



EUTF Reference Guide for Your

Health Benefits



For Active Employees

Plan Year July 1, 2019 - June 30, 2020

What's inside?

- Wellness Programs and Money Saving Tips
- Health plan information
- Premium and employer contribution amounts

Hawaii Employer-Union Health Benefits
Trust Fund (EUTF)



April 2019,

Aloha State and County Employees:

We are pleased to present the EUTF Reference Guide for Your Health Benefits. This Guide provides information on the health benefit plans available to you for fiscal year July 1, 2019 through June 30, 2020. You may make changes to your enrollment in these plans during the open enrollment election period beginning April 1 – 30, 2019 or if you have a qualifying event during the plan year. Any changes you make during open enrollment will take effect on July 1, 2019. We encourage you to attend one of the open enrollment informational sessions scheduled between April 1 – 30, 2019.

We want to actively partner with you to improve your health. Our goal is to provide you with quality health benefit plan options. The information contained in this Guide is intended to help you make good use of your benefits and make choices that best address your needs.

Please pay careful attention to the rates listed in this Guide because changes have occurred that could affect the decisions you make. Health plan premium rate information can be found beginning on page 18.

This Guide and other useful information is also posted on the EUTF website at eutf.hawaii.gov. For specific information on health plan benefits, please contact health plan carriers directly regarding details on the plans and benefits being offered. 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 808-586-7390 or toll free at 1-800-295-0089.

Mahalo,

Roderick Becker, Chair
EUTF Board of Trustees



Introduction

The Hawaii Employer-Union Health Benefits Trust Fund or more commonly known as the EUTF provides medical, prescription drug, dental, vision, and life insurance benefits to nearly two hundred thousand 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 ten member, governor-appointed board of trustees.

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

Disclaimer

This Guide offers general information on your health and other benefit plans which are exclusively governed by the Hawaii Revised Statutes, the EUTF Administrative Rules as they are amended from time to time and the carrier plan documents all of which are available at eutf.hawaii.gov. Nothing in this Guide is intended to amend, change, or contradict these documents. This Guide is not a legal document or contract and the information in their 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 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.

EUTF Website

Want quick and easy access to the most updated information about your health plan benefits and enrollment?

Visit our Website!

eutf.hawaii.gov

Our website gives State and county employees and retirees access to a wealth of information, forms, calendar of events and important reference materials. Explore our site using the menu bar to find the following topics:

- ▶ EUTF Pre-Retirement Workshops
- ▶ Open Enrollment Informational Sessions
- ▶ Introduction to Your EUTF Benefits
- ▶ Human Resource Office Training Materials
- ▶ Forms and Reference Materials
- ▶ Webinar Training Events

The screenshot shows the EUTF website interface. At the top, there is a navigation bar with the following menu items: HOME, ABOUT EUTF, ACTIVE, FUTURE RETIREES, RETIREES, HEALTH AND WELLNESS, LEARNING CENTER, and MEDICARE. Below the navigation bar is a main content area featuring a large banner for 'Save time and money by signing up for CVS Mail Order Service today!' with bullet points: 'Lower copayments and future lower premiums', 'No charge for shipping', and 'Discreet packaging'. To the right of the banner is a sidebar with links for 'Forms', 'Health Care Providers', 'Premium Payment Options', and 'COBRA'. Below the banner are two columns: 'NEWS' with links to 'Pre-Retirement Lunch N' Learn Workshops', 'NEW - Navigating Your Care Choices', and 'NEW - Retiree Health Plan Premium Deduction Option'; and 'REQUIRED NOTICES' with links to 'HIPAA Use and Disclosure of Protected Health Information', 'Creditable Coverage Notice', and 'HIPAA Notice: Notice of HIPAA Privacy Rules'. At the bottom right, there are three buttons: 'EUTF Board Meetings', 'Request For Proposals/Information (RFP/RFIs)', and 'Contact Us'. Callout boxes provide additional context: 'Active: Contains resources specific for active State and county employees' points to the 'ACTIVE' menu item; 'Future Retirees: Thinking of Retiring? Users can access important information on EUTF retiree health plan enrollment procedures' points to the 'FUTURE RETIREES' menu item; 'Learning Center: Training material on a wide array of healthcare enrollment related topics' points to the 'LEARNING CENTER' menu item; 'NEWS: Click here for the latest updates of health plan related information and events' points to the 'NEWS' section; and 'Topic Specific Links: Direct access to our more popular topics including forms, provider links, premium payment options, and EUTF's events calendar' points to the sidebar links.

Active: Contains resources specific for active State and county employees

Future Retirees: Thinking of Retiring? Users can access important information on EUTF retiree health plan enrollment procedures

Learning Center: Training material on a wide array of healthcare enrollment related topics

NEWS: Click here for the latest updates of health plan related information and events

Topic Specific Links: Direct access to our more popular topics including forms, provider links, premium payment options, and EUTF's events calendar

Visit Today!

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Wellness Programs



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

HMSA Members

WHAT YOU CAN DO TO MAINTAIN YOUR HEALTH

Staying healthy is the best way to keep your health care costs down. Take care of minor health problems before they get too big. Take care of yourself all year long by working with your doctor to get the preventive care you need. Talk to your doctor to learn about recommended preventive services and screenings appropriate for your age and gender. Make an appointment for your Annual Preventive Health Exam, 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 on hmsa.com. If you need help finding a doctor, call 948-6499 on Oahu or 1-800-776-4672 toll-free, Monday through Friday, 7 a.m. to 7 p.m., and Saturday, 9 a.m. to 1 p.m.

HMSA's Online Care

With HMSA's Online Care®, you can see a doctor on your smartphone or tablet without an appointment 24 hours a day, seven days a week. Online Care doctors can diagnose conditions and prescribe medication as needed. There's no copayment for Online Care visits. To register, visit hmsaonlinecare.com.

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, or chronic kidney disease, and 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.

Health coaching

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

Tobacco cessation support

The Hawai'i Tobacco Quitline® will provide this benefit instead of QuitNet®. 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 or 1-800-784-8669.

Find out your RealAge

You know your calendar age, but do you know your body's RealAge? To find out, take Sharecare's RealAge Test. The test gives you a RealAge based on your responses to factors that affect health and longevity. You might be surprised to learn that your body is older or younger than you think it is. Once you know your RealAge, Sharecare will help you maintain or improve it in categories such as sleep, stress, and daily activity.

Download Sharecare today!

1. Register on hmsa.com/sharecare. Enter your HMSA subscriber ID.
2. Download Sharecare.
3. Take the RealAge Test to discover your body's age.

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

HMSA Member Discounts

Save money on a variety of health and fitness products and services, including more than 300 fitness centers gym memberships, yoga, and meditation classes, and other services to help improve your well-being.

HMSA's Island Scene

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

Diabetes Prevention Program

Members with diabetic risk factors may be eligible for the Diabetes Prevention Program.

The program can last up to two years and includes lessons, handouts, and resources from the Centers for Disease Control and Prevention to help you manage diabetes through lifestyle changes.

In the first six months of the program, participants attend 16 core sessions. After the first six months, members can attend maintenance sessions and follow-up meetings to keep on track. The program is available at no charge to HMSA members at select YMCA's.

Talk to your doctor or call 948-6499 (Oahu) or 1-800-776-4672 (Neighbor Islands) to find out if this program is right for you.

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

If you have heart disease or multiple cardiac risk factors, you may be eligible for Dr. Ornish's Program for Reversing Heart Disease. This program can help you improve your eating habits, manage stress, and increase physical activity to lower your amount of medications and repeat procedures.

The program consists of 18 four-hour sessions over nine weeks at a cost of \$20 per session. The program is available at four locations. To find out if you're eligible for this program, talk to your doctor or contact an Ornish program site:

- 'Ekahi Healthcare Center, 500 Ala Moana Blvd., Suite 6-D, Honolulu. 777-4001.
- Hawaii Pacific Health, 1100 Ward Ave., Suite 715, Honolulu. 522-4114.
- Island Heart Care, 75-1027 Henry St, Suite 110, Kailua-Kona. 769-5225.
- Hilo Medical Center, 1190 Waiuanuenue Ave., Hilo, HI 96720. 932-3455.

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 to you when you see a participating provider.

Pregnancy Support

HMSA's Pregnancy Support Program supports safe and healthy pregnancies by pairing pregnant women with their own maternity nurse for personalized education and counseling. This service doesn't replace the care that members receive from their doctor, but provides additional services that complement their prenatal care.

AmericanWell® is an independent company providing hosting and software services for HMSA's Online Care platform on behalf of HMSA. QuitNet® is trademark of Sharecare, Inc. All rights reserved. RealAge® is a registered mark of Sharecare, Inc. Sharecare, Inc., is an independent company that provides health and well-being programs to engage members on behalf of HMSA.

Kaiser Permanente Members

Preventive services

Prevention makes good health possible!

Many preventive screening tests are covered at no 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, 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 non-urgent questions, print vaccination records, manage a family member's health, and so much more.¹

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 rewards 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 program, up to 3 programs. Choose from a variety of programs to help in reducing stress, quit smoking, lose weight and more. You can take a program when it's convenient for you at your own pace. Current rewards run from July 1, 2019 until June 30, 2020.² Visit kp.org/eutf, and click on "reap the rewards".

Kaiser Permanente Fit Rewards

Earn a free gym membership

EUTF Kaiser Permanente members 16 years and older can join or renew membership at a participating Tier 1 gym and pay the \$200 annual membership fee. Our expanded network of fitness centers in Tiers 2-4 offers additional discounted monthly fees at rates under market prices. For all tiers, work out at your gym at least 45 times per calendar year for a minimum of 30 minutes per session to get a \$200 reward. Current Fit Rewards runs from January 1, 2019 until December 31, 2020.³ Visit kp.org/fitrewards.

Get a lifestyle coach

If you need a little extra support, we offer lifestyle coaching by phone at no cost. You'll work one-on-one with your personal lifestyle 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 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

quit support and guidance. You are also eligible to receive free tobacco cessation medications at no cost with a doctor's prescription. To talk to a counselor, call 808-643-4622 or 711 (TTY), Monday to Friday 8:30 a.m. to 2:30 p.m.

Join health classes

Take charge of your health and inspire others.

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

Enjoy member discounts

You get reduced 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, 5 a.m. to 3 p.m.

¹ These features are only available when you get care at Kaiser Permanente facilities.

² You are responsible for any taxes that may be due on the amounts received. Please talk to your personal tax adviser 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, 2019 to June 30, 2020 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 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, 2019. Rewards will be issued 4 to 6 weeks after you complete your activity.

³ 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 to December 31, 2019 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 non-refundable and not eligible for reimbursement. Kaiser Permanente Fit Rewards is a value-added service and not part of your medical benefits. Your annual fee does not count toward your annual maximum out-of-pocket. Please see your Evidence of Coverage or kp.org/fitrewards for details, including conditions, limitations, and exclusions.

