
2024	$3,549,407,000	$11,390,407,000	$4,478,522,000	$6,911,885,000	39.3%	$821,984,000	$821,984,000	23.2%	$483,753,000	13.6%	$338,231,000
2025	3,655,889,000	11,923,417,000	5,141,610,000	6,781,807,000	43.1%	830,204,000	830,204,000	22.7%	519,233,000	14.2%	310,971,000
2026	3,765,566,000	12,464,120,000	5,822,909,000	6,641,211,000	46.7%	838,506,000	838,506,000	22.3%	555,369,000	14.7%	283,137,000
2027	3,878,533,000	13,012,588,000	6,523,098,000	6,489,490,000	50.1%	846,891,000	846,891,000	21.8%	592,441,000	15.3%	254,450,000
2028	3,994,889,000	13,560,538,000	7,242,618,000	6,317,920,000	53.4%	855,360,000	855,360,000	21.4%	630,991,000	15.8%	224,369,000
2029	4,114,736,000	14,113,326,000	7,981,378,000	6,131,948,000	56.6%	863,914,000	863,914,000	21.0%	670,093,000	16.3%	193,821,000
2030	4,238,178,000	14,671,383,000	8,740,243,000	5,931,140,000	59.6%	872,553,000	872,553,000	20.6%	709,111,000	16.7%	163,442,000
2031	4,365,323,000	15,235,794,000	9,520,796,000	5,714,998,000	62.5%	881,279,000	881,279,000	20.2%	749,290,000	17.2%	131,989,000
2032	4,496,283,000	15,806,369,000	10,323,442,000	5,482,927,000	65.3%	890,092,000	890,092,000	19.8%	790,845,000	17.6%	99,247,000
2033	4,631,171,000	16,382,722,000	11,148,394,000	5,234,328,000	68.0%	898,993,000	898,993,000	19.4%	833,587,000	18.0%	65,406,000
2034	4,770,106,000	16,964,697,000	11,996,077,000	4,968,620,000	70.7%	907,983,000	907,983,000	19.0%	876,209,000	18.4%	31,774,000
2035	4,913,209,000	17,553,401,000	12,868,297,000	4,685,104,000	73.3%	917,063,000	917,063,000	18.7%	917,823,000	18.7%	(760,000)
2036	5,060,606,000	18,151,068,000	13,767,909,000	4,383,159,000	75.9%	929,200,000	929,200,000	18.4%	958,547,000	18.9%	(29,347,000)
2037	5,212,424,000	18,759,937,000	14,700,911,000	4,059,026,000	78.4%	953,169,000	953,169,000	18.3%	1,000,135,000	19.2%	(46,966,000)
2038	5,368,797,000	19,380,606,000	15,680,986,000	3,699,620,000	80.9%	979,662,000	979,662,000	18.2%	1,042,026,000	19.4%	(62,364,000)
2039	5,529,861,000	20,014,319,000	16,713,727,000	3,300,592,000	83.5%	1,008,759,000	1,008,759,000	18.2%	1,083,668,000	19.6%	(74,909,000)
2040	5,695,756,000	20,662,953,000	17,805,770,000	2,857,183,000	86.2%	1,038,948,000	1,038,948,000	18.2%	1,124,987,000	19.8%	(86,039,000)
2041	5,866,629,000	21,328,603,000	18,962,730,000	2,365,873,000	88.9%	1,070,249,000	1,070,249,000	18.2%	1,166,216,000	19.9%	(95,967,000)
2042	6,042,628,000	22,013,282,000	20,190,394,000	1,822,888,000	91.7%	1,102,676,000	1,102,676,000	18.2%	1,206,103,000	20.0%	(103,427,000)
2043	6,223,907,000	22,720,445,000	21,496,264,000	1,224,181,000	94.6%	1,136,240,000	1,136,240,000	18.3%	1,245,528,000	20.0%	(109,288,000)
2044	6,410,624,000	23,452,873,000	22,887,469,000	565,404,000	97.6%	1,170,895,000	1,170,895,000	18.3%	1,285,036,000	20.0%	(114,141,000)
2045	6,602,943,000	24,371,023,000	24,371,023,000	0	100.0%	450,558,000	450,558,000	6.8%	1,324,497,000	20.1%	(873,939,000)
2046	6,801,031,000	25,172,470,000	25,172,470,000	0	100.0%	468,620,000	468,620,000	6.9%	1,363,913,000	20.1%	(895,293,000)
2047	7,005,062,000	26,007,914,000	26,007,914,000	0	100.0%	487,468,000	487,468,000	7.0%	1,403,615,000	20.0%	(916,147,000)
2048	7,215,214,000	26,880,252,000	26,880,252,000	0	100.0%	507,137,000	507,137,000	7.0%	1,444,612,000	20.0%	(937,475,000)
2049	7,431,670,000	27,791,574,000	27,791,574,000	0	100.0%	527,664,000	527,664,000	7.1%	1,487,250,000	20.0%	(959,586,000)
2050	7,654,620,000	28,743,802,000	28,743,802,000	0	100.0%	549,105,000	549,105,000	7.2%	1,531,297,000	20.0%	(982,192,000)
2051	7,884,259,000	29,739,283,000	29,739,283,000	0	100.0%	571,532,000	571,532,000	7.2%	1,577,984,000	20.0%	(1,006,452,000)
2052	8,120,787,000	30,779,336,000	30,779,336,000	0	100.0%	594,978,000	594,978,000	7.3%	1,626,869,000	20.0%	(1,031,891,000)
2053	8,364,410,000	31,865,859,000	31,865,859,000	0	100.0%	619,435,000	619,435,000	7.4%	1,677,613,000	20.1%	(1,058,178,000)
2054	8,615,343,000	33,001,229,000	33,001,229,000	0	100.0%	644,837,000	644,837,000	7.5%	1,730,344,000	20.1%	(1,085,507,000)
2055	8,873,803,000	34,187,786,000	34,187,786,000	0	100.0%	671,374,000	671,374,000	7.6%	1,784,862,000	20.1%	(1,113,488,000)
2056	9,140,017,000	35,428,438,000	35,428,438,000	0	100.0%	699,075,000	699,075,000	7.6%	1,841,396,000	20.1%	(1,142,321,000)
2057	9,414,217,000	36,726,090,000	36,726,090,000	0	100.0%	727,986,000	727,986,000	7.7%	1,901,290,000	20.2%	(1,173,304,000)

The projection includes liabilites for future employees.

Projection of Funding Progress
Trust contributions are projected to be less than benefits paid starting in FYE 2035



SECTION D

DEVELOPMENT OF BASELINE COSTS

Development of Baseline Costs

The underlying retiree claims costs were estimated using the plan premiums effective January 1, 2024, and are used for both current and future retirees. An inherent assumption in this methodology is that the projected future retirees will have a similar distribution by plan type as the current retirees (82% PPO and 18% HMO). The fully-insured retiree plans are separate from the active plans and are underwritten using the claims experience of the retired members only. The contracts for the retiree plans do not allow for any cross subsidization of premiums or rates. The prescription drug benefit for the PPO plan is self-insured. Based on conversations with EUTF's health care consultant (Segal), we did not believe it was necessary to independently verify the premiums for the PPO prescription drug benefit. The estimated age-adjusted claims shown below include administrative expenses and are net of prescription drug rebates.

Age-graded and sex-distinct premiums are utilized by this valuation. These costs are appropriate for the unique age and sex distribution currently existing. Over the future years covered by this valuation, the age and sex distribution will most likely change. Therefore, our process "distributes" the average premium over all age/sex combinations and assigns a unique premium for each combination. The age/sex specific costs more accurately reflect the health care utilization and cost at that age.

Baseline Costs for Retirees and Spouses (Medical and Prescription Drug) (Expected Monthly Per Capita Costs for 2024)				
	HMSA		Kaiser	
Age	Male	Female	Male	Female
50	$504.68	$621.72	$449.87	$554.20
55	664.10	725.10	591.98	646.36
60	857.72	844.56	764.58	752.85
65	436.30	411.51	397.81	375.22
70	475.28	459.91	433.36	419.34
75	510.46	498.10	465.44	454.16
80	535.89	526.52	488.62	480.07

Dental and vision benefits are not included in the benefits shown above. The underlying claims for the dental and vision benefits were not age-rated. Premiums for all medical, prescription drug, dental, and vision plans are shown in Section E.

SECTION E

SUMMARY OF BENEFIT PROVISIONS

Summary of the Substantive Plan Provisions

Plan Participants

Plan participants are retired members of the employees' retirement system; the County pension system; or the police, firefighters, or bandsmen pension system of the State or County.

Base Monthly Contribution Amount

January 1, 2024 - Base Monthly Contribution			
	Self	Two-Party	Family
Non-Medicare	$1,224.52	$2,468.20	$3,612.50
Medicare	872.30	1,748.34	2,546.42

The Base Monthly Contribution (BMC) determines the maximum amount provided by the employer to cover premiums for medical, prescription drug, dental and vision care. The BMC is adjusted annually based on the change in the Medicare Part B premium. The employer's costs for providing the Medicare Part B premium reimbursement and the life insurance benefit are in addition to the contribution related to the BMC.

Deferred Retirement

Employees who terminate employment are eligible for retiree health care benefits upon commencing a retirement or pension allowance.

Disability Retirement

Employees who terminate due to disability are eligible for retiree health care benefits upon commencing a retirement or pension allowance.

Non-Duty Death in Service Retirement

If an active employee dies while in service and is eligible to retire at the time of death, the ERS will retire the employee and the surviving spouse, domestic or civil union partner and eligible dependents are eligible for retiree health care benefits. If the member was not eligible for retirement at the time of death, the surviving spouse, domestic or civil union partner and eligible dependents are eligible for COBRA benefits only.

Duty Death in Service Retirement

The surviving spouse, domestic or civil union partner and eligible dependents of an employee who is killed in the performance of the employee's duty are eligible for retiree health care benefits. Regardless of the employee's date of hire or years of service, the employer will pay up to the BMC for a spouse, domestic or civil union partner and eligible dependents of an employee who is killed in the performance of duty. Coverage ends when the surviving spouse or domestic or civil union partner remarries or enters into another domestic or civil union partnership or when the surviving child reaches age 19 or 24 if the child is a full-time student.

Surviving Spouses of Retired Employees

The employer's contribution percentage for a surviving spouse, domestic or civil union partner and eligible dependent of a retiree who was hired prior to July 1, 2001 will remain the same as the deceased retiree. For a surviving spouse, domestic or civil union partner and eligible dependent of a retiree who was hired after June 30, 2001, the employer's contribution percentage will be half of the deceased retirees' employer contribution percentage.

Life Insurance

Retiree life insurance benefit is $1,487, and is provided at no cost to the retiree.

Medicare Part B Reimbursement

Retirees and spouses/domestic and civil union partners are required to enroll in Medicare Part B coverage when they become eligible and enroll in a medical and/or prescription drug plan. The employer reimburses the Part B premium for both retiree and, for participants hired before July 1, 2023, spouse/domestic or civil union partner at 100%. Surviving spouses/domestic or civil union partners, regardless of hire date, continue to receive the Part B reimbursement. The 2023 Medicare Part B premiums vary for current retirees due to the hold harmless provisions. The 2024 Part B premium is $174.70 per month for retirees enrolling in Part B for the first time or not enrolled in Social Security. For participants hired before July 1, 2023, EUTF will reimburse the entire Part B premium for retirees who pay income adjusted Part B premiums if they submit proof.