CVS/caremark Members

Diabetes Products

Regular blood glucose testing is essential for people with diabetes. One of the best ways to manage diabetes is to check blood sugar every day with a blood glucose meter. The Diabetic Meter Program provides eligible members with a no-cost blood glucose meter. The meters are funded by LifeScan Inc. or Roche Diabetes Care Inc., the manufacturer of your prescription benefit plan's preferred glucose meters (One Touch or Accu-Chek). To find out if you qualify for this benefit call the CVS/caremark Member Services Diabetic Meter Team toll-free at 1-800-588-4456.

Tobacco Cessation Products

Tobacco cessation products are provided as a plan benefit to support our members to quit smoking. CVS/caremark provides education and plan recommendations for certain products at no or low cost to members such as nicotine patches and other prescription medications. To learn more about this program and covered medications call CVS/caremark customer service center toll-free at 1-855-801-8263.

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

If you have a nagging cough, do not go to the Emergency Room (ER). The ER should be reserved for serious emergency situations. If you have a non-emergency illness or injury, go to your regular doctor or an urgent care facility. Cost savings can be significant. For example, the total cost of a typical office visit is around \$100 while an ER visit could cost \$1,000 or more. Other options for care include Kaiser or HMSA's online or telephonic care and walk-in clinics such as urgent care or the CVS Minute Clinic.

Participating Providers

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

Preventive Care

Preventing disease and detecting health issues at an early state is key to living a healthy life. Getting regular preventive care may help you ward off potential serious health issues. It is 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 are on your way to staying healthy. Most preventive services are completely free of charge for you and your dependents when participating providers (in-network providers) are used. Examples include immunizations, routine physical exams, mammograms, and well-baby 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 Rosuvastatin or another generic. Doing so could save you up to \$300 annually per prescription. Additionally, these changes could potentially save the EUTF hundreds of thousands of dollars annually which would result in lower plan premiums.

Another great way to save money is by switching to mail order. In addition to saving money, mail order offers the added convenience of receiving your prescriptions at your doorstep saving you time and money by not having to make regular trips to the pharmacy. For more information, visit caremark.com or call CVS Customer Care toll-free at 1-855-801-8263. For Kaiser members, if you have not done so already, you'll need to register for a secure kp.org account in order to refill prescriptions online. You 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, 2019

HMSA

1. For EUTF PPO and HMO plans, improved the Advance Care Planning benefit whether provided during a physician visit or an ER physician visit to 100% coverage for in-network providers (not subject to the 75/25 deductible) and standard plan benefits* for out-of-network providers.
2. For HSTA VB plans, added an Advance Care Planning benefit, covered at 100% for in-network providers and standard plan benefits* for out-of-network providers.
3. For EUTF PPO, HMO, and HSTA VB plans, added coverage for genetic counseling at standard plan benefits* for both in-network and out-of-network providers.
4. For EUTF PPO and HMO plans, replaced the Routine Physical Exam benefit with the Annual Preventive Health Exam benefit, covered at 100% for both in-network and out-of-network providers (not subject to the deductible).
5. For EUTF PPO, HMO, and HSTA VB plans, added benefit for chlamydia and gonorrhea screenings for men, covered at 100% for in-network providers (not subject to the 75/25 deductible) and the same plan benefits as provided for women* for out-of-network providers.
6. HSTA VB members with pre-diabetes, now have access to the Diabetes Prevention Program, covered at 100% from in-network providers and limited to once per lifetime. This program was previously added for the EUTF PPO and HMO plans effective 7/1/2018.
7. For HSTA VB plans, added Dr. Ornish's Program for Reversing Heart Disease, covered at \$20 per session from in-network providers and limited to once per lifetime. This program was previously added for the EUTF PPO and HMO plans effective 1/1/2016.
8. For HSTA VB plans, added a supportive care benefit, covered at 100% from in-network providers and limited to 90 calendar days in a 12-month period. This benefit was previously added for the EUTF PPO and HMO plans effective 7/1/2017.

*For more information about your coinsurance or copayment, see your *HMSA Guide to Benefits*.

Kaiser

9. Kaiser Permanente EUTF and HSTA VB active members diagnosed with pre-diabetes have additional resources to help manage your health. Starting July 1, 2019, Kaiser Permanente will be offering a facility-based and digital-based Diabetes Prevention Program at no cost to the member. Contact a Kaiser Permanente lifestyle coach at 808-432-2260 to get started.

CVS/caremark

10. Added Two-Trial Step Therapy to EUTF active plans where members will be required to try two generic medications before certain brand-name medications will be covered for the following drug classes: ACE/ARB (treats high blood pressure), COX 2 Inhibitors/NSAIDs (treats pain), Proton Pump Inhibitors (treats acid reflux) and Urinary

Antispasmodics (treats urinary incontinence). Existing members in the ACE/ARB and COX 2 Inhibitors/NSAIDs drug classes will not be required to try a second generic.

- 11. EUTF 75/25 PPO drug plan calendar year maximum out-of-pocket (MOOP) will increase from \$2,350/\$4,700 (Individual/Family) to \$2,900/\$5,800.
- 12. The specialty calendar year MOOP for EUTF active members will increase from \$2,000 to \$2,500.
- 13. Added tiered specialty copayments to EUTF active plans where the specialty copayment will change from 20% up to \$250 per fill to:
 - Specialty generic: 10% up to \$200 per fill
 - Specialty preferred brand: 20% up to \$300 per fill
 - Specialty non-preferred brand: 30% up to \$400 per fill

HDS Dental

- 14. Added benefits designed for prevention: **Total Health Plus** gives you access to more services and shares the importance of maintaining good oral health care. This supplemental set of benefits is essential to improving your overall health and is designed to prevent oral disease and tooth decay that accompanies certain medical conditions or diseases. Discuss with your dentist to see if you qualify for **Total Health Plus** benefits.

Medical Condition or Diagnosis	Benefit	Frequency
Diabetes <i>(or history of diabetes)</i>	Cleanings	Two additional per year*
Cancer <i>(or history of cancer or undergoing treatment such as chemotherapy or radiation; not including oral cancer)</i>	Cleanings Fluoride Treatments	Two additional per year Two additional per year
Oral Cancer <i>(or history of oral cancer or undergoing treatment for oral cancer)</i>	Cleanings Fluoride Treatments	Two additional per year Four additional per year
Sjögren's Syndrome <i>(or history of Sjögren's Syndrome)</i>	Cleanings Fluoride Treatments	Two additional per year Four additional per year
Stroke <i>(or history of stroke; TIA - Transient Ischemic Attack)</i>	Cleanings	Two additional per year
Heart Attack, Congestive Heart Failure <i>(or history of heart attack; MI - Myocardial Infarction)</i>	Cleanings	Two additional per year
Kidney Failure <i>(or history of renal failure or dialysis)</i>	Cleanings	Two additional per year
Organ Transplants <i>(or history of organ transplants)</i>	Cleanings	Two additional per year
Pregnancy <i>(expectant mothers)</i>	Cleanings	One additional per year*
Medical Risk for Cavities	Fluoride Treatments	Three additional per year

* Previously covered under the EUTF and HSTA VB plans.

VSP Vision

- 15. Standard progressive lenses (no-line multi-focal lenses) covered at 100% for VSP Providers, excluding any lens option add-ons.
- 16. Wal-Mart & Sam's Club have been added to the VSP Network for EUTF.
- 17. \$120 Frame benefit available at all VSP Providers (including Costco, Wal-Mart & Sam's Club).

Life Insurance

18. Securian Financial (Securian) has been chosen as the new carrier for your Group Life Insurance effective July 1, 2019. Coverage is underwritten by Minnesota Life Insurance Company, an affiliate of Securian Financial.
19. The life insurance benefit provided through Securian Financial will change from \$41,116 to \$38,505 for active employees under age 65.
20. Benefits will be reduced once you turn age 65 as follows:
 - a. \$25,028 for participants age 65 through 69
 - b. \$17,737 for participants age 70 through 74
 - c. \$11,552 for participants age 75 through 79
 - d. \$7,701 for participants age 80 and over
21. Increased the maximum age at which the portability provision applies from age 65 to 79. Also increased the maximum age at which such coverage will terminate from age 70 to 80. The portability provision allows a terminated participant to continue their life insurance at a group discounted rate instead of an individual rate, if eligible.
22. The accelerated death benefit will change from up to 75% to 100% of your life insurance benefit. The accelerated death benefit allows a terminally ill participant with a life expectancy of 12 months or less to request early payment of their life insurance benefit.

Come join us at an Open Enrollment Informational Session near you!

Open Enrollment

For EUTF Active Employees

Election period: April 1, 2019 to April 30, 2019

Plan and rate changes effective: July 1, 2019

During the open enrollment election period employees can:

- Add, change, or drop a plan
- Add or remove dependents

No action needed if you are not making any changes



Learn about your health plans
Attend an Open Enrollment Informational Session. EUTF representatives and representatives from each of the health carriers will be there to answer questions.



Fill out the appropriate form
Please complete an EC-1 enrollment form (or EC-1H form for HSTA VB) if making any changes.



Gather information
Educate yourself on the different health plan options and decide if you are going to make changes or stay in your current plan.



Submit forms by the deadline
Completed enrollment form must be submitted with proof documents by April 30, 2019.

**DEADLINE TO SUBMIT
FORM IS APRIL 30, 2019**

DO NOT SUBMIT FORMS TO THE EUTF. Submit EC-1/EC-1H forms to your:

- Departmental Human Resource Office
- DOE-EBU, P.O. Box 2360, Honolulu, HI 96804 (DOE employees)
- Enrollment Designee

2019 Open Enrollment Informational Session Schedule

 OAHU		
Dates	Location	Session Times
April 2, 26	Aloha Stadium Hospitality Room 99-500 Salt Lake Boulevard, Honolulu, HI 96818	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
April 5	Leeward Community College Education Building, Room 201 A & B 96-045 Ala Ike Street, Pearl City, HI 96782	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
April 8, 24	State Capital Auditorium - Basement Level 415 S. Beretania Street, Honolulu, HI 96813	9:00-10:30am, 11:00am-12:30pm, 2:30-4:00pm
		9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
		9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
		9:00-10:30am, 11:00am-12:30pm, 2:30-4:00pm
 KAUAI		
April 1, 29	Kauai War Memorial Exhibit Hall 4191 Hardy Street, Lihue, HI 96766	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
 MAUI		
April 9, 23	UH Maui College Ka'a'ike Building, Room 105 C & D 310 W. Kaahumanu Avenue, Kahului, HI 96732	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
 HAWAII		
March 28	Aunty Sally Kaleohano's Luau Hale 799 Piilani Street, Hilo, HI 96720	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
April 3	West Hawaii Civic Center Community Meeting Hale, Building G 74-5044 Ane Keohokalole Highway, Kailua-Kona, HI 96740	9:30-11:00am, 3:00-4:30pm
April 16	'Imiloa Astronomy Center Moanahoku Hall 600 'Imiloa Place, Hilo, HI, 96720	9:30-11:00am, 11:30am-1:00pm, 3:00-4:30pm
 MOLOKAI and LANAI		
April 11	Lanai Community Center 8 th Street, Lanai City, HI 96763	11:00am-12:30pm, 1:00-2:30pm
April 15	Kualapuu Park & Community Center 1 Uwao Street, Kualapuu, HI 96757	9:30-11:00am, 11:30am-1:00pm
ONLINE WEBINARS		
April 4,10,17	How to access the webinar: Go to eulf.hawaii.gov select "Learning Center" in the menu bar, click the "Webinar" tab, and select the desired webinar.	8:30-10:00am, 1:30-3:00pm, 3:00-4:30pm

IMPORTANT DATES

Open Enrollment Dates

	April 1 – 30, 2019
	April 30, 2019

New Coverage and Rate Changes

	July 1, 2019
	July 15, 2019 through June 30, 2020
	July 20, 2019 through July 5, 2020

Benefit Periods

	July 1, 2019 through June 30, 2020
	January 1, 2019 through December 31, 2019

ENROLLMENT FORM AND ALL REQUIRED PROOF DOCUMENTS MUST BE SUBMITTED ON OR BEFORE APRIL 30, 2019 TO YOUR DEPARTMENTAL HUMAN RESOURCE OFFICE, DOE EBU OFFICE OR ENROLLMENT DESIGNEE

NO ACTION NEEDED IF YOU ARE NOT MAKING ANY CHANGES

Confirmation Notice for Open Enrollment

The EUTF will send you an enrollment Confirmation Notice after processing of EC-1/EC-1H form is completed. The Confirmation Notice allows you to review the changes that were made to your coverages for Open Enrollment.

This Confirmation Notice details the Open Enrollment changes that were made to your account. Please carefully review its contents to make sure it does not contain any errors. Please use the Corrective Action Request Form attached to inform us of any data entry errors. Please be advised that all plan selections are final if you are outside of your initial Open Enrollment period. Any additional changes to your plans will not be allowed until the next Open Enrollment period, unless you experience a mid-year qualifying event that permits changes under the EUTF Administrative Rules.

Open Enrollment forms will be processed during the months of May and June 2019. If you do not receive your Confirmation Notice by the end of June 2019, please contact the EUTF at (808)586-7390 or toll-free at 1-800-295-0089. Although your coverage changes are effective on July 1, 2019, your enrollment may not be processed right away. Therefore, if you need to fill a prescription or go to the doctor prior to receiving your ID cards you should email EUTF at eutf@hawaii.gov. In the email subject line type "URGENT – Confirmation of coverage needed". EUTF checks this email daily and will contact the carrier to rush your enrollment.

IMPORTANT: If any of your dependents are no longer eligible due to a divorce, legal separation, or for dental and vision only, child is no longer a full-time student or is married, they cannot continue to be covered under EUTF or HSTA VB plans. You are required to notify the EUTF and make these terminations when these events occur. Do not wait for open enrollment to submit these terminations. If your child dependent is reaching the maximum age of 26 for medical and prescription drug or 19 for dental and vision (24 for full-time students), disenrollment will occur automatically, and an enrollment form is not necessary.

COBRA PARTICIPANTS

The COBRA Open Enrollment period is April 1 – 30, 2019. See COBRA Open Enrollment instructions on page 80 for information and deadlines for COBRA Open Enrollment.

Premiums

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND ACTIVE EMPLOYEES

EFFECTIVE JULY 1, 2019

ALL BARGAINING UNITS EXCEPT BU 12

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

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution*	Percent Employer	Total
MEDICAL PLANS						
PPO - 90/10 Plan - HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	199.42	398.84	368.50	48.0%	\$767.34
	Two-Party	485.11	970.22	893.72	47.9%	\$1,863.94
	Family	620.10	1,240.20	1,136.36	47.8%	\$2,376.56
PPO - 80/20 Plan - HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	132.50	265.00	368.50	58.2%	\$633.50
	Two-Party	322.49	644.98	893.72	58.1%	\$1,538.70
	Family	412.66	825.32	1,136.36	57.9%	\$1,961.68
PPO - 75/25 Plan - HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	41.15	82.30	316.06	79.3%	\$398.36
	Two-Party	100.26	200.52	766.80	79.3%	\$967.32
	Family	127.90	255.80	977.26	79.3%	\$1,233.06
HMO - HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	252.42	504.84	368.50	42.2%	\$873.34
	Two-Party	613.89	1,227.78	893.72	42.1%	\$2,121.50
	Family	784.40	1,568.80	1,136.36	42.0%	\$2,705.16
HMO - Kaiser Comprehensive Medical, Prescription Drug, and Chiropractic	Self	127.73	255.46	368.50	59.1%	\$623.96
	Two-Party	311.26	622.52	893.72	58.9%	\$1,516.24
	Family	398.97	797.94	1,136.36	58.7%	\$1,934.30
HMO - Kaiser Standard Medical, Prescription Drug and Chiropractic	Self	30.20	60.40	343.74	85.1%	\$404.14
	Two-Party	73.44	146.88	835.20	85.0%	\$982.08
	Family	93.66	187.32	1,065.54	85.0%	\$1,252.86
Supplemental Medical and Prescription Drug - HMA	Self	6.82	13.64	19.20	58.5%	\$32.84
	Two-Party	14.34	28.68	39.94	58.2%	\$68.62
	Family	15.77	31.54	43.84	58.2%	\$75.38
DENTAL PLAN						
HDS Dental	Self	7.21	14.42	20.22	58.4%	\$34.64
	Two-Party	14.42	28.84	40.44	58.4%	\$69.28
	Family	23.71	47.42	66.54	58.4%	\$113.96
VISION PLAN						
VSP Vision	Self	1.12	2.24	3.64	61.9%	\$5.88
	Two-Party	2.07	4.14	6.76	62.0%	\$10.90
	Family	2.72	5.44	8.82	61.9%	\$14.26
LIFE INSURANCE						
Securian Life Insurance	Employee	-	-	4.12	100.0%	\$4.12

* Continuation of July 1, 2018 to June 30, 2019 monthly employer contributions until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website at www.eutf.hawaii.gov for updated information regarding their premiums and contributions.

Premiums

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

EFFECTIVE JULY 1, 2019

BU 12: FOR CITY AND COUNTY OF HONOLULU, COUNTY OF KAUAI, COUNTY OF HAWAII, COUNTY OF MAUI

Benefit Plan	Type of Enrollment	Semi-Monthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution*	Percent Employer	Total
MEDICAL PLANS						
PPO - 90/10 Plan - HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	232.38	464.76	302.58	39.4%	\$767.34
	Two-Party	555.64	1,111.28	752.66	40.4%	\$1,863.94
	Family	701.52	1,403.04	973.52	41.0%	\$2,376.56
PPO - 80/20 Plan - HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	165.46	330.92	302.58	47.8%	\$633.50
	Two-Party	393.02	786.04	752.66	48.9%	\$1,538.70
	Family	494.08	988.16	973.52	49.6%	\$1,961.68
PPO - 75/25 Plan - HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	70.19	140.38	257.98	64.8%	\$398.36
	Two-Party	161.35	322.70	644.62	66.6%	\$967.32
	Family	199.08	398.16	834.90	67.7%	\$1,233.06
HMO - HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	285.38	570.76	302.58	34.6%	\$873.34
	Two-Party	684.42	1,368.84	752.66	35.5%	\$2,121.50
	Family	865.82	1,731.64	973.52	36.0%	\$2,705.16
HMO - Kaiser Comprehensive Medical, Prescription Drug, and Chiropractic	Self	160.69	321.38	302.58	48.5%	\$623.96
	Two-Party	381.79	763.58	752.66	49.6%	\$1,516.24
	Family	480.39	960.78	973.52	50.3%	\$1,934.30
HMO - Kaiser Standard Medical, Prescription Drug and Chiropractic	Self	59.40	118.80	285.34	70.6%	\$404.14
	Two-Party	134.39	268.78	713.30	72.6%	\$982.08
	Family	164.22	328.44	924.42	73.8%	\$1,252.86
Supplemental Medical and Prescription Drug - HMA	Self	6.82	13.64	19.20	58.5%	\$32.84
	Two-Party	14.34	28.68	39.94	58.2%	\$68.62
	Family	15.77	31.54	43.84	58.2%	\$75.38
DENTAL PLAN						
HDS Dental	Self	7.21	14.42	20.22	58.4%	\$34.64
	Two-Party	14.42	28.84	40.44	58.4%	\$69.28
	Family	23.71	47.42	66.54	58.4%	\$113.96
VISION PLAN						
VSP Vision	Self	1.12	2.24	3.64	61.9%	\$5.88
	Two-Party	2.07	4.14	6.76	62.0%	\$10.90
	Family	2.72	5.44	8.82	61.9%	\$14.26
LIFE INSURANCE						
Securian Life Insurance	Employee	-	-	4.12	100.0%	\$4.12

* Continuation of July 1, 2018 to June 30, 2019 monthly employer contributions until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website at www.eutf.hawaii.gov for updated information regarding their premiums and contributions.

Premiums

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

EFFECTIVE JULY 1, 2019

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	171.94	343.88	329.76	49.0%	\$673.64
	Two-Party	416.49	832.98	798.14	48.9%	\$1,631.12
	Family	531.00	1,062.00	1,017.42	48.9%	\$2,079.42
HSTA VB - PPO - 80/20 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug, VSP Vision	Self	116.05	232.10	329.76	58.7%	\$561.86
	Two-Party	280.88	561.76	798.14	58.7%	\$1,359.90
	Family	357.97	715.94	1,017.42	58.7%	\$1,733.36
HSTA VB - HMO - Kaiser Comprehensive Medical, Drug, Chiropractic, and VSP Vision	Self	112.95	225.90	329.76	59.3%	\$555.66
	Two-Party	274.36	548.72	798.14	59.3%	\$1,346.86
	Family	350.58	701.16	1,017.42	59.2%	\$1,718.58
DENTAL PLAN						
HSTA VB - HDS Dental	Self	7.85	15.70	22.12	58.5%	\$37.82
	Two-Party	15.71	31.42	44.22	58.5%	\$75.64
	Family	25.85	51.70	72.74	58.5%	\$124.44
HSTA VB - HDS Supplemental Dental	Self	4.11	8.22	11.34	58.0%	\$19.56
	Two-Party	8.21	16.42	22.70	58.0%	\$39.12
	Family	12.31	24.62	34.06	58.0%	\$58.68
VISION PLAN						
HSTA VB - VSP Vision	Self	1.12	2.24	3.64	61.9%	\$5.88
	Two-Party	2.07	4.14	6.76	62.0%	\$10.90
	Family	2.72	5.44	8.82	61.9%	\$14.26
LIFE INSURANCE						
HSTA VB - Securian Life Insurance	Employee	-	-	4.12	100.0%	\$4.12

* Continuation of July 1, 2018 to June 30, 2019 monthly employer contributions until a collective bargaining agreement is reached. Employees should contact their employer or check the EUTF website at www.eutf.hawaii.gov for updated information regarding their premiums and contributions.