Employer's Contribution

The Employer's percentage of the BMC for the year determines the maximum employer contribution payable. Any difference between the maximum employer contribution and the total premium for plans selected (medical, prescription drug, dental and vision) will be paid by the retiree.

Hire Date	Year of Service	% of BMC*
Before 7/1/1996	< 10	50%
	10+	100%
Post 7/1/1996	< 10	0%
	10-14	50%
	15-24	75%
	25+	100%

* Employees hired after 6/30/2001 only receive the % of the "Self" BMC.

EUTF Monthly Retiree Rates
Effective January 1, 2024 through December 31, 2024

Benefit Plan	Type of Enrollment	Total Contribution Required
MEDICAL AND PRESCRIPTION DRUG PLANS – MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$251.52
	Two-Party	490.10
	Family	726.60
Humana Medicare Advantage PPO Medical Plan	Self	$51.88
	Two-Party (both Medicare)	103.76
	Three-Party (all Medicare; maximum of 3 enrollees)	155.64
SilverScript Prescription Drug Plan	Self	$235.34
	Two-Party	458.24
	Family	679.44
Kaiser Senior Advantage Medical and Prescription Drug Plan	Self	$462.50
	Two-Party	901.84
	Family	1,336.60
MEDICAL AND PRESCRIPTION DRUG PLANS - NON-MEDICARE		
HMSA 90/10 PPO Medical Plan	Self	$581.96
	Two-Party	1,133.96
	Family	1,681.08
CVS Caremark Prescription Drug Plan	Self	$244.24
	Two-Party	475.68
	Family	705.26
Kaiser HMO Comprehensive Medical and Prescription Drug Plan	Self	$763.08
	Two-Party	1,541.42
	Family	2,273.98
DENTAL PLAN		
HDS Dental	Self	$43.78
	Two-Party	85.38
	Family	104.62
VISION PLAN		
VSP Vision	Self	$3.54
	Two-Party	7.10
	Family	9.52
LIFE INSURANCE		
Securian Life Insurance (Retiree only)	Self	$4.12

HSTA VB Monthly Retiree Rates
Effective January 1, 2024 through December 31, 2024

Benefit Plan	Type of Enrollment	Total Contribution Required
MEDICAL AND PRESCRIPTION DRUG PLANS – MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, SilverScript Prescription Drug, and VSP Vision Plans	Self	$541.24
	Two-Party	1,054.72
	Family	1,560.86
Kaiser Senior Advantage Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$473.54
	Two-Party	923.60
	Family	1,367.82
MEDICAL AND PRESCRIPTION DRUG PLANS - NON-MEDICARE		
HMSA 90/10 PPO Medical and Chiropractic, CVS Caremark Prescription Drug, and VSP Vision Plans	Self	$795.52
	Two-Party	1,550.10
	Family	2,295.34
Kaiser HMO Comprehensive Medical, Chiropractic and Prescription Drug, and VSP Vision Plans	Self	$752.22
	Two-Party	1,519.46
	Family	2,240.64
DENTAL PLAN		
HDS Dental	Self	$51.80
	Two-Party	101.02
	Family	123.82
VISION PLAN		
VSP Vision	Self	$3.54
	Two-Party	7.10
	Family	9.52
LIFE INSURANCE		
Securian Life Insurance (Retiree only)	Self	$4.12

Medical Plan Benefits - EUTF
Non-Medicare Retirees

Medical	HMSA 90/10 PPO		Kaiser HMO
	In-Network	Out-of-Network	HMO Network
Calendar Year Deductible	$100 per person $300 per family		None
Calendar Year Maximum Out-of-Pocket Limit	$2,500 per person $7,500 per family		$2,000 per person $6,000 per family
Lifetime Benefit Maximum	None		None
Physician Office Visit	10%*	30%	$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge*	Not covered	No charge
Urgent Care Visit	10%*	30%	$15 (in service area) 20% (out of service area)
Emergency Room	10%*	10%*	$50 (in service area) 20% (out of service area)
Ambulance Air	20%	20%	20%
Ambulance Ground	20%	30%	20%
Inpatient Hospital Services	10%*	30%	No charge
Outpatient Surgery	10%*	30%	$15
Outpatient Testing, Lab and X-ray Services	20%*	30%	$15
Annual Physical Exam	No charge*	30%*	No charge
Preventative Screening	20%*	30%	No charge
Inpatient Mental Health	10%*	30%	No charge
Outpatient Mental Health	10%*	30%	$15
Chiropractic Services	Not covered	Not covered	Not covered

* Not subject to the deductible

Medical Plan Benefits – HSTA VB
Non-Medicare Retirees

Medical	HMSA 90/10 PPO		Kaiser HMO
	In-Network	Out-of-Network	HMO Network
Calendar Year Deductible	None	$100 per person $300 per family	None
Calendar Year Maximum Out-of-Pocket Limit	$2,000 per person $6,000 per family		$2,000 per person $6,000 per family
Lifetime Benefit Maximum	$2,000,000 for all individuals combined; $25,000/ calendar year thereafter		None
Physician Office Visit	10%	30%	$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge	Not covered	No charge
Urgent Care Visit	10%	30%	$15 (in service area) 20% (out of service area)
Emergency Room	10%	10%*	$50 (in service area) 20% (out of service area)
Ambulance Air	10%	10%*	20%
Ambulance Ground	10%	30%	20%
Inpatient Hospital Services	10%	30%	No charge
Outpatient Surgery	10%	30%	$15
Outpatient Testing, Lab and X-ray Services	10%	30%	$15
Annual Physical Exam	No charge (limits apply)	No charge* (limits apply)	No charge
Preventative Screening	10%	30%	No charge
Inpatient Mental Health	10%	30%	No charge
Outpatient Mental Health	10%	30%	$15
Chiropractic Services (administered through American Specialty Health, Inc.)	$12 (20 visits/year)	Not covered	$12 (20 visits/year)

* Not subject to the deductible

Prescription Drug Plan Benefits – EUTF
Non-Medicare Retirees

Prescription Drug	CVS PPO Drug Plan*			Kaiser HMO Plan+	
	In-Network	Out-of-Network**	Retail 90/Mail Order	HMO Network	Mail Order
Day Supply	30/60/90			30/60/90	
Generic	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10	$15/$30/$45	$15/$30/$30
Preferred Brand	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30		
Non-Preferred Brand	$30/$60/$90	$30/$60/$90 + 20%	$30/$60/$60		
Preferred Insulin	$5/$10/$15	$5/$10/$15 + 20%	$5/$10/$10	$15/$30/$45	Not covered
Other Insulin	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30		
Preferred Diabetic Supplies	No charge	20%	No charge	$15/$30/$45	$15/$30/$30
Other Diabetic Supplies	$15/$30/$45	$15/$30/$45 + 20%	$15/$30/$30		
Specialty Drugs/ Injectables	20% (up to a 30-day supply) Up to $250 per fill; $2,000 maximum out-of-pocket per calendar year; $30 copay for oral oncology specialty medications Mail Pharmacy: Not covered			$15 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

* This plan is the prescription drug coverage for the HMSA PPO medical plan option and is administered by CVS Caremark. Note: Maintenance medications can be filled at any retail network pharmacy or through mail order but must be filled in a 90-day supply after the first three 30-day initial fills.

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

+ The Kaiser prescription drug coverage is included under the Kaiser HMO medical plan.

Prescription Drug Plan Benefits – HSTA VB
Non-Medicare Retirees

Prescription Drug	CVS PPO Drug Plan*		Kaiser HMO Plan+	
	In-Network / Mail Order	Out-of-Network**	HMO Network	Mail Order
Day Supply	30/60/90		30/60/90	
Generic	$5/$9/$9	$5/$9/$9 + 30%	$10/$20/$30	$10/$20/$20
Brand	$15/$27/$27	$15/$27/$27 + 30%		
Insulin	$5/$9/$9	$5/$9/$9 + 30%	$10/$20/$30	Not covered
Diabetic Supplies	No charge	No charge	50%	50%
Specialty Drugs/ Injectables	Generic/brand copays apply Mail Pharmacy: Not covered		$10 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

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

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

+ The Kaiser prescription drug coverage is included under the Kaiser HMO medical plan.

Medical Plan Benefits – EUTF
Medicare Retirees

Medical	HMSA 90/10 PPO Plan (Supplemental Plan to Medicare)		Humana Medicare Advantage Plan	Kaiser Senior Advantage Plan
	In-Network	Out-of-Network	In-Network/ Out-of-Network	HMO Network
Calendar Year Deductible	$100 per person $300 per family		$100 per person	None
Calendar Year Maximum Out-of-Pocket Limit	$2,500 per person $7,500 per family		$2,500 per person	$2,000 per person $6,000 per family
Lifetime Benefit Maximum	None		None	None
Physician Office Visit	10%*	30%	10%*	$15
Online Care (through hmsaonlinecare.com, myhumana.com, or kp.org)	No charge*	Not covered	Primary Care: No charge Specialist: 10% Behavioral Health and Substance Abuse: No charge	No charge
Urgent Care Visit	10%*	30%	10%*	$20
Emergency Room	10%*	10%*	10%* (waived if admitted within 24 hours)	$50
Ambulance Air	20%	20%	10%	20%
Ambulance Ground	20%	30%	10%	20%
Inpatient Hospital Services	10%*	30%	10%	No charge
Outpatient Surgery	10%*	30%	10%	$15
Outpatient Testing, Lab, and X-ray Services	20%*	30%	10%	No charge
Annual Physical Exam	No charge*	30%*	No charge*	No charge
Preventative Screening	20%*	30%	No charge*	No charge
Inpatient Mental Health	10%*	30%	10%	No charge
Outpatient Mental Health	10%*	30%	Facility: 10% Physician visit: 10%*	$15
Chiropractic Services	Not covered	Not covered	10%* For Medicare-covered services only (manual manipulation of the spine to correct subluxation)	$15 For Medicare-covered services only (manual manipulation of the spine to correct subluxation)

* Not subject to the deductible

Medical Plan Benefits – HSTA VB
Medicare Retirees

Medical	HMSA 90/10 PPO Plan		Kaiser Senior Advantage Plan
	In-Network	Out-of-Network	HMO Network
Calendar Year Deductible	None	$100 per person $300 per family	None
Calendar Year Maximum Out-of-Pocket Limit	$2,000 per person $6,000 per family		$2,000 per person $6,000 per family
Lifetime Benefit Maximum	$2,000,000 for all individuals combined; $25,000/ calendar year thereafter		None
Physician Office Visit	10%	30%	$15
Online Care (through hmsaonlinecare.com or kp.org)	No charge	Not covered	No charge
Urgent Care Visit	10%	30%	$20
Emergency Room	10%	10%*	$50
Ambulance Air	10%	10%*	20%
Ambulance Ground	10%	30%	20%
Inpatient Hospital Services	10%	30%	No charge
Outpatient Surgery	10%	30%	$15
Outpatient Testing, Lab, and X-ray Services	10%	30%	No charge
Annual Physical Exam	No charge (limits apply)	No charge* (limits apply)	No charge
Preventative Screening	10%	30%	No charge
Inpatient Mental Health	10%	30%	No charge
Outpatient Mental Health	10%	30%	$15
Chiropractic Treatment (administered through American Specialty Health, Inc.)	$12 (20 visits per year)	Not covered	$12 (20 visits per year)