EUTF Health Plan Information

This section provides 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 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 Guide to Benefits, the language in the carrier's Guide to Benefits will take precedence.

EUTF Health Plan Options



Preferred Provider Organization Plans

- HMSA PPO 90/10 Plan
- HMSA PPO 80/20 Plan
- HMSA PPO 75/25 Plan



Dental Plan
Hawaii Dental Service (HDS)



Health Maintenance Organization Plans

- KAISER HMO Comprehensive
- KAISER HMO Standard
- HMSA EUTF HMO



Vision Plan
Vision Service Plan (VSP)



Prescription Drug Plans

- CVS Caremark Prescription Drug Plan
- Kaiser Prescription Drug Plan



Life Insurance
Securian



Supplemental Plan

- Hawaii-Mainland Administrators (HMA)

Medical Plan Options

EUTF medical plans include prescription drug and chiropractic coverage. Employees are given a choice of seven 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.

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

A PPO is a medical plan that includes a network of preferred medical providers who have contracts with the insurance carrier. Health care benefits are also available if you go to a provider who is not in the network. A PPO gives you the flexibility to visit the providers you choose – inside or outside of the Plan's network. With the HMSA PPO plan, your out-of-pocket medical costs will be lower if you receive care from an in-network provider or facility. The plan title – 90/10 – refers to the share of the cost by the health plan and member. The plan pays 90% of the eligible charges for most covered in-network services, and the member pays 10%. Before making an appointment, first ask if your medical provider is in your plan's network. With the HMSA PPO plan, if you use an out-of-network provider, your out-of-pocket costs may be higher. Also, you will often be responsible for submitting your own claims. 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.

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

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

Supplemental Plan (Copayment/Coinsurance Plan) - EUTF 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 non-State/County employed 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 have Medicare or Med-QUEST coverage you are not eligible to enroll in this plan.

Healthcare Terms and Definitions

The following is a list of important healthcare terms and definitions.

Calendar Year: A twelve-month period starting January 1 and ending December 31.

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

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

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 in order to safeguard a member's Protected Health Information (PHI).

In-Network or Participating Provider: A physician, hospital, pharmacy, laboratory, or other healthcare provider your insurance carrier has contracted with to provide services at a negotiated fee or eligible charge rate. In most cases, participating providers are preferable to non-participating providers because of the lower out-of-pocket 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, but the limiting age is 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, non-covered services such as taxes, charges in excess of the maximum allowable fee, and dental plan and vision plan expenses. The MOOP protects the 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).

Network: A group of providers that contract with an insurance carrier to provide healthcare 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 delete dependents outside of experiencing a mid-year qualifying event.

Out-of-Network or Non-Participating Provider: A physician, hospital, pharmacy, laboratory or other healthcare 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 carriers' eligible charge.

For example, if the non-participating provider's charge for a primary care office visit is \$120, the plan's eligible charge is \$100 and the out-of-network coinsurance is 30%, the plan will pay \$70 ($\$100 \times 70\%$) 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 non-covered services.

Plan Year: For active employees, a twelve-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 healthcare.

Primary Care Provider (PCP): A healthcare 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 healthcare professional who provides treatment or service.

Qualifying Event: An event such as loss of coverage, acquisition of 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 sugar monitors, blood sugar 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 significantly 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 PPO MEDICAL PLAN COVERAGE CHART

GENERAL	Provider Network	Out-of-Network*		Out-of-Network*	
	Calendar Year Deductible**	None	\$100 per person \$300 per family	None	\$250 per person \$750 per family
Calendar Year Maximum Out-of-Pocket**		\$2,000 per person \$4,000 per family		\$2,500 per person \$5,000 per family	
Lifetime Benefit Maximum		None		None	
Plan Year Benefit Maximum		None		None	
PHYSICIAN SERVICES		10%	30%	20%	40%
	Annual Preventive Health Exam	No Charge	No Charge***	No Charge	No Charge***
	Screening Mammography	No Charge	30%***	No Charge	40%***
	Immunizations	No Charge	No Charge***	No Charge	No Charge***
	Well Child Care Visits	No Charge	30%***	No Charge	40%***
	Maternity	10%	30%	20%	40%
Advance Care Planning	No Charge	30%	No Charge	40%	
ER	Ambulance	10%	30%	20%	40%
INPATIENT CARE	Ancillary Services	10%	30%	20%	40%
	Physician Services	10%	30%	20%	40%
	Surgery	10%	30%	20%	40%
	Anesthesia	10%	30%	20%	40%
	Mental Health Services – Facility Services	10%	30%	20%	40%
OUTPATIENT CARE	Lab & Pathology	10%	30%	20%	40%
	Diagnostic Testing & X-ray (incl. genetic testing, screening, and counseling)	10%	30%	20%	40%
	Surgery	10%	30%	20%	40%
	Anesthesia	10%	30%	20%	40%
	Mental Health Services – Facility Services	10%	30%	20%	40%
OTHER SERVICES	Durable Medical Equipment				
	Home Health Care	No Charge (150 visits/CY)	30% (150 visits/CY)	20% (150 visits/CY)	40% (150 visits/CY)
	Hospice Care	No Charge	Not Covered	No Charge	Not Covered
	Skilled Nursing Facility Care	10% (120 days/CY)	30% (120 days/CY)	20% (120 days/CY)	40% (120 days/CY)
	Physical & Occupational Therapy	10%	30%	20%	40%

NOTES

*If you receive services from an out-of-network provider you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge.

**Amounts paid toward the deductible and the maximum out-of-pocket are measured on a calendar year basis. However, if your new plan effective 7/1/19 is with the same carrier, the amounts paid from 1/1/19 – 6/30/19 will apply to your new plan deductible and maximum out-of-pocket. No refunds will be issued. Under Calendar Year Deductible, “family” is defined as three or more persons. Under Calendar Year Maximum Out-of-Pocket, “family” is defined as two or more persons.

***Deductible does not apply.

For prescription drug coverage, refer to the PPO Prescription Drug Plan Coverage Chart on page 26.

EUTF HMO MEDICAL PLAN COVERAGE CHART

GENERAL		KAISER COMPREHENSIVE*	KAISER STANDARD*	HMSA HMO
	Calendar Year Deductible	None	None	None
	Calendar Year Maximum Out-of-Pocket**	\$2,000 per person \$6,000 per family	\$2,500 per person \$7,500 per family	\$1,500 per person \$3,000 per family
	Lifetime Benefit Maximum	None	None	None
	Plan Year Benefit Maximum	None	None	None
PHYSICIAN SERVICES	Physician Office Visit (incl. primary care and specialist office visits)	\$15	\$20	\$15
	Annual Health Exam	No Charge	No Charge	No Charge
	Screening Mammography	No Charge	No Charge	No Charge
	Immunizations	No Charge	No Charge	No Charge
	Well Child Care Visits	No Charge	No Charge	No Charge
	Maternity	No charge for routine prenatal visits, delivery, and one postpartum visit	No charge for routine prenatal visits and one postpartum visit; 15% for delivery	No charge for routine prenatal visits, delivery, and one postpartum visit
	Advance Care Planning	No Charge (Continuing Care)	No Charge (Continuing Care)	No Charge
ER	Emergency Room (ER care)	\$50	\$100	\$100
	Ambulance	20%	20%	20%
INPATIENT CARE	Room & Board	No Charge	15%	No Charge
	Ancillary Services	No Charge	15%	No Charge
	Physician Services	No Charge	15%	No Charge
	Surgery	No Charge	15%	No Charge
	Anesthesia	No Charge	15%	No Charge
	Mental Health Services – Facility Services	No Charge	15%	No Charge
OUTPATIENT CARE			\$20 for chemotherapy 20% for radiation therapy	\$15
		\$15/ department/ day	\$10/ department/ day for basic; 20% for specialty	No Charge
	Diagnostic Testing & X-ray	\$15/ department/ day	20% for testing services; \$10/ department/ day for basic radiology; 20% for specialty imaging services	No charge for diagnostic testing; \$15 per X-ray
		\$15	15% for outpatient surgery center services; \$20 for outpatient professional charges	No charge for outpatient surgery center services; \$15 for outpatient professional charges
		\$15	\$20	\$15
	\$15	\$20	No Charge	
OTHER SERVICES	Durable Medical Equipment	20%	50%	20%
	Home Health Care	No Charge	No Charge	No Charge (365 visits/illness or injury)
	Hospice Care	No Charge	No Charge	No Charge
	Skilled Nursing Facility Care	No Charge (100 days/benefit period)	15% (60 days/benefit period)	No Charge (100 days/CY)
	Physical & Occupational Therapy – Outpatient	\$15	\$20	\$15

NOTES	<p>*For Kaiser Members only:</p> <p>1. Except for certain situations described in your Group Medical and Hospital Service Agreement, all claims, disputes, or causes of action arising out of or related to your Group Medical and Hospital Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your <i>Group Medical and Hospital Service Agreement</i>.</p> <p>2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.</p> <p>**Kaiser: Amounts paid toward the maximum out-of-pocket, include both medical and prescription drug costs, are measured on a calendar year basis. However, if your new plan effective 7/1/19 is with the same carrier through EUTF, the amounts paid from 1/1/19 – 6/30/19 will apply to your new plan maximum out-of-pocket. No refunds will be issued.</p> <p>For prescription drug coverage, refer to HMO Prescription Drug Plan Coverage Chart on page 27.</p>	<p>HMSA HMO:</p> <p>**Amounts paid toward the maximum out-of-pocket are measured on a calendar year basis. However, if your new plan effective 7/1/19 is with the same carrier, the amounts paid from 1/1/19 – 6/30/19 will apply to your new plan maximum out-of-pocket. No refunds will be issued.</p> <p>For prescription drug coverage, refer to HMO Prescription Drug Plan Coverage Chart on page 27.</p>
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EUTF PPO PRESCRIPTION DRUG PLAN COVERAGE CHART

GENERAL	CVS/caremark* EUTF HMSA PPO		
		In-Network Pharmacy	Out-of-Network** Pharmacy
	Calendar Year Maximum Out-of-Pocket (Single/Family)***	90/10 and 80/20 PPO Plan: \$4,350/\$8,700 75/25 PPO Plan: \$2,900/\$5,800	
RETAIL	Day Supply	30/60/90	30/60/90
	Generic	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges
	Preferred Brand	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges
	Non-Preferred Brand	\$50/\$100/\$150	\$50/\$100/\$150 + 20% of eligible charges
	Preferred Insulin	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges
	Other Insulin	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges
	Preferred Diabetic Supplies	No Copayment	20% of eligible charges
	Other Diabetic Supplies	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges
	Injectables and Specialty Drug	30-DAY SUPPLY ONLY	
	Specialty Calendar Year Maximum Out-of-Pocket	\$2,500 per person	
	Specialty Generic	10% of eligible charges; Up to \$200 per fill	
	Specialty Preferred Brand	20% of eligible charges; Up to \$300 per fill	
	Specialty Non-Preferred Brand	30% of eligible charges; Up to \$400 per fill	
Oral Oncology	\$30		
RETAIL 90 & MAIL ORDER	Day Supply	30/60/90	For non-Retail 90 pharmacies, see benefits above For out-of-network mail pharmacies, not a benefit
	Generic	\$5/\$10/\$10	
	Preferred Brand	\$25/\$50/\$50	
	Non-Preferred Brand	\$50/\$100/\$100	
	Preferred Insulin	\$5/\$10/\$10	
	Other Insulin	\$25/\$50/\$50	
	Preferred Diabetic Supplies	No Copayment	
	Other Diabetic Supplies	\$25/\$50/\$50	
	Injectables and Specialty Drug	Not Covered	

For more information on Retail 90 and mail order please call CVS at 1-855-801-8263

*This plan is the prescription drug coverage for the HMSA PPO medical plans and is administered by CVS/caremark.
 **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. Mail order is not a benefit through out-of-network vendors.
 ***Applicable copayments and caps for specialty medications apply and are counted towards the total annual maximum out-of-pocket for the 90/10 plan, the 80/20 plan and the 75/25 plan.

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

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

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

RETAIL	Day Supply	30/60/90	30/60/90	30/60/90
	Generic	\$5/\$10/\$15 – tier 1	\$5/\$10/\$15 – tier 1	\$5/\$10/\$15
		\$10/\$20/\$30 – tier 2	\$15/\$30/\$45 – tier 2	
	Preferred Brand	\$35/\$70/\$105	\$50/\$100/\$150	\$25/\$50/\$75
	Non-Preferred Brand	\$35/\$70/\$105	\$50/\$100/\$150	\$50/\$100/\$150
	Preferred Insulin	\$35/\$70/\$105	\$50/\$100/\$150	\$5/\$10/\$15
	Other Insulin	\$10/\$20/\$30 (Generic)	\$15/\$30/\$45 (Generic)	\$25/\$50/\$75 (Non-Preferred)
	Preferred Diabetic Supplies			No Copayment
	Other Diabetic Supplies	\$35/\$70/\$105	50% of applicable charges	\$25/\$50/\$75
	Injectables and Specialty Drug			30-DAY SUPPLY ONLY
	Specialty Calendar Year Maximum Out-of-Pocket	Applies towards the medical maximum out-of-pocket	Applies towards the medical maximum out-of-pocket	\$2,500 per person
	Specialty Generic			10% of eligible charges; Up to \$200 per fill
	Specialty Preferred Brand	\$75/\$150/\$225	\$75/\$150/\$225	20% of eligible charges; Up to \$300 per fill
	Specialty Non-Preferred Brand			30% of eligible charges; Up to \$400 per fill
Oral Oncology	No Copayment	Generic: \$15 Brand: \$50 Specialty: \$75	\$30	
RETAIL 90 & MAIL ORDER	Day Supply	30/60/90	30/60/90	30/60/90
	Generic	\$5/\$10/\$10 – tier 1	\$5/\$10/\$10 – tier 1	\$5/\$10/\$10
		\$10/\$20/\$20 – tier 2	\$15/\$30/\$30 – tier 2	
	Preferred Brand	\$35/\$70/\$70	\$50/\$100/\$100	\$25/\$50/\$50
	Non-Preferred Brand	\$35/\$70/\$70	\$50/\$100/\$100	\$50/\$100/\$100
	Preferred Insulin	Not available through Mail Order	Not available through Mail Order	\$5/\$10/\$10
	Other Insulin			\$25/\$50/\$50
	Preferred Diabetic Supplies			No Copayment
Other Diabetic Supplies	\$35/\$70/\$70	50% of applicable charges	\$25/\$50/\$50	

For information on mail order please call Kaiser at 808-643-7979 or CVS at 1-855-801-8263

*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 towards the total annual maximum out-of-pocket for the HMO plan.

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.

Additional Information on CVS/caremark EUTF Prescription Drug

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 medication without compromising care as these medications have the same level of effectiveness. 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 are covered with no copayment (if you have a prescription from your physician) including but not limited to generic statin drugs, tobacco cessation products, aspirin, folic acid and iron supplements. Please contact CVS/caremark for additional information on coverage for these preventive care drugs.

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

Web Service

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

Customer Care

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

Coordination of Benefits

Some participants may be enrolled in additional prescription coverage outside of their EUTF benefits. If this applies to you, please contact CVS/caremark Customer Care at 1-855-

801-8263 to advise if your EUTF plan is secondary. When you go to the pharmacy, let them know that your EUTF plan is secondary and they will be able to coordinate benefits for you at the Point of Sale. You also have the option to send in a paper claim form for reimbursement. Below is a list of the required documentation to submit a paper claim for reimbursement. Please note that Coordination of Benefits does not guarantee 100% coverage of your medication. All EUTF plan parameters and guidelines will still apply and may conflict with your other benefits in some cases.

Required Documentation for Paper Claims

Paper claims must be submitted to CVS/caremark within 1 year from the date of purchase.

- Pharmacy receipt including:

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

- Completely filled out paper claim form with patient signature

All paper claim reimbursement requests should be mailed to:

CVS/caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Pharmacy Network

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

Utilization Management Programs

In an ongoing effort to effectively manage the prescription drug benefit, certain medications are subject to clinical

guidelines as part of the prescription benefit plan design. The drug benefit includes the addition of the following three (3) clinical guidelines:

1. **Quantity Limitations** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies and input, review, and approval from the CVS/caremark National Pharmacy and Therapeutics (P&T) Committee.
2. **Generic Step Therapy Program (GSTP)** - The EUTF encourages the use of generic medications as an alternative to certain brand medications as an affordable and effective form of treatment to many health conditions. In an effort to promote use of generic medications, CVS/caremark has a generic step therapy program in place for all EUTF active employees. For certain 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 1 & 2) Program on this page.
3. **Prior Authorization (PA)** – Authorization process to ensure medical necessity of targeted drugs/classes before they are covered by the plan.

Specialty Drug Program

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

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

ACSF requires the use of preferred specialty medications prescribed for the treatment of certain conditions. For coverage of non-preferred specialty medications, your physician may call 808-254-4414 to obtain a prior authorization or to submit a medical exception request.

Specialty Tiers

Most medications that fall within a specialty tier will be subject to the applicable coinsurance up to a maximum-capped copayment per fill. Exception: Oral oncology medications provided under the Specialty Drug Program will have a \$30 copayment instead of a tier level coinsurance. There is a \$2,500 maximum out-of-pocket per person, per calendar year for specialty drug copayments.

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

Dispensed as Written (DAW 1&2) Program

The Dispensed as Written Program requires participants to use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic copayment will apply. However, if a participant 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.

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



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. Typically, your physician may write your prescription for these medications in a 90-day supply. The

Mail Order Program is voluntary, but the requirement to fill maintenance medications in a 90-day supply is still required when you fill your prescription for maintenance medications at the CVS/caremark Mail Order Facility, or through any retail pharmacy in the CVS/caremark network. Participants are allowed (3) 30-day initial fills at the retail pharmacy for each new medication or new dosage amount in order to determine if the medication or dosage is correct. When you fill a prescription for a 90-day supply of a medication through either the mail order facility or through a Retail 90 pharmacy, you will pay two copayments for a three-month supply. If you fill a prescription for a 90-day supply of medication at a non-Retail 90 pharmacy, you will pay three copayments for a three-month supply. Overall, the cost to the plan is the lowest when you use the mail-pharmacy to fill your prescriptions for maintenance medications. You are encouraged to use mail order services to keep plan costs lower. To start mail order contact CVS/caremark at 1-855-801-8263.

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

EUTF SUPPLEMENTAL MEDICAL AND PRESCRIPTION DRUG PLAN COVERAGE CHART

GENERAL		All Services: \$2,750 per person, including the Prescription Drug Sublimit listed below
PHYSICIAN SERVICES	Physician Office Visit (incl. primary care and specialist office visits)	Copayment/Coinsurance covered
	Routine Physical Exams	Copayment/Coinsurance covered
	Screening Mammography	Copayment/Coinsurance covered
	Immunizations	Copayment/Coinsurance covered
	Well Child Care Visits	Copayment/Coinsurance covered
	Maternity	Copayment/Coinsurance covered
ER	Emergency Room (ER care)	Copayment/Coinsurance covered
	Ambulance	Copayment/Coinsurance covered
INPATIENT CARE	Room & Board	Copayment/Coinsurance covered
	Ancillary Services	Copayment/Coinsurance covered
	Physician Services	Copayment/Coinsurance covered
	Surgery	Copayment/Coinsurance covered
	Anesthesia	Copayment/Coinsurance covered
	Mental Health Services	Copayment/Coinsurance covered
OUTPATIENT CARE	Chemotherapy/Radiation Therapy	Copayment/Coinsurance covered
	Lab & Pathology	Copayment/Coinsurance covered
	Diagnostic Testing & X-ray	Copayment/Coinsurance covered
	Surgery	Copayment/Coinsurance covered
	Anesthesia	Copayment/Coinsurance covered
	Mental Health Services	Copayment/Coinsurance covered
OTHER SERVICES	Durable Medical Equipment	Copayment/Coinsurance covered
	Home Health Care	Copayment/Coinsurance covered
	Hospice Care	Copayment/Coinsurance covered
	Skilled Nursing Facility Care	Copayment/Coinsurance covered
	Physical & Occupational Therapy	Copayment/Coinsurance covered
PRESCRIPTION DRUGS	Plan Year Benefit Maximum Prescription Drug Sublimit	\$250 per person
	Prescription Drugs	Reimbursement for prescription drug copayments charges shall not exceed \$20 per 30-day supply. Reimbursement for prescription drugs copayment counts towards the Plan Year Benefit Maximum.
NOTES	<p>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 prior to receiving any supplemental plan reimbursements. This plan does not coordinate benefits, pre-authorizations are not required and ID cards will not be provided.</p> <p>Claims can easily be submitted online at www.hma-hi.com/eutf. All claim submissions require an Explanation of Benefits (EOB) from your primary medical plan or pharmacy receipts for all prescription drug reimbursements. Claims may also be submitted by mail or fax. Please mail a claim form, along with any supporting EOB's or receipts, to HMA Claims Dept., P.O. Box 135005, Honolulu, HI 96801-5005. Please fax any claims to (808) 951-4620.</p> <p>Please Note: This supplemental plan does not cover chiropractic benefits.</p> <p>Please Note: 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.</p> <p>Please contact our EUTF Customer Service team at (866) 437-1992 for any assistance. Visit www.hma-hi.com/eutf for all plan documents and additional helpful information.</p>	