* Not subject to the deductible

Prescription Drug Plan Benefits – EUTF
Medicare Retirees

Prescription Drug	SilverScript (SSI) Medicare Part D PPO Drug Plan*		Kaiser Senior Advantage Plan+	
	In-Network/ Mail Order	Out-of-Network**	HMO Network	Mail Order
Day Supply	30/60/90		30/60/90	
Generic	$5/$10/$10	$5/$10/$10 + 20%	$15/$30/$45	$15/$30/$30
Preferred Brand	$15/$30/$30	$15/$30/$30 + 20%		
Non-Preferred Brand	$30/$60/$60	$30/$60/$60 + 20%		
Insulin	$5/$10/$10	$5/$10/$10 + 20%	$15/$30/$45	Not covered
Diabetic Supplies	No charge Meters: Covered by Medicare Part B and the HMSA and Humana medical plans	20% Meters: Covered by Medicare Part B and the HMSA and Humana medical plans	Lancets, strips & meters: 20% Syringes/ needles: $15/$30/$45	Lancets, strips & meters: 20% Syringes/ needles: $15/$30/$30
Specialty Drugs (including high-cost drugs as defined by CMS) and Injectables	20% (up to a 30-day supply) Up to $250 per fill; $2,000 In-Network maximum out-of-pocket per calendar year; $30 copay for oral oncology specialty medications Mail Pharmacy: Not covered	50% $30 copay (up to a 30-day supply) + 20% for oral oncology specialty medications	$15 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

* The EUTF's Medicare Part D prescription drug plan is administered by SilverScript (SSI), the Medicare Part D administrator for CVS Caremark. This plan is the prescription drug coverage for Medicare retirees enrolled in the HMSA and Humana PPO medical plan options and for stand-alone drug coverage.

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

+The Kaiser Medicare Part D prescription drug coverage is included under the Kaiser Permanente Senior Advantage medical plan.

Prescription Drug Plan Benefits – HSTA VB Medicare Retirees

Prescription Drug	SilverScript (SSI) Medicare Part D PPO Drug Plan*		Kaiser Senior Advantage Plan+	
	In-Network/Mail Order	Out-of-Network**	HMO Network	Mail Order
Day Supply	30/60/90		30/60/90	
Generic	$3/$9/$9	$3/$9/$9 + 30%	$10/$20/$30	$10/$20/$20
Brand	$9/$27/$27	$9/$27/$27 + 30%		
Insulin	$3/$9/$9	$3/$9/$9 + 30%	$10/$20/$30	Not covered
Diabetic Supplies	No charge Meters: Covered by Medicare Part B and the HMSA PPO medical plan	30% Meters: Covered by Medicare Part B and the HMSA PPO medical plan	20%	20%
Specialty Drugs/ Injectables	Generic/brand copays apply Mail Pharmacy: Not covered		$10 (up to a 30-day supply) Not all drugs can be mailed; restrictions and limitations apply	

* The HSTA VB's Medicare Part D prescription drug plan is administered by SilverScript (SSI), the Medicare Part D administrator for CVS Caremark. This plan is the prescription drug coverage for Medicare retirees enrolled in the HMSA PPO medical plan option.

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

+The Kaiser Medicare Part D prescription drug coverage is included under the Kaiser Permanente Senior Advantage medical plan.

Dental Plan Benefits (Hawaii Dental Service [HDS]) – EUTF & HSTA VB

DENTAL BENEFIT	PLAN COVERS
Plan Maximum per calendar year per member (Jan 1 - Dec 31)	$2,000
DIAGNOSTIC	
Examinations – 2 per calendar year	100%
Bitewing X-rays – 2 per calendar year through age 14; 1 per calendar year ages 15 and older	100%
Other X-rays – full mouth X-rays limited to 1 every 5 years	100%
PREVENTIVE	
Cleanings — 2 per calendar year, additional cleanings or gum maintenance covered for expectant mothers and members with a history of cancer treatment (chemotherapy or radiation), diabetes, Sjögren's syndrome, stroke, heart attack, congestive heart failure, kidney failure, or organ transplant	100%
Fluoride – 2 per calendar year through age 19, additional fluoride treatments for members with a history of certain cancers, Sjögren's syndrome, or at medical risk for cavities	100%
Silver Diamine Fluoride	100%
Space Maintainers – through age 17	100%
Sealants – through age 18 (one treatment per tooth per lifetime to permanent molars with no prior fillings on biting surfaces)	100%
BASIC CARE	
Fillings – silver fillings; white-colored fillings limited to front teeth	60%
Root Canals	60%
Gum Surgeries & Maintenance – cleaning (maintenance) for gum disease limited to 2 per calendar year after qualifying gum treatment where qualifying gum treatment is one or more of the following: • Root Planing and Scaling – 1 every 2 years per quadrant • Gum/Bone Surgeries – 1 every 3 years per quadrant	60%
Oral Surgeries	60%
MAJOR CARE	
Crowns – 1 every 5 years when teeth cannot be restored with silver or white fillings; white crowns limited to front teeth and bicuspids	60%
Fixed Bridges & Dentures – 1 every 5 years; age 16 and older	60%
Implants	60%
OTHER SERVICES	
Emergency Treatments of Dental Pain	100%

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

Vision Exam & Eye Wear Benefits: Members can have an eye exam and choose between a pair of lenses or contact lenses every calendar year. Frames are covered every other calendar year.

Vision Benefit	Frequency	In-Network	Out-of-Network Plan Pays
Exam	Every calendar year	$10 copay	Up to $45
Prescription Glasses		$25 copay	
Prescription Glasses Frame	Every other calendar year	$150 allowance plus 20% off out-of-pocket cost	Up to $47
Prescription Glasses Lenses:			
- Single vision lenses	Every calendar year	- Included in $25 copay	- Up to $45
- Lined bifocal lenses		- Included in $25 copay	- Up to $65
- Lined trifocal lenses		- Included in $25 copay	- Up to $85
- Impact-resistant lenses for dependent children up to age 18		- Included in $25 copay	- Not covered
- Standard progressive lenses		- Included in $25 copay	- Up to $85
- Premium progressive lenses		- $80-$90 copay	- Up to $85
- Custom progressive lenses		- $120-$160 copay	- Up to $85
- Lenticular lenses		- No charge	- Up to $125
- UV protection		- No charge	- Not covered
Contact Lenses			
- Contact lenses (elective)	Every calendar year	- $130 allowance	- Up to $105
- Contact lenses (medically necessary)		- No charge	- Up to $210
- Contact lenses fitting and evaluation		- $60 copay max	- Not covered

Extra Discounts and Savings from VSP Providers

Glasses & Sunglasses

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

Retinal Screening

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

Contact Lenses

- VSP partners with leading contact lens manufacturers to provide VSP members exclusive offers. Check out www.vsp.com for details

Laser Vision Correction

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

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

Summary of Benefit Eligibility
(For Members Hired Prior to 7/1/2012)

	Noncontributory Plan	Contributory Plan	Hybrid Plan
Normal Retirement	Age 62 and 10 years credited service; or age 55 and 30 years credited service	Age 55 and 5 years credited service	Age 62 and 5 years credited service; or age 55 and 30 years credited service
Early Retirement	Age 55 and 20 years credited service	Any age and 25 years credited service	Age 55 with 20 years credited service
Deferred Vesting	10 years credited service	5 years credited service and contributions left in the ERS	5 years credited service and contributions left in the ERS
Ordinary Disability	10 years credited service	10 years credited service	10 years credited service
Service-Connected Disability	Any age or credited service	Any age or credited service	Any age or credited service
Ordinary Death	Active employee at time of death with at least 10 years of credited service	Active employee at time of death with at least 1 year of service	Active employee at time of death with at least 5 years of service
Service-Connected Death	Any age or service	Any age or service	Any age or service

The benefit eligibilities summarized above apply to teachers and most State and County employees. Special provisions applicable to other groups of employees are outlined below:

Police officers, firefighters, investigators of the Department of the Prosecuting Attorney and the Attorney General, narcotic enforcement investigators, and public safety investigators may retire at age 55 with 5 years of credited service or at any age with 25 years of credited service.

Judges, elected officials, and legislative officers may retire at age 55 with at least 5 years of credited service, or at any age with at least 10 years of credited service. Judges hired after June 30, 1999 require 25 years of credited service in order to retire before age 55.

Sewer workers in specified classifications, water safety officers, and emergency medical technicians (EMTs) may retire at any age if they are credited with 25 years of such service with the last 5 or more years in these occupations. (The 25-year feature is phased in through 7/1/2008 for EMTs.)

Sewer workers in specified classifications, water safety officers, and emergency medical technicians (EMTs) that transfer to the Hybrid Plan may retire at age 62 with 5 years of credited service or at any age if they are credited with 25 years of such service with the last 5 or more years in these occupations.

Summary of Benefit Eligibility
(For Members Hired After 6/30/2012)

	Contributory Plan (for Police/Fire)	Contributory Plan (for Judges/Elected Officers)	Hybrid Plan
Normal Retirement	Age 60 and 10 years credited service	Age 60 and 10 years credited service	Age 65 and 10 years credited service; or age 60 and 30 years credited service Sewer workers, water safety officers, and EMTs may retire with 25 years credited service at age 55
Early Retirement	Age 55 and 25 years credited service	Age 55 and 25 years credited service any age with 10 years for elected officers	Age 55 with 20 years credited service Sewer workers, water safety officers, and emergency medical technicians (EMTs) may retire with 25 years credited service
Deferred Vesting	10 years credited service and contributions left in the ERS	10 years credited service and contributions left in the ERS	10 years credited service and contributions left in the ERS
Ordinary Disability	10 years credited service	10 years credited service	10 years credited service
Service-Connected Disability	Any age or credited service	Any age or credited service	Any age or credited service
Ordinary Death	Active employee at time of death with at least 1 year of credited service	Active employee at time of death with at least 1 year of credited service	Active employee at time of death with at least 10 years of service
Service-Connected Death	Any age or service	Any age or service	Any age or service

SECTION F

SUMMARY OF PARTICIPANT DATA

Active Employee Age/Service Distribution

Attained Age	Years of Credited Service												
	0	1	2	3	4	5-9	10-14	15-19	20-24	25-29	30-34	35 & Over	Total
Under 25	455	179	31	14	9	1	-	-	-	-	-	-	689
25-29	662	713	461	371	288	268	-	-	-	-	-	-	2,763
30-34	510	518	330	398	437	1,717	159	-	-	-	-	-	4,069
35-39	399	403	278	362	409	1,673	1,197	191	-	-	-	-	4,912
40-44	374	395	255	307	354	1,563	1,233	1,400	163	-	-	-	6,044
45-49	306	334	206	289	298	1,296	1,047	1,447	1,272	108	2	-	6,605
50-54	243	273	161	237	235	1,074	920	1,187	1,405	1,176	222	-	7,133
55-59	168	210	124	174	188	885	701	1,074	1,050	995	1,028	118	6,715
60-64	101	137	87	145	166	729	617	840	892	645	767	433	5,559
65 & Over	71	69	51	89	108	546	538	593	639	423	493	600	4,220
Total	3,289	3,231	1,984	2,386	2,492	9,752	6,412	6,732	5,421	3,347	2,512	1,151	48,709