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 have maintained continuous enrollment under HSTA VB health and/or life insurance plans. HSTA VB members must complete an EC-1H enrollment form if making changes. New employees CANNOT 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 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 plan options include:

Health Plan Options	
 <p>Preferred Provider Organization Plans</p> <ul style="list-style-type: none"> - HMSA PPO 90/10 Plan - HMSA PPO 80/20 Plan 	 <p>Dental Plan Hawaii Dental Service (HDS)</p> <ul style="list-style-type: none"> - HSTA VB Dental Plan - HSTA VB Supplemental Plan
 <p>Health Maintenance Organization Plans</p> <ul style="list-style-type: none"> - Kaiser HMO Comprehensive Plan 	 <p>Vision Plan Vision Service Plan (VSP)</p>
 <p>Prescription Drug Plans</p> <ul style="list-style-type: none"> - CVS Caremark Prescription Drug Plan - Kaiser Prescription Drug Plan 	 <p>Life Insurance Securian</p>

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

HSTA VB PPO & HMO MEDICAL PLAN COVERAGE CHART

GENERAL	Provider Network	HSTA VB HMSA 90/10 PPO		HSTA VB HMSA 80/20 PPO		HSTA VB KAISER COMPREHENSIVE HMO
		In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network
	Calendar Year Deductible**	None	\$100 per person \$300 per family	None	None	None
	Calendar Year Maximum Out-of-Pocket**	\$2,000 per person \$4,000 per family		\$2,500 per person \$5,000 per family		\$2,000 per person \$6,000 per family
	Lifetime Benefit Maximum	None		None		None
	Plan Year Benefit Maximum	None		None		None
PHYSICIAN SERVICES	Physician Office Visit (incl. primary care and specialist office visits)	10%	30%	20%	20%	\$15
	Routine Physical Exams	No Charge	No Charge***	No Charge	No Charge	No Charge
	Screening Mammography	No Charge	30%	No Charge	No Charge	No Charge
	Immunizations	No Charge	30%	No Charge	No Charge	No Charge
	Well Child Care Visits	No Charge	30%***	No Charge	No Charge	No Charge
	Maternity	10%	30%	20%	20%	No charge for routine prenatal visits, delivery, and one postpartum visit
	Advance Care Planning	No Charge	30%	No Charge	20%	No Charge (Continuing Care)
ER	Emergency Room (ER care)	10%	10%***	20%	20%	\$50
	Ambulance	10%	30%	20%	20%	20%
INPATIENT CARE	Room & Board	10%	30%	20%	20%	No Charge
	Ancillary Services	10%	30%	20%	20%	No Charge
	Physician Services	10%	30%	20%	20%	No Charge
	Surgery	10%	30%	20%	20%	No Charge
	Anesthesia	10%	30%	20%	20%	No Charge
	Mental Health Services	10%	30%	20%	20%	No Charge
OUTPATIENT CARE	Chemotherapy/Radiation Therapy	10%	30%	20%	20%	\$15
	Surgery	10%	30%	20%	20%	\$15
	Lab & Pathology	10%	30%	No Charge	No Charge	\$15/ department/ day
	Diagnostic Testing & X-ray (incl. genetic testing, screening, and counseling)	10%	30%	20%	20%	\$15/ department/ day
	Anesthesia	10%	30%	20%	20%	\$15
	Mental Health Care	10%	30%	20%	20%	\$15
OTHER SERVICES	Durable Medical Equipment	10%	30%	20%	20%	20%
	Home Health Care	No Charge (150 visits/CY)	30% (150 visits/CY)	No Charge (150 visits/CY)	No Charge (150 visits/CY)	No Charge
	Hospice Care	No Charge	Not Covered	No Charge	No Charge	No Charge
	Skilled Nursing Facility Care	10% (120 days/CY)	30% (120 days/CY)	20% (120 days/CY)	20% (120 days/CY)	No Charge (100 days/benefit period)
	Physical & Occupational Therapy	10%	30%	20%	20%	\$15

NOTES	
<p>*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.</p> <p>**Amounts paid toward the deductible and the maximum out-of-pocket are measured on a calendar year basis. However, if your new plan effective 7/1/19 is with the same carrier, the amounts paid from 1/1/19 – 6/30/19 will apply to your new plan deductible and maximum out-of-pocket. No refunds will be issued.</p> <p>***Deductible does not apply.</p> <p>For prescription drug coverage, refer to the HSTA VB PPO/HMO Prescription Drug Plan Coverage Chart on page 34.</p>	<p>For Kaiser Members only:</p> <ol style="list-style-type: none"> 1. Except for certain situations described in your Group Medical and Hospital Service Agreement, all claims, disputes, or causes of action arising out of or related to your Group Medical and Hospital Service Agreement, its performance or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your <i>Group Medical and Hospital Service Agreement</i>. 2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

RETAIL	Day Supply		30/60/90
		\$5/\$9/\$9	\$5/\$9/\$9 + 30% of eligible charges
		\$15/\$27/\$27	\$15/\$27/\$27 + 30% of eligible charges
		\$5/\$9/\$9	\$5/\$9/\$9 + 30% of eligible charges
		No Copayment	30% of eligible charges
MAIL ORDER	Day Supply	30/60/90	30/60/90
	Generic	\$5/\$9/\$9	Not a benefit
	Brand	\$15/\$27/\$27	
	Insulin	\$5/\$9/\$9	
	Diabetic Supplies	No Copayment	50% of eligible charges

For information on mail order please call CVS at 1-855-801-8263 or Kaiser at 808-643-7979

*This plan is the prescription drug coverage for the HMSA PPO medical plans and is administered by CVS/caremark.
 **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.
 Please note: 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.
 Medications prescribed for treatment that are not approved by the Food and Drug Administration (FDA) are excluded from the plan.

Additional Information on CVS/caremark HSTA VB Prescription Drug Plans

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. Preferred medications are usually priced lower than other brand name medications.

To comply with the Affordable Care Act, certain preventive care drugs are covered with no copayment (if you have a prescription from your physician) including but not limited to generic statin drugs, tobacco cessation products, aspirin, folic acid and iron supplements. Please contact CVS/caremark for additional information on coverage for these preventive care drugs.

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

Web Service

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

Customer Care

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

Coordination of Benefits

Some participants may be enrolled in additional prescription coverage outside of their HSTA VB benefits. If this applies to you, please contact CVS/caremark

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

Required Documentation for Paper Claims

Paper claims must be submitted to CVS/caremark within 1 year from the date of purchase.

Pharmacy receipt including:

- | | |
|--|--|
| <input type="checkbox"/> Patient's name | <input type="checkbox"/> Metric quantity |
| <input type="checkbox"/> Date of fill | <input type="checkbox"/> Day supply |
| <input type="checkbox"/> Prescription number | <input type="checkbox"/> Prescribing Doctor's name or NPI number |
| <input type="checkbox"/> Name of medication | <input type="checkbox"/> Pharmacy name & address or pharmacy NABP number |

- Completely filled out paper claim form with patient signature

All paper claim reimbursement requests should be mailed to:

CVS/caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Utilization Management Programs

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

1. **Quantity Limitations** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies and input, review, and approval from the CVS/caremark National Pharmacy and Therapeutics (P&T) Committee.

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

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

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

Dispensed as Written (DAW 2) Program
 The Dispensed as Written Program requires participants use a generic equivalent medication, when available, in place of the associated brand name medication. The standard generic copayment will apply. However, if a participant chooses to use 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.

Specialty Drug Program

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

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

Dental, Vision, Chiro and Life Insurance Benefits

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.

Hawaii Dental Service (HDS)

The Hawaii Dental Service benefit chart begins on page 39. The HDS public website at www.HawaiiDentalService.com includes a section exclusively for EUTF members. In this section, you will find valuable information on your HDS dental plan including your dental benefits and plan brochure.

In-Network and Out-of-Network Providers

Search online at HawaiiDentalService.com or contact HDS to find an in-network or participating dentist to maximize your benefits and help keep your out-of-pocket cost down. If you choose to have services performed by a dentist who is not an HDS or Delta Dental participating dentist, you are responsible for the difference between the amount that the non-participating dentist actually charges and the amount paid by HDS in accordance with your plan. In most cases you will need to pay in full at the time of service. The non-participating dentist will render services and may provide you with the completed claim form (universal ADA claim form) to submit to HDS. Mail the completed claim form for processing to:

HDS – Dental Claims
700 Bishop Street, Suite 700
Honolulu, HI 96813-4196

HDS Online

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

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

1. Go to HawaiiDentalService.com
2. Follow the directions on-screen to create a new account.
3. Complete the "Member Registration" form.
4. Select "Yes" to "Request electronic Explanation of Benefits."

HDS will then send you an e-mail 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.

Vision Service Plan (VSP)

The Vision Service Plan benefit chart is located on page 41.

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. Before seeing an out-of-network provider, call VSP at 1-866-240-8420, or go on-line at www.vsp.com to search for a VSP doctor near you.

No ID Cards

There are no ID cards issued for VSP members. Members simply notify their vision provider that they are VSP members and VSP Providers will file a claim to VSP. Members can download and print an ID card if desired, by setting up an online account at www.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), get a "VSP Savings Statement" detailing your past service, and 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 www.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 User Name and Password.

Dental Benefits Coverage Chart - EUTF and HSTA VB

HAWAII DENTAL SERVICE (HDS)

	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	\$2,000
DEDUCTIBLE per plan year (July 1 – June 30) (does not apply to benefits covered at 100% and orthodontics)	\$50/person
Examinations - 2 per year	
Bitewing X-rays - 2 per year through age 14; 1 per year thereafter	100%
Other X-rays - full mouth X-rays limited to 1 every 5 years	100%
Cleanings – 2 per year	100%
Expectant mothers – additional 1 per year; cleanings or gum maintenance	100%
Members with a history of cancer (chemotherapy or radiation), diabetes, Sjogren's Syndrome, stroke, heart attack, congestive heart failure, kidney failure or organ transplant – additional 2 per year; cleanings or gum maintenance	100%
Fluoride - 2 per year through age 19	100%
For HSTA VB Members: Fluoride – 1 per year through age 19	100%
Members with a history of oral cancer (chemotherapy or radiation) or Sjogren's Syndrome – additional 4 per year	100%
Members with a history of cancer other than oral cancer (chemotherapy or radiation) – additional 2 per year	100%
Medical risk for cavities – additional 3 per year	100%
Space maintainers - through age 17	100%
Sealants - through age 18 (one treatment application, once per lifetime only to permanent molars with no cavities and no occlusal restorations, regardless of the number of surfaces sealed)	100%
BASIC CARE	
Fillings – silver fillings; white-colored fillings limited to front teeth	
Root Canals	
Gum/Bone Surgeries & Maintenance	80%
Cleaning for gum disease – 2 per year after qualifying gum treatment	
Oral Surgeries	
MAJOR CARE	
Crowns and Gold Restorations - once every 5 years when teeth cannot be restored with silver or white fillings	60%
Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
Fixed Bridges & Dentures - 1 every 5 years; ages 16 and older	60%
Implants - Surgical placement of endosteal implant and abutment, 1 per tooth, every 5 years (ages 19 and older)	60%
For HSTA VB Members: Implants (covered as an alternate benefit) when one tooth is missing between two natural teeth, 1 per tooth, every 5 years (age 16 and older)	
OTHER SERVICES	
Adjunctive General Services	80%
Emergency Treatment of Dental Pain	100%
Orthodontics	50%
Maximum amount payable by HDS for an eligible patient shall be \$1,000 lifetime per case paid in eight quarterly payments of \$125.	
Orthodontic services are not covered:	
*If services were started prior to the date the patient became eligible under this employer's plan.	
*If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue.	
*If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	

*Note: If a subscriber has met the 12-month waiting period, his/her dependents will have met the waiting period requirement as well.