Inactive Age Distribution

Age	Deferred Inactives	Retirees	Total
<35	45	8	53
35-39	536	2	538
40-44	1,010	16	1,026
45-49	1,196	26	1,222
50-54	1,434	85	1,519
55-59	1,502	890	2,392
60-64	1,225	2,875	4,100
65-69	417	6,587	7,004
70-74	132	8,706	8,838
75-79	16	8,392	8,408
80-84	4	5,398	5,402
85-89	3	3,651	3,654
90-94	0	2,420	2,420
95+	0	1,080	1,080
Total	7,520	40,136	47,656

State of Hawaii
Distribution by Health Plan and Coverage Type

Actives

	Single	Two-Party	Family	Waived	Total
PPO	15,053	4,407	6,446	0	25,906
HMO	6,251	1,841	2,335	0	10,427
Others	121	102	220	0	443
Waived				11,933	11,933
Total Medical					**48,709**
Dental	21,063	8,598	9,343	9,705	**48,709**
Vision	20,762	7,935	8,569	11,443	**48,709**

Retirees

	Single	Two-Party	Family	Total
PPO	19,094	11,407	702	31,203
HMO	3,913	1,790	105	5,808
Medicare Adv	32	7	0	39
Others	105	52	3	160
Total Medical				**37,210**
Dental	23,119	13,952	820	**37,891**
Vision	23,081	13,885	828	**37,794**
Life				**36,178**

SECTION G

ACTUARIAL ASSUMPTIONS AND METHODS

Summary of Actuarial Assumptions and Methods

The actuarial assumptions used in the valuation are shown in this Section. Assumptions that are specific to certain groups (i.e. General Employees, Teachers, Police and Firefighters) are discussed under the first subsection that follows. Assumptions that are common to all types of members and unique to this valuation are then shown on the following pages.

Demographic and Certain Economic Assumptions

This actuarial valuation of the OPEB is similar to the actuarial valuations performed for ERS. All of the demographic assumptions and most of the economic assumptions used in this OPEB Valuation were identical to those used in the June 30, 2023 retirement system valuations performed by Gabriel, Roeder, Smith and Company. The assumptions which are common to the pension and OPEB valuations are described in Appendix A of this report.

Healthcare and Other Economic Assumptions

General Inflation was assumed to be 2.50% per year.

The rate of investment return was assumed to be 7.00% a year, compounded annually net after investment expenses. The assumed real return is the rate of return in excess of price inflation. Considering other assumptions used in the valuation, the nominal rate translates to a net real return of 4.50% a year.

Health Cost and Premium Increases – *See table below*

Year	HMSA (PPO)	Kaiser (HMO)	Dental	Vision	Part B Premiums
2025	6.30%	6.30%	4.00%	2.50%	5.00%
2026	6.20%	6.20%	4.00%	2.50%	5.00%
2027	6.10%	6.10%	4.00%	2.50%	5.00%
2028	6.00%	6.00%	4.00%	2.50%	5.00%
2029	5.90%	5.90%	4.00%	2.50%	5.00%
2030	5.80%	5.80%	4.00%	2.50%	5.00%
2031	5.70%	5.70%	4.00%	2.50%	5.00%
2032	5.60%	5.60%	4.00%	2.50%	5.00%
2033	5.50%	5.50%	4.00%	2.50%	5.00%
2034	5.40%	5.40%	4.00%	2.50%	5.00%
2035	5.30%	5.30%	4.00%	2.50%	5.00%
2036	5.20%	5.20%	4.00%	2.50%	5.00%
2037	5.10%	5.10%	4.00%	2.50%	5.00%
2038	5.00%	5.00%	4.00%	2.50%	5.00%
2039	4.90%	4.90%	4.00%	2.50%	4.90%
2040	4.80%	4.80%	4.00%	2.50%	4.80%
2041	4.70%	4.70%	4.00%	2.50%	4.70%
2042	4.60%	4.60%	4.00%	2.50%	4.60%
2043	4.50%	4.50%	4.00%	2.50%	4.50%
2044	4.40%	4.40%	4.00%	2.50%	4.40%
2045	4.30%	4.30%	4.00%	2.50%	4.30%
2046	4.25%	4.25%	4.00%	2.50%	4.25%

The premiums for 2024 were known at the time of the valuation. The first trend rate shown above is assumed to occur at 1/1/2025. Future increases are also assumed to occur on 1/1. The HMSA and Kaiser trend rates are blended rates used to project both medical and prescription drug costs.

The trend rates shown above for the Part B premiums apply to the BMC and the Part B premiums.

The 4.25% ultimate trend assumption for the HMSA and Kaiser plans is comprised of 2.50% long-term price inflation + 1.75% real GDP growth.

Healthcare and Other Economic Assumptions (Continued)

Plan Participation

The plan participation rates were assumed to vary based on the employer contribution percentage, as follows:

Employer Contribution	Rates of Participation		
	Medical, Prescription Drug, Dental and Vision	Life Insurance	Medicare Part B
0%	25%	100%	98%
50%	65%	100%	98%
75%	90%	100%	98%
100%	98%	100%	98%

The same assumptions were used for terminated participants with vested pension benefits. However, current active employees who terminate service prior to the age of 35 are not assumed to ever participate in the retiree health plan.

For current retirees, the actual family coverage election is used. For future retirees, the family coverage assumptions are 35% single / 50% two-party / 15% family prior to age 65 and 50% single / 50% two-party after the age of 65. It was assumed 45% of eligible future retirees would receive Medicare Part-B reimbursements for a spouse. For those that elect two-party or family coverage, it was assumed that coverage would continue to the spouse upon death of the retiree.

Plan Elections

For current retirees, plan elections were based on the plan in which they are currently enrolled. For future retirees, plan participation was assumed to be 82% HMSA / 18% Kaiser.

Administration Fees

The following table provides the 2024 monthly administration fees. The EUTF Board approved to pay third party administration fees through December 31, 2028, using the Agency Fund assets. As a result, it was assumed that the administration fees would be in addition to the premiums shown in Section E for years after 2028.

Monthly Fee	Single Party	Two-Party	Family
Medical and Drug	$5.42	$10.84	$16.26
Dental	0.36	0.72	1.08
Vision	0.04	0.08	0.12
Life	0.04	0.04	0.04

Healthcare and Other Economic Assumptions (Continued)

Aging Factors: In any given year, the cost of medical and prescription drug benefits vary by age. As the ages of retirees in the covered population increase so does the cost of benefits. Morbidity tables are employed to develop Per Capita Costs at every relevant age. The following table represents the percent by which the cost of medical and prescription drug benefits at one age is higher than the cost for the previous age. For example, according to the following table, the cost of benefits for a male age 55 is 5.50% higher than for one age 54. These percentages below are separate from the annual Medical Trend, which operates to increase costs independent of and in addition to the Aging Factors shown below.

Sample Ages	Cost Increases by Age	
	Male	Female
45	4.66%	1.88%
50	5.83%	3.53%
55	5.50%	2.85%
60	5.06%	3.45%
65	3.34%	3.28%
70	1.77%	2.02%
75	1.15%	1.32%
80	0.82%	1.05%
85	-0.27%	0.49%
90	-0.32%	0.03%

Actuarial Methods

The individual entry age actuarial cost method was used in determining liabilities and normal cost. Differences between assumed experience and actual experience ("actuarial gains and/or losses") become part of actuarial accrued liabilities.

Unfunded actuarial accrued liabilities are amortized to produce payments (principal & interest) which are a level percent of payroll. Closed bases will be established at each valuation for new unfunded liabilities. If experience produces a loss, the new base will be amortized over a period of 20 years. Experience gains will be amortized over the same period as the initial liability base, until the initial liability base is fully amortized.

Miscellaneous and Technical Assumptions

Actuarial Value of Assets	The actuarial value of assets is based on the market value of assets with a four-year phase-in of actual investment return in excess of (less than) expected investment income. Offsetting unrecognized gains and losses are immediately recognized, with the shortest remaining bases recognized first and the net remaining bases continue to be recognized on their original timeframe. The expected actuarial value of assets is calculated net of investment expenses, and the expected investment return is equal to the assumed investment return rate multiplied by the prior year's actuarial value of assets, adjusted for contributions, benefits paid, and refunds.
Claims Utilization	To model the impact of aging on the underlying health care costs, the valuation relied on the Society of Actuaries' 2013 Study "Health Care Costs – From Birth to Death". Chart 1 (2010 Aggregate Commercial Costs) was used to model the impact of aging for ages less than 65 and Table 4 (Development of Plan Specific Medicare Age Curve) was used to model the impact of aging for ages 65 and over.
Marriage Assumption	100% of males and females are assumed to be married for purposes of death-in-service benefits. For future retirees, husbands are assumed to be four years older than wives.
Pay Increase Timing	Beginning of (fiscal) year. This is equivalent to assuming that reported pays represent amounts paid to members during the year ended on the valuation date.
Decrement Timing	Except for teachers, decrements of all types are assumed to occur mid-year. For teachers, the normal retirement, early retirement and termination decrements are assumed to occur at the beginning of the year.
Eligibility Testing	Eligibility for benefits is determined based upon the age nearest birthday and service nearest whole year on the date the decrement is assumed to occur.
Decrement Operation	Disability and mortality decrements are added to the termination decrements during the first 5 years. Disability is added to the retirement decrement during retirement eligibility.

Miscellaneous and Technical Assumptions (continued)

Deferred Age	Terminated employees with vested pension benefits are assumed to commence their benefit at age 62 or their current age if they are older than 62 as of the valuation date.
Timing of ARC Contributions	The ARC is assumed to be received at the middle of the year.
Administrative Expenses	Third party administrative expenses related to providing benefits are included in the age-rated costs. The administrative costs related to operating the trust are included in the normal cost.
Reliance on Other Actuaries	We have relied on the premiums developed by Segal Consulting for the self-insured prescription drug benefit.
Assumption, Method And Plan Changes	There were no assumption changes this year.

APPENDIX A

DEMOGRAPHIC AND CERTAIN ECONOMIC ASSUMPTIONS

Demographic and Certain Economic Assumptions

A. Economic Assumptions

1. Wage inflation: 3.00% per annum

2. Salary increase rate: As shown below

	General Employees		Teachers	
Years of Service	Service-related Component	Total Rate Including 2.50% Inflation Component and 1.25% Productivity Component	Service-related Component	Total Rate Including 2.50% Inflation Component and 1.25% Productivity Component
1	3.00%	6.75%	3.00%	6.75%
2	3.00%	6.75%	3.00%	6.75%
3	2.00%	5.75%	2.00%	5.75%
4	1.50%	5.25%	1.50%	5.25%
5	1.50%	5.25%	1.50%	5.25%
6	1.25%	5.00%	1.25%	5.00%
7	1.25%	5.00%	1.25%	5.00%
8	1.00%	4.75%	1.00%	4.75%
9	1.00%	4.75%	1.00%	4.75%
10	1.00%	4.75%	1.00%	4.75%
11	0.75%	4.50%	0.75%	4.50%
12	0.75%	4.50%	0.75%	4.50%
13	0.50%	4.25%	0.50%	4.25%
14	0.50%	4.25%	0.50%	4.25%
15	0.50%	4.25%	0.50%	4.25%
16	0.50%	4.25%	0.50%	4.25%
17	0.50%	4.25%	0.50%	4.25%
18	0.50%	4.25%	0.50%	4.25%
19	0.50%	4.25%	0.50%	4.25%
20	0.25%	4.00%	0.25%	4.00%
21	0.25%	4.00%	0.25%	4.00%
22	0.25%	4.00%	0.25%	4.00%
23	0.25%	4.00%	0.25%	4.00%
24	0.25%	4.00%	0.25%	4.00%
25 or more	0.00%	3.75%	0.00%	3.75%

2. Salary increase rates (continued):

	Police & Firefighters	
Years of Service	Service-related Component	Total Annual Rate of Increase Including 2.50% Inflation Component and 2.50% General Increase Rate
1	1.00%	6.00%
2	1.00%	6.00%
3	1.00%	6.00%
4	1.00%	6.00%
5	1.00%	6.00%
6	1.00%	6.00%
7	1.00%	6.00%
8	1.00%	6.00%
9	1.00%	6.00%
10	1.00%	6.00%
11	1.00%	6.00%
12	1.00%	6.00%
13	1.00%	6.00%
14	1.00%	6.00%
15	1.00%	6.00%
16	0.75%	5.75%
17	0.75%	5.75%
18	0.75%	5.75%
19	0.50%	5.50%
20	0.50%	5.50%
21	0.50%	5.50%
22	0.25%	5.25%
23	0.25%	5.25%
24	0.25%	5.25%
25 or more	0.00%	5.00%

Salary increases are assumed to occur once a year, on July 1. Therefore the pay used for the period between the valuation date and the first anniversary of the valuation date is equal to the reported pay for the prior year, annualized if necessary, and then increased by the salary increase assumption. To adjust the pays received as of March 31st to the June 30th valuation date, the reported pay for each member is increased by 1%.

B. Demographic Assumptions

1. Mortality rates:

Active Members: Multiples of the Pub-2010, Employee Tables for active employees based on the occupation of the member as follows:

	General Employees	Teachers	Police and Fire
Type	Male & Female	Male & Female	Male & Female
Ordinary	94%	92%	80%
% of Ordinary Choosing Annuity	41%	52%	24%
Duty Related	6%	8%	20%

Healthy Retirees: The 2022 Public Retirees of Hawaii mortality tables. The rates are projected on a fully generational basis by scale MP21 with immediate convergence from the year 2022 and with multipliers and setbacks based on plan and group experience. The following are sample rates of the base table with the corresponding multipliers:

Healthy Annuitant Mortality Rates Before Projection (Multiplier Applied)

	General Employees		Teachers		Police and Fire	
Age	Male	Female	Male	Female	Male	Female
50	0.2094%	0.1276%	0.1698%	0.0951%	0.2421%	0.1130%
55	0.3215%	0.1687%	0.2883%	0.1596%	0.3473%	0.1633%
60	0.5570%	0.3095%	0.4672%	0.2467%	0.6179%	0.2799%
65	0.8041%	0.4488%	0.7256%	0.4063%	0.8426%	0.4283%
70	1.2621%	0.7066%	1.0762%	0.6015%	1.4172%	0.6565%
75	2.0700%	1.0964%	1.7879%	0.9358%	2.3227%	1.0121%
80	3.5996%	2.1275%	3.0429%	1.6565%	4.1824%	1.8863%
85	6.5891%	4.1569%	5.5564%	3.2698%	7.6513%	3.6977%
90	11.9340%	8.3647%	10.1056%	6.5007%	13.6689%	7.3991%
Multiplier	102%	98%	97%	101%	93%	100%
Setback	0	-1	1	1	-2	0

The following table provides the life expectancy for individuals retiring in future years based on the assumption with full generational projection:

Life Expectancy for an Age 65 Retiree in Years

	Year of Retirement				
Gender	2025	2030	2035	2040	2045
	General Retirees				
Male	22.8	23.2	23.5	23.9	24.2
Female	26.3	26.6	26.9	27.2	27.5
	Teachers				
Male	24.1	24.5	24.9	25.2	25.5
Female	28.0	28.3	28.6	28.9	29.2
	Police and Fire				
Male	21.8	22.1	22.4	22.8	23.1
Female	27.1	27.4	27.7	28	28.3

Disabled retirees: Base Table for healthy retirees' occupation, set forward 3 years, generational projection using the UMP projection table from the year 2022. Minimum mortality rate of 3.5% for males and 2.5% for females.

2. Disability rates – The assumed total disability rates at select ages are multiples of the client specific table that follows:

Age	Male & Female
25	0.000%
30	0.001%
35	0.008%
40	0.026%
45	0.064%
50	0.146%
55	0.198%
60	0.217%

Note: The disability rates project the percentage of employees at each age that is assumed to become disabled before retiring. Multiples of the rates above are assumed to be ordinary disability or accidental disability, and varies by employee group as follows:

	General Employees	Teachers	Police and Fire
Type	Male & Female	Male & Female	Male & Female
Ordinary	200%	100%	50%
Accidental	60%	8%	120%

3. Termination Rates - Same male and female rates, based solely on the member's service. Rates reflect terminations for causes other than death, disability or retirement. Employees eligible for retirement are assumed to have no probability of termination. Sample rates are shown below:

	Expected Terminations per 1000 Lives (Male & Female)		
Years of Service	General Employees	Teachers	Police & Fire
0	177.2	0.0	140.0
1	142.2	197.9	52.4
2	114.2	165.2	41.3
3	92.0	134.8	34.8
4	74.8	108.2	30.2
5	61.7	86.3	26.6
6	51.9	69.4	23.7
7	44.7	57.3	21.3
8	39.6	49.4	19.1
9	35.8	44.5	17.2
10	32.8	41.0	15.6
11	30.3	35.8	10.6
12	27.9	32.4	10.0
13	22.6	29.1	9.4
14	19.8	26.1	8.8
15	17.7	23.2	8.2
16	16.1	20.6	7.6
17	14.8	18.1	7.0
18	13.7	15.8	6.4
19	12.8	13.6	5.8
20	11.9	11.7	5.2
21	11.1	10.0	4.6
22	10.2	8.4	4.0
23	9.3	7.0	3.4
24	8.3	5.8	2.8
25	7.1	4.8	0.0
26	6.0	4.0	0.0
27	4.7	3.3	0.0
28	3.5	2.8	0.0
29	2.4	2.6	0.0
30 and more	0.0	0.0	0.0

4. Retirement rates - Separate male and female rates, based on age. Sample rates are shown below:

Contributory Members

Expected Retirements per 100 Lives

	General Employees				Teachers				Police/Fire
	Unreduced Retirement		Reduced Retirement		Unreduced Retirement		Reduced Retirement		Unreduced Retirement
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male & Female
45	0	0	0	0	0	0	0	0	15.5
46	0	0	0	0	0	0	0	0	15.5
47	0	0	0	0	0	0	0	0	15.5
48	0	0	0	0	0	0	0	0	15.5
49	0	0	0	0	0	0	0	0	15.5
50	0	0	0	0	0	0	1	0	18.0
51	0	0	2	1	0	0	1	1	18.0
52	0	0	2	1	0	0	1	1	18.0
53	0	0	2	1	0	0	2	2	18.0
54	0	0	3	2	0	0	3	3	18.0
55	25	20			20	18			22.0
56	25	20			15	16			22.0
57	16	13			15	16			22.0
58	16	13			15	16			24.0
59	13	13			15	16			27.0
60	13	15			14	18			30.0
61	13	15			14	18			30.0
62	28	25			14	25			30.0
63	20	20			14	20			30.0
64	20	20			14	15			30.0
65	20	20			20	25			100.0
66	18	20			15	25			
67	18	20			15	20			
68	18	20			15	20			
69	18	20			15	20			
70	20	20			15	20			
71	20	20			15	20			
72	20	20			15	20			
73	20	20			15	20			
74	20	20			15	20			
75	100	100			100	100			

Noncontributory Members

	Expected Retirements per 100 Lives									
	General Employees						Teacher			
	Unreduced		25 & Out		Reduced		Unreduced		Reduced Retirement	
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
55	20	11	15	11	1	1	10	13	1	2
56	18	11	23	11	1	1	10	7	1	2
57	13	11	18	11	1	1	10	8	1	2
58	10	11	15	11	2	2	10	10	2	2
59	10	11	15	11	2	2	10	20	3	3
60	10	14	15	14	4	4	10	11	5	5
61	11	18	16	18	4	4	10	16	7	5
62	20	20	25	20			16	25		
63	20	20	25	20			12	20		
64	12	20	17	20			10	15		
65	14	20	19	20			20	25		
66	20	20	25	20			15	25		
67	20	20	25	20			15	25		
68	20	20	25	20			15	25		
69	20	20	25	20			15	25		
70	20	20	25	20			15	25		
71	20	20	25	20			15	25		
72	20	20	25	20			15	25		
73	20	20	25	20			15	25		
74	20	20	25	20			15	25		
75	100	100	100	100			100	100		

Note: Retirement rates for the 25&out group age 50-54 are 15% for male and 11% for female.

Hybrid Members

	Expected Retirements per 100 Lives							
	General Employees				Teachers			
	Unreduced		Reduced		Unreduced		Reduced	
Age	Male	Female	Male	Female	Male	Female	Male	Female
55	18	18	1	1	20	16	2	2
56	12	13	1	1	13	10	2	2
57	12	13	1	1	13	10	2	2
58	16	13	2	2	13	12	2	2
59	16	13	2	2	13	12	3	3
60	14	13	4	4	14	14	3	5
61	14	15	4	4	14	18	3	10
62	21	20			22	30		
63	18	20			14	20		
64	18	20			14	20		
65	21	20			20	25		
66	18	18			15	25		
67	18	18			15	25		
68	18	18			15	25		
69	18	18			15	25		
70	20	20			15	25		
71	20	20			15	25		
72	20	20			15	25		
73	20	20			15	25		
74	20	20			15	25		
75	100	100			100	100		

Note: For the 25&out group with membership dates before July 1, 2012, the retirement rates prior to age 55 are 6% for both male and female.

For members hired after June 30, 2012 the retirement rates for members once they reach unreduced retirement eligibility are increased 10% (multiplicative) for each year the member is beyond the age the member would have been eligible under the Hybrid provisions for members hired prior to June 30, 2012.

APPENDIX B

GLOSSARY

Glossary

Accrued Service. The service credited under the plan which was rendered before the date of the actuarial valuation.

Actuarial Accrued Liability. The difference between (i) the actuarial present value of future plan benefits, and (ii) the actuarial present value of future normal cost. Sometimes referred to as "accrued liability" or "past service liability."

Actuarial Assumptions. Estimates of future plan experience with respect to rates of mortality, disability, turnover, retirement, rate or rates of investment income and salary increases. Decrement assumptions (rates of mortality, disability, turnover and retirement) are generally based on past experience, often modified for projected changes in conditions. Economic assumptions (salary increases and investment income) consist of an underlying rate in an inflation-free environment plus a provision for a long-term average rate of inflation.