Dental Benefits Coverage Chart - HSTA VB Supplemental Plan

HAWAII DENTAL SERVICE (HDS)

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	\$750
DIAGNOSTIC & PREVENTIVE CARE (Time limitations based on calendar year)	
Examinations - 2 per year	50%
Bitewing X-rays - 2 per year through age 14; 1 per year thereafter	50%
Other X-rays - full mouth X-rays limited to 1 every 5 years	50%
Cleanings – 2 per year	50%
Expectant mothers – additional 1 per year; cleanings or gum maintenance	
Members with a history of cancer (chemotherapy or radiation), diabetes, Sjogren's Syndrome, stroke, heart attack, congestive heart failure, kidney failure or organ transplant – additional 2 per year; cleanings or gum maintenance	100%
Fluoride – 1 per year through age 19	50%
Members with a history of oral cancer (chemotherapy or radiation) or Sjogren's Syndrome – additional 4 per year	
Members with a history of cancer other than oral cancer (chemotherapy or radiation) – additional 2 per year	100%
Medical risk for cavities – additional 3 per year	
Space maintainers – through age 17	50%
Sealants – through age 18 – one treatment application, once per lifetime only to permanent molars with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	50%
BASIC CARE	
Fillings – silver fillings; white-colored fillings limited to front teeth	45%
Root Canals	45%
Gum/Bone Surgeries & Maintenance	45%
Cleaning for gum disease – 2 per year after qualifying gum treatment	
Oral Surgeries	50%
MAJOR CARE	
Crowns and Gold restorations – once every 5 years when teeth cannot be restored with amalgam or composite fillings	45%
Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist.	
Fixed Bridges & Dentures – 1 every 5 years; ages 16 and older	45%
Implants – (covered as an alternate benefit) when one tooth is missing between two natural teeth, 1 per tooth, every 5 years (ages 16 and older)	50%
OTHER SERVICES	
Adjunctive General Services	45%
Emergency Treatment of Dental Pain	50%
Orthodontics	100%
Maximum amount payable by HDS for an eligible patient shall be \$750 lifetime per case paid in eight quarterly payments of \$93.75.	
Orthodontic services are not covered:	
*If services were started prior to the date the patient became eligible under this employer's plan.	
*If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue.	
*If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	

Vision Benefits Coverage Chart – EUTF and HSTA VB

Vision Service Plan (VSP)

Service	Frequency	In-Network	Out-of-Network
Exam – Covered in full	Every plan year*	Plan covers 100% after \$10 copayment	Plan reimburses up to \$45.00
Prescription Glasses – Lenses: – Single vision, bifocals, trifocals, including standard progressives – Polycarbonate (children up to age 18) – UV Coating	Every plan year*	Plan covers 100% after \$25 copayment	Plan reimburses Single Lens - up to \$45.00 Bifocal Lens - up to \$65.00 Trifocal Lens - up to \$85.00
Prescription Glasses – Frames	Every other plan year*	\$120 allowance	Plan reimburses up to \$47.00
Contact Lenses <i>(Instead of Glasses)</i>	Every plan year*	\$120 allowance (applies to cost of contacts, fitting & evaluation)	Plan reimburses up to \$105.00

*Plan year is July 1st – June 30th

Extra Discounts and Savings from VSP Providers

Glasses & Sunglasses

- 20% off frame costs exceeding \$120 allowance[†]
- Average 35-40% savings on all non-covered lens options (such as tints, progressive lenses, anti-scratch coatings, etc.)[†].
- 30% off additional glasses & sunglasses, including lens options, from the same VSP doctor on the same day as your exam.
- 20% off any VSP doctor within 12 months of your last exam.

Contact Lenses

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

Laser Vision Correction

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

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

[†]Discounts not applicable at retail locations such as Costco, Wal-Mart & Sam's Club.

Chiropractic Plan Benefits – EUTF and HSTA VB

The American Specialty Health Group, Inc. (ASH Group) is the provider of chiropractic benefits. The chiropractic benefit is included with all active employee medical plans excluding the supplemental medical and prescription drug plan.

Chiropractic Plan Benefits

The plan benefits include the initial exam, any necessary x-rays (when taken by an ASH Group network provider), therapeutically necessary chiropractic treatment and therapeutic modalities.

- For EUTF, the copayment is \$15 per visit for up to 20 visits per calendar year.
- For HSTA VB, the copayment is \$12 per visit for up to 20 visits per calendar year.

Chiropractic services must be received by a credentialed ASH Group network provider. A complete list of ASH Group providers and plan information may be obtained from HMSA and Kaiser. Please refer to the plan certificate for complete information on benefits, limitations and exclusions.

Life Insurance Benefits – EUTF and HSTA VB

The life insurance benefit is provided through Securian Financial and will be \$38,505 for active employees.

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

- \$25,028 for participants age 65 through 69
- \$17,737 for participants age 70 through 74
- \$11,552 for participants age 75 through 79
- \$7,701 for participants age 80 and over

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

- If you had an existing beneficiary designation on file with USABLE, it will transfer to Securian and no action is needed.
- After July 1, 2019, Securian will be sending you a letter with instructions on how to view or update your designation online.
- If you still have questions, contact Securian at 877-291-8466 Monday – Friday, 7:30 a.m.– 6:00 p.m. HST, excluding State observed holidays.

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

- **Conversion** – If your life insurance ceases because of termination of employment or retirement, you may convert your group term life coverage to an individual whole life insurance policy within the first 31 days after termination. You do not need to provide evidence of good health.
- **Portability** – This provision allows a terminated participant to continue their life insurance at a group discounted rate instead of an individual rate, provided they meet the eligibility requirements. Portability must be applied for within the first 31 days after your employment ends.
- **Accelerated Benefit** – This benefit allows you to 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 of Remains Benefit** – This benefit reimburses an individual who incurs expenses related to transporting your remains back to a mortuary near your primary place of residence if you pass away 200 miles or more away from home. This benefit will pay up to 10% of your life insurance benefit.

- **Lifestyle Benefits:** You have automatic access to a suite of additional resources. Employees covered under our group life insurance program can access these resources as needed. There is no additional fee or enrollment.
 - **Travel assistance services from RedpointWTP LLC**

While traveling 100 or more miles from home, you have access to pre-trip planning and emergency services. These include medical relocation and medical or security evacuation, assistance replacing lost or stolen luggage or other critical items, repatriation of mortal remains and much more.

Visit www.LifeBenefits.com/travel or call 1-855-516-5433 in the U.S. and Canada (outside of the US and Canada +1-415-484-4677).
 - **Legal, financial and grief resources from LifeWorks by Morneau Shepell**

Whether it is creating a will or advice on a legal matter, getting a handle on financial security, or struggling to cope with the loss of a loved one — get the professional support you need. Resources include templates to create a will and other key legacy documents, complimentary 30-minute face-to-face consultation with an attorney, unlimited telephone consultation with attorneys and counselors, and much more.

Visit www.LifeBenefits.com/LFG (user name: lfg, password: resources) or call 1-877-849-6034.
 - **Legacy planning resources from Securian Financial**

This website provides 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 to the online tools and resources available, 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.

Visit www.Securian.com/legacy.
 - **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 and more.

Access information is provided with claims payment.

Premium Conversion Plan

State of Hawaii Employees Only

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

Annual Open Enrollment Period (OEP): During the annual open enrollment period (OEP), employees may enroll, make changes to, or cancel their existing PCP enrollment without experiencing a qualifying change in status event. Employees wishing to enroll, change, or cancel their PCP enrollment shall make their selection in the “Plan Selection” section of the EUTF’s EC-1/EC-1H form and submit it to their Human Resources Office 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 shall make a PCP election by making their selection in “Plan Selection” section of the EUTF’s EC-1/EC-1H form. The form must be filed with the employee’s Human Resources Office within 90 days of the date of hire or event that made the employee newly eligible for coverage. The PCP enrollment shall become effective as soon as administratively possible on a prospective basis.

Mid-Plan Year Election Changes: During the Plan Year, employees may make a mid-plan year PCP election change if the employee has an allowable IRS “change in status” event (e.g., marriage, birth or adoption of children, divorce), the change is consistent with the IRS “change in status” event, and the PCP Election Change Form (PCP-2) is submitted to the employee’s Human Resources Office within 90 days of the event. The PCP enrollment, change, or cancellation shall become effective as soon as administratively possible, on a prospective basis.

The PCP-2 must be submitted with the EC-1/EC-1H form. PCP effective date is determined by the date the Human Resource Office/enrollment designee completes the “Date EC-1 Received in Employing Office” section.

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

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

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PCP Example #1:

Joanne experiences a “change in status” event during the plan year. This “change in status” causes her to move from a 2-party plan to a Self-Only Plan.

Change in Status Timeline	EUTF	PCP
Divorce effective August 2, 2019 (moving from 2-party to Self-only plan)	Under EUTF Rules, employee must notify EUTF within 45 days (180 days for birth) of the event in order to make the change in coverage	Under PCP Rules, employee must submit their form within 90 days of the event (changes are PROSPECTIVE from Employer Receipt Date per IRS Section 125 rules)
Submits EC-1/EC-1H (HSTA VB form) and PCP-2 Election Change Form on August 18, 2019 to HRO (this is the Employer Receipt Date)	Coverage is changed effective August 15, 2019 (end of pay period in which event occurred)	PCP deduction is changed effective September 1, 2019 (PROSPECTIVE from Employer Receipt Date)
Forfeitures, if applicable		Forfeitures are due for one pay period ❖ (8/16/19-8/31/19)

- ❖ In this example, forfeitures from PCP would be avoided if Joanne submitted her EC-1/EC-1H (HSTA VB form) and the PCP-2 Election Change Form PRIOR to August 15, 2019

PCP Example #2:

Ross acquires health coverage through his spouse’s plan effective July 1, 2019.