Actuarial Cost Method. A mathematical budgeting procedure for allocating the dollar amount of the "actuarial present value of future plan benefits" between the actuarial present value of future normal cost and the actuarial accrued liability. Sometimes referred to as the "actuarial funding method."

Actuarial Equivalent. A single amount or series of amounts of equal value to another single amount or series of amounts, computed on the basis of the rate(s) of interest and mortality tables used by the plan.

Actuarial Present Value. The amount of funds presently required to provide a payment or series of payments in the future. It is determined by discounting the future payments at a predetermined rate of interest, taking into account the probability of payment.

Amortization. Paying off an interest-bearing liability by means of periodic payments of interest and principal, as opposed to paying it off with a lump sum payment.

Annual Required Contribution (ARC). The ARC is the normal cost plus the portion of the unfunded actuarial accrued liability to be amortized in the current period. The ARC is an amount that is actuarially determined in accordance with the requirements so that, if paid on an ongoing basis, it would be expected to provide sufficient resources to fund both the normal cost for each year and the amortized unfunded liability.

Medical Trend Rate (Health Inflation). The increase in the plan's cost over time. Trend includes all elements that may influence a plan's cost, assuming that enrollments and the plan benefits do not change. Trend includes such elements as, pure price inflation, changes in utilization, advances in medical technology, and cost shifting.

Normal Cost. The annual cost assigned, under the actuarial funding method, to current and subsequent plan years. Sometimes referred to as "current service cost." Any payment toward the unfunded actuarial accrued liability is not part of the normal cost.

Other Post-Employment Employee Benefits (OPEB). OPEB are post-employment benefits other than pensions. OPEB generally takes the form of health insurance and dental, vision, prescription drugs or other healthcare benefits.

Reserve Account. An account used to indicate that funds have been set aside for a specific purpose and are not generally available for other uses.

Unfunded Actuarial Accrued Liability. The difference between the actuarial accrued liability and valuation assets. Sometimes referred to as "unfunded accrued liability."

Valuation Assets. The value of current plan assets recognized for valuation purposes.

EXHIBIT G

ACT 268, SLH 2013

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (THE EUTF)

EXHIBIT G

EXECUTIVE CHAMBERS
HONOLULU

NEIL ABERCROMBIE
GOVERNOR

July 3, 2013

GOV. MSG. NO. 1371

The Honorable Donna Mercado Kim,
President
and Members of the Senate
Twenty-Seventh State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Joseph M. Souki,
Speaker and Members of the
House of Representatives
Twenty-Seventh State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kim, Speaker Souki, and Members of the Legislature:

This is to inform you that on July 3, 2013, the following bill was signed into law:

HB546 HD2 SD2 CD1

RELATING TO THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
ACT 268 (13)

Sincerely,

NEIL ABERCROMBIE
Governor, State of Hawaii

EXHIBIT G

Approved by the Governor
on JUL 3 2013

ACT 268

HOUSE OF REPRESENTATIVES
TWENTY-SEVENTH LEGISLATURE, 2013
STATE OF HAWAII

H.B. NO. 546 H.D. 2 S.D. 2 C.D. 1

A BILL FOR AN ACT

RELATING TO THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

PART I

SECTION 1. The purpose of this part is to convene a task force in the department of budget and finance to examine the unfunded liability of the Hawaii employer-union health benefits trust fund.

SECTION 2. (a) There is established a Hawaii employer-union health benefits trust fund task force within the department of budget and finance for administrative purposes to consist of the following members:

(1) Two members from the house of representatives selected by the speaker of the house of representatives;

(2) Two members from the senate selected by the senate president;

(3) The director of finance, or the director's designee;

(4) One member from the Hawaii Council of Mayors;

(5) One member from the Hawaii State Association of Counties;

(6) Four members representing public sector unions who shall be invited to participate by the director of finance;

(7) One member representing public employee retirees who shall be invited to participate by the director of finance; and

(8) Four members representing the respective interests of the four counties who shall be selected by the governor.

The director of finance, or the director's designee, shall serve as the chairperson of the task force. The task force shall cease to exist on June 30, 2014.

(b) The members of the task force shall serve without compensation, but shall be reimbursed for expenses, including travel expenses, necessary for the performance of their duties. No member shall be made subject to chapter 84, Hawaii Revised Statutes, solely because of that member's participation as a member of that task force.

SECTION 3. The Hawaii employer-union health benefits trust fund task force shall examine the unfunded liability of the Hawaii employer-union health benefits trust fund (trust fund), including:

(1) The current and projected unfunded actuarial accrued liability of the trust fund;

(2) The availability of medical benefits plans other than plans that pay or reimburse medical services providers under a fee-for-service model;

(3) The costs and benefits of alternative medical benefits plans in relation to the medical benefits plans currently offered by the trust fund;

(4) An evaluation of the costs and process of transitioning from the current medical benefits plans to an alternative medical benefits plan, including recommended proposed legislation;

(5) An evaluation of the current structure of state and county public employers paying a percentage of health insurance policy premiums and providing recommendations for a benefits plan for prospective employees; and

(6) Any other matters that are relevant to gaining a full and meaningful understanding of the circumstance of the trust fund.

SECTION 4. The director of finance, in consultation with the task force, shall submit a report to the legislature,

including findings, recommendations, and proposed legislation, no later than twenty days prior to the convening of the regular session of 2014.

SECTION 5. There is appropriated out of the general revenues of the State of Hawaii the sum of $185,750 or so much thereof as may be necessary for fiscal year 2013-2014 to support the work of the Hawaii employer-union health benefits trust fund task force, including necessary travel expenses for task force members who reside outside of Oahu and consulting services of persons knowledgeable in relevant issues.

The sum appropriated shall be expended by the department of budget and finance for the purposes of this part.

PART II

SECTION 6. Chapter 87A, Hawaii Revised Statutes, is amended by adding two new sections to part IV to be appropriately designated and to read as follows:

"**§87A-A Public employers; defined.** For the purposes of this part, "public employer" means a governmental entity whose employees', beneficiaries', and retirees' health benefits coverage is provided through the fund.

§87A-B Payment of public employer contributions to the other post-employment benefits trust. (a) Commencing with

fiscal year 2018-2019, each of the counties and all other public employers shall make annual required contributions in accordance with section 87A-42 for the benefit of their retirees and beneficiaries.

(b) The board shall determine the annual required contribution owed by each public employer under this part for each fiscal year, beginning with fiscal year 2018-2019."

SECTION 7. Section 87A-24, Hawaii Revised Statutes, is amended to read as follows:

"**§87A-24 Other powers.** In addition to the power to administer the fund, the board may:

(1) Collect, receive, deposit, and withdraw money on behalf of the fund;

(2) Invest moneys in the same manner specified in section 88-119(1)(A), (1)(B), (1)(C), (2), (3), (4), (5), (6), and (7);

(3) Hold, purchase, sell, assign, transfer, or dispose of any securities or other investments of the fund, as well as the proceeds of those investments and any money belonging to the fund;

(4) Appoint, and at pleasure dismiss, an administrator and other fund staff. The administrator and staff shall

be exempt from chapter 76 and shall serve under and at the pleasure of the board;

(5) Make payments of periodic charges and pay for reasonable expenses incurred in carrying out the purposes of the fund;

(6) Contract for the performance of financial audits of the fund and claims audits of its insurance carriers;

(7) Retain auditors, actuaries, investment firms and managers, benefit plan consultants, or other professional advisors to carry out the purposes of this chapter[~~.~~], including the retaining of an actuary to determine the annual required public employer contribution for the separate trust fund established under section 87A-42;

(8) Establish health benefits plan and long-term care benefits plan rates that include administrative and other expenses necessary to effectuate the purposes of the fund; and

(9) Require any department, agency, or employee of the State or counties to furnish information to the board to carry out the purposes of this chapter."

SECTION 8. Section 87A-42, Hawaii Revised Statutes, is amended to read as follows:

"[~~[~~]§87A-42[~~]~~] **Other post-employment benefits trust.** (a) Notwithstanding sections 87A-31 and 87A-31.5, the board, upon terms and conditions set by the board, [~~may~~] shall establish and administer a separate trust fund for the purpose of receiving employer contributions that will prefund other post-employment health and other benefit plan costs for retirees and their beneficiaries. [~~If a fund is established, it~~] The separate trust fund shall meet the requirements of the Government Accounting Standards Board regarding other post-employment benefits trusts. The board shall establish and maintain a separate account for each public employer within the separate trust fund to accept and account for each public employer's contributions. Employer contributions to the separate trust fund shall be irrevocable, all assets of the fund shall be dedicated exclusively to providing health and other benefits to retirees and their beneficiaries, and assets of the fund shall not be subject to appropriation for any other purpose and shall not be subject to claims by creditors of the employers or the board or plan administrator. The board's powers under section

87A-24 shall also apply to [~~any~~] the fund established pursuant to this section.

(b) Public employer contributions shall be paid into the fund in each fiscal year, and commencing with the 2018-2019 fiscal year, the amount of the annual public employer contribution shall be equal to the amount of the annual required contribution, as determined by an actuary retained by the board.

(c) In any fiscal year subsequent to the 2017-2018 fiscal year in which the state public employer's contributions into the fund are less than the amount of the annual required contribution, the amount that represents the excess of the annual required contribution over the state public employer's contributions shall be deposited into the appropriate account of the separate trust fund from a portion of all general excise tax revenues collected by the department of taxation under section 237-31.

If any general excise tax revenues are deposited into the separate trust fund in any fiscal year as a result of this subsection, the director of finance shall notify the legislature and governor whether the general fund expenditure ceiling for that fiscal year would have been exceeded if those revenues had been legislatively appropriated instead of deposited without

appropriation into the trust fund. The notification shall be submitted within thirty days following the end of the applicable fiscal year.

(d) In any fiscal year subsequent to the 2017-2018 fiscal year in which a county public employer's contributions into the fund are less than the amount of the annual required contribution, the amount that represents the excess of the annual required contribution over the county public employer's contributions shall be deposited into the fund from a portion of all transient accommodations tax revenues collected by the department of taxation under section 237D-6.5(b)(3). The director of finance shall deduct the amount necessary to meet the county public employer's annual required contribution from the revenues derived under section 237D-6.5(b)(3) and transfer the amount to the board for deposit into the appropriate account of the separate trust fund.

(e) In any fiscal year subsequent to fiscal year 2017-2018 in which a public employer's contributions into the fund are less than the amount of the annual required contribution and the public employer is not entitled to transient accommodations tax revenues sufficient to satisfy the total amount of the annual required contribution, the public employer's contributions shall

be deposited into the fund from portions of any other revenues collected on behalf of the public employer or held by the State. The director of finance shall deduct the amount necessary to meet the public employer's annual required contribution from any revenues collected on behalf of the public employer held by the State and transfer the amount to the board for deposit into the appropriate account of the separate trust fund.

(f) For the purposes of this section, "annual required contribution" means a public employer's required contribution to the trust fund established in this section that is sufficient to cover:

(1) The normal cost, which is the cost of other post-employment benefits attributable to the current year of service; and

(2) An amortization payment, which is a catch-up payment for past service costs to fund the unfunded actuarial accrued liability over the next thirty years."

SECTION 9. Section 237-31, Hawaii Revised Statutes, is amended to read as follows:

"§237-31 **Remittances.** All remittances of taxes imposed by this chapter shall be made by money, bank draft, check, cashier's check, money order, or certificate of deposit to the

office of the department of taxation to which the return was transmitted. The department shall issue its receipts therefor to the taxpayer and shall pay the moneys into the state treasury as a state realization, to be kept and accounted for as provided by law; provided that:

(1) The sum from all general excise tax revenues realized by the State that represents the difference between $45,000,000 and the proceeds from the sale of any general obligation bonds authorized for that fiscal year for the purposes of the state educational facilities improvement special fund shall be deposited in the state treasury in each fiscal year to the credit of the state educational facilities improvement special fund;

(2) A sum, not to exceed $5,000,000, from all general excise tax revenues realized by the State shall be deposited in the state treasury in each fiscal year to the credit of the compound interest bond reserve fund; [~~and~~]

(3) A sum from all general excise tax revenues realized by the State that is equal to one-half of the total amount of funds appropriated or transferred out of the

hurricane reserve trust fund under sections 4 and 5 of Act 62, Session Laws of Hawaii 2011, shall be deposited into the hurricane reserve trust fund in fiscal year 2013-2014 and in fiscal year 2014-2015; provided that the deposit required in each fiscal year shall be made by October 1 of that fiscal year[~~.~~]; and

(4) Commencing with fiscal year 2018-2019, a sum from all general excise tax revenues realized by the State that represents the difference between the state public employer's annual required contribution for the separate trust fund established under section 87A-42 and the amount of the state public employer's contributions into that trust fund shall be deposited to the credit of the State's annual required contribution into that trust fund in each fiscal year, as provided in section 87A-42."

SECTION 10. Section 237D-6.5, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) Revenues collected under this chapter, except for revenues collected under section 237D-2(b), shall be distributed as follows, with the excess revenues to be deposited into the general fund:

(1) 17.3 per cent of the revenues collected under this chapter shall be deposited into the convention center enterprise special fund established under section 201B-8; provided that beginning January 1, 2002, if the amount of the revenue collected under this paragraph exceeds $33,000,000 in any fiscal year, revenues collected in excess of $33,000,000 shall be deposited into the general fund;

(2) 34.2 per cent of the revenues collected under this chapter shall be deposited into the tourism special fund established under section 201B-11 for tourism promotion and visitor industry research; provided that for any period beginning on July 1, 2012, and ending on June 30, 2015, no more than $71,000,000 per fiscal year shall be deposited into the tourism special fund established under section 201B-11; provided further that beginning on July 1, 2012, and ending on June 30, 2015, $2,000,000 shall be expended from the tourism special fund for development and implementation of initiatives to take advantage of expanded visa programs and increased travel opportunities for international visitors to Hawaii; and provided further

that beginning on July 1, 2002, of the first $1,000,000 in revenues deposited:

(A) Ninety per cent shall be deposited into the state parks special fund established in section 184-3.4; and

(B) Ten per cent shall be deposited into the special land and development fund established in section 171-19 for the Hawaii statewide trail and access program;

provided that of the 34.2 per cent, 0.5 per cent shall be transferred to a sub-account in the tourism special fund to provide funding for a safety and security budget, in accordance with the Hawaii tourism strategic plan 2005-2015; provided further that of the revenues remaining in the tourism special fund after revenues have been deposited as provided in this paragraph and except for any sum authorized by the legislature for expenditure from revenues subject to this paragraph, beginning July 1, 2007, funds shall be deposited into the tourism emergency trust fund, established in section 201B-10, in a manner sufficient

to maintain a fund balance of $5,000,000 in the tourism emergency trust fund; and

(3) 44.8 per cent of the revenues collected under this chapter shall be transferred as follows: Kauai county shall receive 14.5 per cent, Hawaii county shall receive 18.6 per cent, city and county of Honolulu shall receive 44.1 per cent, and Maui county shall receive 22.8 per cent; provided that for any period beginning on July 1, 2011, and ending on June 30, 2015, the total amount transferred to the counties shall not exceed $93,000,000 per fiscal year[~~.~~]; provided that commencing with fiscal year 2018-2019, a sum that represents the difference between a county public employer's annual required contribution for the separate trust fund established under section 87A-42 and the amount of the county public employer's contributions into that trust fund shall be retained by the state director of finance and deposited to the credit of the county public employer's annual required contribution into that trust fund in each fiscal year, as provided in section 87A-42, if the respective county fails to remit the total amount of the county's

required annual contributions, as required under section 87A-B.

Revenues collected under section 237D-2(b) shall be deposited into the general fund. All transient accommodations taxes shall be paid into the state treasury each month within ten days after collection and shall be kept by the state director of finance in special accounts for distribution as provided in this subsection.

As used in this subsection, "fiscal year" means the twelve-month period beginning on July 1 of a calendar year and ending on June 30 of the following calendar year."

SECTION 11. Notwithstanding the amount of a public employer annual required contribution determined in any fiscal year by an actuary retained by the board for this purpose, for the five-year fiscal period from 2014-2015 to 2018-2019, public employer contributions into the separate trust fund established under section 87A-42, Hawaii Revised Statutes, shall be at the specified percentages of the respective annual required contributions, as follows:

	Fiscal Year	Annual Required Contribution
(1)	2014-2015	Twenty per cent;
(2)	2015-2016	Forty per cent;

(3) 2016-2017 Sixty per cent;

(4) 2017-2018 Eighty per cent; and

(5) 2018-2019 One hundred per cent.

SECTION 12. Not less than twenty days prior to the convening of the regular session of 2015, the director of finance, in order to maximize the efficient use of resources and public funds, shall submit an implementation plan and any proposed legislation to the legislature to execute the following:

(1) Joint use of any investment information, advice, and services provided by fund managers retained by the board of trustees of the employees' retirement system with the board of trustees of the employer-union health benefits trust fund for the purpose of investing moneys contained in the separate trust fund established under section 87A-42, Hawaii Revised Statutes; and

(2) Procedures to accept and deposit employer contributions from county public employers into the separate trust fund established under section 87A-42, Hawaii Revised Statutes.

SECTION 13. There is appropriated out of the general revenues of the State of Hawaii the sum of $500,000 or so much thereof as may be necessary for fiscal year 2013-2014 and the same sum or so much thereof as may be necessary for fiscal year 2014-2015 for the department of budget and finance to conduct a study and develop an implementation plan to have both the employer-union health benefits trust fund and the employees' retirement system jointly share investment information and services.

The sums appropriated shall be expended by the department of budget and finance for the purposes of this Act.

SECTION 14. In codifying the new sections added by section 6 of this Act, the revisor of statutes shall substitute appropriate section numbers for the letters used in designating the new sections in this Act.

SECTION 15. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 16. This Act shall take effect on July 1, 2013; provided that the amendments made to section 237D-6.5, Hawaii Revised Statutes, in section 10 of this Act shall not be repealed when section 237D-6.5, Hawaii Revised Statutes, is repealed and reenacted on June 30, 2015, pursuant to Act 61,

Session Laws of Hawaii 2009, and Act 103, Session Laws of Hawaii 2011.

APPROVED this 3 day of JUL , 2013

Neil Abercrombie

GOVERNOR OF THE STATE OF HAWAII

EXHIBIT H

ACT 093, SLH 2017

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (THE EUTF)

EXHIBIT H

EXECUTIVE CHAMBERS
HONOLULU

DAVID Y. IGE
GOVERNOR

July 5, 2017

GOV. MSG. NO. 1194

The Honorable Ronald D. Kouchi,
President
and Members of the Senate
Twenty-Ninth State Legislature
State Capitol, Room 409
Honolulu, Hawai'i 96813

The Honorable Scott K. Saiki,
Speaker and Members of the
House of Representatives
Twenty-Ninth State Legislature
State Capitol, Room 431
Honolulu, Hawai'i 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

This is to inform you that on July 5, 2017, the following bill was signed into law:

SB133 SD2 HD2

RELATING TO PUBLIC EMPLOYEES' FRINGE BENEFITS
ACT 093 (17)

Sincerely,

DAVID Y. IGE
Governor, State of Hawai'i

Approved by the Governor
on JUL 5 2017

THE SENATE
TWENTY-NINTH LEGISLATURE, 2017
STATE OF HAWAII

ACT 093

S.B. NO. 133 S.D. 2 H.D. 2

EXHIBIT H

A BILL FOR AN ACT

RELATING TO PUBLIC EMPLOYEES' FRINGE BENEFITS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that the State's and counties' liabilities and obligations for the pension and health insurance coverage of public employees are of major concern. State and county contributions as employers for the normal cost and unfunded liability amortization of the employees' retirement system and Hawaii employer-union health benefits trust fund (EUTF) are increasing. The legislature notes that section 88-105, Hawaii Revised Statutes, presently requires annual valuation reports for the employees' retirement system of the State of Hawaii. The legislature finds that more frequent monitoring of the experience and valuations of the employees' retirement system and EUTF is necessary to properly plan future state and county budgetary needs.

The purpose of this Act is to address public employees' fringe benefits by:

(1) Requiring the actuary of the EUTF to make an annual valuation of the assets and liabilities of the EUTF

that includes an update of assumptions specific to the EUTF at least once in each three-year period; and

(2) Reducing the maximum period between experience studies of the employees' retirement system from five years to three years.

SECTION 2. Chapter 87A, Hawaii Revised Statutes, is amended by adding a new section to part III to be appropriately designated and to read as follows:

"**§87A- Actuarial investigation; valuations.** Beginning on July 1, 2017, the actuary retained by the board pursuant to section 87A-42 shall make an annual valuation of the assets and liabilities of the fund based on tables and other factors adopted by the board annually. The annual valuation shall include an update of assumptions specific to the fund that are not updated pursuant to section 88-105, as deemed necessary by the actuary, at least once in each three-year period."

SECTION 3. Section 88-105, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) At least once in each [~~five-year~~] three-year period, commencing with fiscal year [~~1994-1995,~~] 2018-2019, the actuary shall make an actuarial investigation of the experience of the

system and shall recommend to the board of trustees the adoption for actuarial valuation of the system of mortality, service, and other assumptions, factors, and tables as shall be deemed appropriate and necessary. The actuary shall further recommend the acceptable funded ratio for the system, taking into consideration the guaranties of article XVI, section 2 of the state constitution, section 88-107, and section 88-127."

SECTION 4. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 5. This Act shall take effect upon its approval.

APPROVED this 5 day of JUL , 2017

GOVERNOR OF ~~THE STATE~~ OF HAWAII

S.B. No. 133, S.D. 2, H.D. 2

THE SENATE OF THE STATE OF HAWAII

Date: April 28, 2017
Honolulu, Hawaii 96813

We hereby certify that the foregoing Bill this day passed Final Reading in the Senate of the Twenty-ninth Legislature of the State of Hawaii, Regular Session of 2017.

President of the Senate

Clerk of the Senate

EXHIBIT H

SB No. 133, SD 2, HD 2

THE HOUSE OF REPRESENTATIVES OF THE

STATE OF HAWAII

Date: April 11, 2017
Honolulu, Hawaii

We hereby certify that the above-referenced Bill on this day passed Third Reading in the House of Representatives of the Twenty-Ninth Legislature of the State of Hawaii, Regular Session of 2017.

Joseph M. Souki
Speaker
House of Representatives

Brian L. Takeshita
Chief Clerk
House of Representatives

EXHIBIT I

ACTS 040 and 041, SLH 2023

RFP No. 25-001, Actuarial Valuation Services
STATE OF HAWAII, DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (THE EUTF)

EXHIBIT I

GOV. MSG. NO. 1140

EXECUTIVE CHAMBERS
KE KE'ENA O KE KIA'ĀINA

JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

June 1, 2023

The Honorable Ronald D. Kouchi
President of the Senate,
and Members of the Senate
Thirty-Second State Legislature
State Capitol, Room 409
Honolulu, Hawai'i 96813

The Honorable Scott K. Saiki
Speaker, and Members of the
House of Representatives
Thirty-Second State Legislature
State Capitol, Room 431
Honolulu, Hawai'i 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

This is to inform you that on June 1, 2023, the following bill was signed into law:

SB1314 SD2 HD1

RELATING TO THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND SPOUSAL MEDICARE PART B PREMIUM REIMBURSEMENT.
ACT 040

Sincerely,

Josh Green

Josh Green, M.D.
Governor, State of Hawai'i

Approved by the Governor

on JUN 1 2023

EXHIBIT I

ACT 040

THE SENATE
THIRTY-SECOND LEGISLATURE, 2023
STATE OF HAWAII

S.B. NO. 1314 S.D. 2 H.D. 1

A BILL FOR AN ACT

RELATING TO THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND SPOUSAL MEDICARE PART B PREMIUM REIMBURSEMENT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that the State and counties reimburse retirees and their spouses for medicare part B premiums, including spouses of retirees hired after June 30, 2001. Employers do not receive any benefit from the enrollment of self-only retiree spouses in medicare part B, since the employers do not contribute to the spouse's premiums. The Hawaii employer-union health benefits trust fund board of trustees estimates that eliminating medicare part B premium reimbursements for spouses of employees hired on or after July 1, 2023, will reduce the State's future annual required contributions by $1.2 billion over a thirty-year period. Current retirees; vested, terminated employees; and current employees will not be impacted by this Act.

SECTION 2. Section 87A-23, Hawaii Revised Statutes, is amended to read as follows:

"§87A-23 **Health benefits plan supplemental to medicare.** The board shall establish a health benefits plan, which takes into account benefits available to an employee-beneficiary and spouse under medicare, subject to the following conditions:

(1) There shall be no duplication of benefits payable under medicare. The plan under this section, which shall be secondary to medicare, when combined with medicare and any other plan to which the health benefits plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall provide benefits that approximate those provided to a similarly situated beneficiary not eligible for medicare;

(2) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a contribution equal to an amount not less than the medicare part B premium, for each of the following who are enrolled in the medicare part B medical insurance plan: (A) an employee-beneficiary who is a retired employee, (B) [~~an employee-beneficiary's spouse~~] a

spouse of an employee-beneficiary hired prior to July 1, 2023, while the employee-beneficiary is living, and (C) an employee-beneficiary's spouse, after the death of the employee-beneficiary, if the spouse qualifies as an employee-beneficiary. For purposes of this section, a "retired employee" means retired members of the employees' retirement system; county pension system; or a police, firefighters, or bandsmen pension system of the State or a county as set forth in chapter 88. If the amount reimbursed by the fund under this section is less than the actual cost of the medicare part B medical insurance plan due to an increase in the medicare part B medical insurance plan rate, the fund shall reimburse each employee-beneficiary and [~~employee-beneficiary's spouse~~] spouse of an employee-beneficiary hired prior to July 1, 2023, for the cost increase within thirty days of the rate change. Each employee-beneficiary and employee-beneficiary's spouse who becomes entitled to reimbursement from the fund for medicare part B premiums after July 1, 2006, shall designate a

financial institution account into which the fund shall be authorized to deposit reimbursements. This method of payment may be waived by the fund if another method is determined to be more appropriate;

(3) The benefits available under this plan, when combined with benefits available under medicare or any other coverage or plan to which this plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall approximate the benefits that would be provided to a similarly situated employee-beneficiary not eligible for medicare;

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

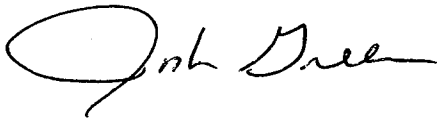
(5) The board shall determine which of the employee-beneficiaries and dependent-beneficiaries, who are not enrolled in the medicare part B medical insurance plan, may participate in the plans offered by the fund."

SECTION 3. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 4. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 5. This Act shall take effect on July 1, 2023.

APPROVED this 1st day of June , 2023



GOVERNOR OF THE STATE OF HAWAI'I

S.B. No. 1314, S.D. 2, H.D. 1

THE SENATE OF THE STATE OF HAWAI'I

Date: April 19, 2023
Honolulu, Hawai'i 96813

We hereby certify that the foregoing Bill this day passed Final Reading in the Senate of the Thirty-Second Legislature of the State of Hawai'i, Regular Session of 2023.

President of the Senate

Clerk of the Senate

EXHIBIT I

SB No. 1314, SD 2, HD 1

THE HOUSE OF REPRESENTATIVES OF THE

STATE OF HAWAII

Date: April 6, 2023
Honolulu, Hawaii

We hereby certify that the above-referenced Bill on this day passed Third Reading in the House of Representatives of the Thirty-Second Legislature of the State of Hawaii, Regular Session of 2023.

Scott K. Saiki
Speaker
House of Representatives

Brian L. Takeshita
Chief Clerk
House of Representatives

EXHIBIT I

GOV. MSG. NO. 1141

EXECUTIVE CHAMBERS
KE KE'ENA O KE KIA'ĀINA

JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

June 1, 2023

The Honorable Ronald D. Kouchi
President of the Senate,
and Members of the Senate
Thirty-Second State Legislature
State Capitol, Room 409
Honolulu, Hawai'i 96813

The Honorable Scott K. Saiki
Speaker, and Members of the
House of Representatives
Thirty-Second State Legislature
State Capitol, Room 431
Honolulu, Hawai'i 96813

Dear President Kouchi, Speaker Saiki, and Members of the Legislature:

This is to inform you that on June 1, 2023, the following bill was signed into law:

SB1315 SD2 HD1

RELATING TO THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND MEDICARE PART B PREMIUM REIMBURSEMENT.
ACT 041

Sincerely,

Josh Green

Josh Green, M.D.
Governor, State of Hawai'i

Approved by the Governor

on JUN 1 2023

EXHIBIT I

ACT 041

THE SENATE
THIRTY-SECOND LEGISLATURE, 2023
STATE OF HAWAII

S.B. NO. 1315 S.D. 2 H.D. 1

A BILL FOR AN ACT

RELATING TO THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND MEDICARE PART B PREMIUM REIMBURSEMENT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that the State and counties reimburse retirees and their spouses medicare part B premiums including income-related monthly adjustment amounts (IRMAA). An IRMAA is added to the monthly medicare part B standard premium amount of $170.10 for 2022 if the retiree's annual federal tax return income two years prior was over a certain threshold. The IRMAA is assessed on retirees with 2020 federal tax return modified adjusted gross income of greater than $91,000 and $182,000 for single and joint filers, respectively. This threshold is adjusted annually for inflation. The State's approximate annual medicare part B premium reimbursement is $98,000,000 of which approximately $8,500,000 is the IRMAA.

The Hawaii employer-union health benefits trust fund estimates elimination of reimbursement of IRMAA for new hires on or after July 1, 2023, will reduce future state annual required

contributions by $400,000,000 over a thirty-year period. Current retirees; vested, terminated employees; and current employees will not be impacted by this Act.

Accordingly, the purpose of this Act is to eliminate the reimbursements for income-related monthly adjustment amounts for new hires on or after July 1, 2023, and their spouses.

SECTION 2. Section 87A-23, Hawaii Revised Statutes, is amended to read as follows:

"**§87A-23 Health benefits plan supplemental to medicare.** The board shall establish a health benefits plan, which takes into account benefits available to an employee-beneficiary and spouse under medicare, subject to the following conditions:

(1) There shall be no duplication of benefits payable under medicare. The plan under this section, which shall be secondary to medicare, when combined with medicare and any other plan to which the health benefits plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall provide benefits that approximate those provided to a similarly situated beneficiary not eligible for medicare;

(2) The State, through the department of budget and finance, and the counties, through their respective departments of finance, shall pay to the fund a contribution equal to an amount not less than the medicare part B premium, excluding medicare income-related monthly adjustment amounts for a retired employee hired after June 30, 2023, and their spouse, for each of the following who are enrolled in the medicare part B medical insurance plan: (A) an employee-beneficiary who is a retired employee, (B) an employee-beneficiary's spouse while the employee-beneficiary is living, and (C) an employee-beneficiary's spouse, after the death of the employee-beneficiary, if the spouse qualifies as an employee-beneficiary. [~~For purposes of this section, a "retired employee" means retired members of the employees' retirement system; county pension system; or a police, firefighters, or bandsmen pension system of the State or a county as set forth in chapter 88.~~] If the amount reimbursed by the fund under this section is less than the actual cost of the medicare

part B medical insurance plan, excluding medicare income-related monthly adjustment amounts for a retired employee hired after June 30, 2023, and their spouse, due to an increase in the medicare part B medical insurance plan rate, the fund shall reimburse each employee-beneficiary and employee-beneficiary's spouse for the cost increase within thirty days of the rate change. Each employee-beneficiary and employee-beneficiary's spouse who becomes entitled to reimbursement from the fund for medicare part B premiums after July 1, 2006, shall designate a financial institution account into which the fund shall be authorized to deposit reimbursements. This method of payment may be waived by the fund if another method is determined to be more appropriate[~~:~~]. For purposes of this section, a "retired employee" means retired members of the employees' retirement system; county pension system; or a police, firefighters, or bandsmen pension system of the State or a county as set forth in chapter 88;

(3) The benefits available under this plan, when combined with benefits available under medicare or any other coverage or plan to which this plan is subordinate under the National Association of Insurance Commissioners' coordination of benefit rules, shall approximate the benefits that would be provided to a similarly situated employee-beneficiary not eligible for medicare;

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

(5) The board shall determine which of the employee-beneficiaries and dependent-beneficiaries, who are not enrolled in the medicare part B medical insurance plan, may participate in the plans offered by the fund."

SECTION 3. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 4. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 5. This Act shall take effect on July 1, 2023.

APPROVED this 1st day of June , 2023

GOVERNOR OF THE STATE OF HAWAI'I

S.B. No. 1315, S.D. 2, H.D. 1

THE SENATE OF THE STATE OF HAWAI'I

Date: April 19, 2023
Honolulu, Hawai'i 96813

We hereby certify that the foregoing Bill this day passed Final Reading in the Senate of the Thirty-Second Legislature of the State of Hawai'i, Regular Session of 2023.

President of the Senate

Clerk of the Senate

SB No. 1315, SD 2, HD 1

THE HOUSE OF REPRESENTATIVES OF THE

STATE OF HAWAII

Date: April 6, 2023
Honolulu, Hawaii

We hereby certify that the above-referenced Bill on this day passed Third Reading in the House of Representatives of the Thirty-Second Legislature of the State of Hawaii, Regular Session of 2023.

Scott K. Saiki
Speaker
House of Representatives

Brian L. Takeshita
Chief Clerk
House of Representatives