Change in Status Timeline	EUTF	PCP
Termination of EUTF coverage due to acquiring coverage under spouse’s plan effective July 1, 2019	Under EUTF Rules, employee must notify EUTF within 45 days (180 days for birth) of the event in order to make the change in coverage	Under PCP Rules, employee must submit their form within 90 days of the event (changes are PROSPECTIVE from Employer Receipt Date per IRS Section 125 rules)
Submits EC-1/EC-1H (HSTA VB form) and PCP-2 Election Change Form on July 7, 2019 to HRO (this is the Employer Receipt Date)	Coverage is terminated effective June 30, 2019	PCP deduction is terminated effective July 15, 2019 (PROSPECTIVE from Employer Receipt Date and end of pay period in which termination occurred)
Forfeitures, if applicable		Forfeitures are due for one pay period ❖ (7/1/19-7/15/19)

- ❖ In this example, forfeitures from PCP would be avoided if Ross submitted his EC-1/EC-1H or HSTA VB and the PCP-2 Election Change Form PRIOR to June 30, 2019

For County Employees Only
Please contact your human resource office for more information on available options.

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. Requests for enrollment, termination, and other changes must be submitted to the EUTF through your human resource office or enrollment designee. DOE employees must submit changes to the DOE-EBU office. If you have any questions concerning eligibility provisions, please refer to the EUTF Administrative Rules posted on the EUTF website at eutf.hawaii.gov.

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 dental and vision coverage, dependent children under age 19, and from age 19 through age 23 if they are full-time students. For children covered under legal guardianship or foster children, 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



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. 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 the dependent's birthday.

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 will be terminated at the end of the pay period of the school end date.

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:

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

Employee's 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 of Hawaii 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, 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 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 rules;
- Notifying EUTF immediately following termination, transfer, and bargaining unit changes or death.

How to Enroll



To enroll in EUTF health plans you must complete an EUTF Enrollment Form for Active Employees (EC-1 or EC-1H [if you are already enrolled in the HSTA VB plans]) (see the perforated pages at the end of this Guide). If you do not enroll eligible members of your family within 45 days (180 days for newborns) 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 mailed a Confirmation Notice indicating your enrollment and dependents covered (if any). You will have 15 calendar days from the date indicated on the Confirmation Notice to notify the EUTF in writing if you need to correct

EUTF data entry errors. More information can be found on the Confirmation Notice.

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 HMA, American Specialties Health Group Inc., Securian 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 filing an EC-1/EC-1H form during regular or limited enrollment periods described in EUTF Administrative Rules. 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 our website at eutf.hawaii.gov.
- During the open enrollment period. Open enrollment information can be found on page 14.
- If you experience a Qualifying Event. Please refer to the Common Qualifying Events Additions and Deletions Charts on pages 51 and 52.

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

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

1. You marry and want to enroll your spouse and/or newly eligible dependent children. A copy of your marriage certificate is required.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide appropriate documents verifying the

adoption in order to have the application accepted. To enroll a newborn, a copy of the birth certificate is required only if the child has a different last name from the employee. A Social Security Number is required within 60 days from the date of the EUTF Confirmation Notice.

3. You have a change in family status involving the loss of eligibility of a family member due to legal separation, divorce, death, child turns age 26 for medical and prescription drug, child age 19-23 is no longer a full-time student for dental & vision or other related qualifying event. See the Common Qualifying Events Charts on pages 51 and 52 for a list of required documents.
4. You, your spouse/partner or eligible dependent lose their health coverage. A copy of the Loss of Coverage letter from the previous employer or insurance plan is required.
5. You move out of your plan's service area.

To change your coverage, you must complete the EC-1 or EC-1H (if currently enrolled in the HSTA VB plans) form and submit it to your employer representative within 45 days of the date of the event (180 days for newborns).

Dependents who reach limiting age are automatically terminated from the medical and prescription drug plans at the end of the month that they attain age 26 and do not require the completion of an enrollment form to terminate coverage.

Dental and vision coverage for the dependent automatically terminates at the age of 24 if the dependent is a full-time student or 19 if not; and, does not require the completion of an enrollment form to terminate their coverage. If a dependent age 19-23 is no longer a full-time student, an enrollment form must be submitted to terminate their coverage.

If events are filed within 45 days of the qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Date. These events include: Adoption, Birth (filed within 180 days of the date of birth), Guardianship, Newly Eligible Student, Marriage, New Domestic Partner, New Civil Union Partner, Reinstatement in Employment, and Return from Authorized Leave of Absence (if not currently enrolled).

See Common Qualifying Events Additions and Deletions on pages 51 and 52.

End of Coverage

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

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

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

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

For example:

Date of hire or date you became newly eligible is January 3, 2019:

- Option 1 effective date of coverage: January 3, 2019
- Option 2 effective date of coverage: January 16, 2019
- Option 3 effective date of coverage: February 1, 2019

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

your enrollment after it receives the EC-1 or EC-1H from your employer.

If you 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 for processing time and the payroll lag. If applicable, you will receive a separate notice, EUTF Health Insurance Premium Deduction Notice, to inform you of the additional premiums to be collected and the pay periods that will be adjusted.

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; 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 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:

1. The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
2. The application is not filed within the time limitations prescribed by the EUTF Administrative Rules (see Common Qualifying Events for Additions/Deletions on pages 51 and 52);
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The employee-beneficiary owes past due contributions or other amounts to the EUTF; or
5. Acceptance of the application would violate applicable federal or state law or any other provision of the rules.

Employee-beneficiaries will be notified by mail of the rejection of 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) lasting more than 30 days, an L-1 Authorized Leave of Absence Without Pay form must be completed by your personnel office. Employee health plan options include:

- **Cancelling EUTF Coverage.** You may cancel your EUTF coverage by submitting an EC-1/EC-1H form within 45 days of the beginning of LWOP. Employees may re-enroll in the same benefit plans upon return from LWOP by submitting an EC-1/EC-1H form within 45 days of your return from LWOP.
- **Continuing EUTF Coverage.** You may continue coverage while on a LWOP by submitting premium payments directly to the EUTF. Employees may submit payment using personal check, cashier's check or money order to our office. 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 our website at eutf.hawaii.gov.

If any employee on LWOP fails to cancel EUTF plans 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 non-payment from all plans (except for the EUTF Life Insurance plan) and will not be able to re-enroll until the next open enrollment period.

If at any time the EUTF fails to receive an employee-beneficiary's premium deduction or receives only a partial deduction from his/her payroll, he/she will receive a Contribution Shortage Reminder Notice from the EUTF.

If the employee-beneficiary fails to pay the premium shortage by the date specified in the contribution shortage notice, his/her plans will be cancelled retroactive to the date of the last paid premium. Reinstatement of the terminated employee-beneficiary and their dependent's health benefit coverage which was cancelled for non-payment, will be allowed if within 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 non-payment of premiums within 12 months from the date of the notice of cancellation. Otherwise, employees may only reenroll during the next open enrollment or qualifying event occurring within the next plan year.

Address Changes



Employees are responsible for reporting address changes to the EUTF as soon as possible. Address changes may be submitted by completing the Employee Address Change Form available on our website at eutf.hawaii.gov. Submit your Employee Address Change Form to the EUTF through your designated human resource office or enrollment designee. DOE employees must submit address change forms to the DOE-EBU office. Once the Employee Address Change Form is received, the EUTF will notify the health carriers of your new address. Be advised that all address changes must go through the EUTF as health plan carriers are not able to make changes.

Common Qualifying Events – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Adoption	<u>EC-1/EC-1H</u> form within 45 days of adoption date. <u>Adoption decree</u> or placement for adoption documents submitted within 45 days from the adoption date.	Employee can choose: the adoption date (or placement for adoption), first day of the pay period following the adoption date or first day of the 2 nd pay period following the adoption date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Birth	<u>EC-1/EC-1H</u> form within 180 days of birth date. <u>Birth certificate</u> only if child has a different last name from the employee. <u>Social Security Number</u> within 60 days from date of the EUTF Confirmation Notice.	Employee can choose: the birth date, first day of the pay period following the birth date or first day of the 2 nd pay period following the birth date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Civil Union	<u>EC-1/EC-1H</u> form within 45 days of civil union. <u>Civil Union Certificate</u> and <u>Affidavit of Dependency</u> submitted within 45 days from the civil union date.	Employee can choose: the event date, first day of the pay period following the event date or first day of the 2 nd 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 if already enrolled.
Domestic Partnership	<u>EC-1/EC-1H</u> form within 45 days of notarized signature. <u>Notarized Declaration of Domestic Partnership & Affidavit of Dependency & Acknowledgement form</u> submitted within 45 days from the domestic partnership notary date.	Employee can choose: the notarization date, first day of the pay period following the notarization date or first day of the 2 nd pay period following the notarization date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Guardianship (Employee wishes to add child to EUTF plans)	<u>EC-1/EC-1H</u> form within 45 days of guardianship date. Guardianship decree submitted within 45 days from the guardianship date.	Employee can choose: the guardianship date, first day of the pay period following the guardianship date or first day of the 2 nd pay period following the guardianship date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Loss of Coverage (Employee and/or dependent loses health coverage and wishes to enroll in EUTF or HSTA VB plans)	<u>EC-1/EC-1H</u> form within 45 days of loss of coverage. <u>Letter from previous employer or carrier</u> detailing type of coverages lost (i.e. medical, drug, dental, vision), date of loss of coverage, and names of any covered dependents within 45 days.	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 if already enrolled.
Marriage	<u>EC-1/EC-1H</u> form within 45 days of marriage. Marriage Certificate submitted within 45 days from the marriage date.	Employee can choose: the marriage date, first day of the pay period following the marriage date or first day of the 2 nd pay period following the marriage date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Newly Eligible Student (Unmarried dependent age 19 thru 23 becomes a full-time student)	<u>EC-1/EC-1H</u> form within 45 days from school start date. <u>Student certification</u> : a letter from an accredited school on school letterhead with registrar's signature confirming full-time status or letter from National Student Clearinghouse within 45 days of becoming a full-time student. Transcripts not accepted.	Employee can choose: the school start date, first day of the pay period following the school start date or first day of the 2 nd pay period following the school start date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents if already enrolled.
New Hire/Newly Eligible Employee (New employee wishes to enroll in EUTF plans)	<u>EC-1</u> form within 45 days from new hire/newly eligible start date. 1) Student Certificate if enrolling a dependent 19 through 23 in dental and/or vision (on school letterhead, signed by registrar) 2) Birth certificate if enrolling a dependent with a different last name 3) Marriage certificate if married or civil union certificate. Employees have 45 days from date of hire to turn in documents.	Employee can choose: the hire date or date employee became eligible for plans, first day of the pay period following the hire date or date employee became eligible for plans or first day of the 2 nd pay period following the hire date or date employee became eligible for plans.	N/A
Retirement	<u>EC-2</u> form within 60 days of retirement date. <u>ERS Retirement Estimate Letter</u> . If Medicare eligible, <u>copy of Medicare Part B card, Direct Deposit Agreement form</u> , and <u>letter from Social Security</u> indicating Medicare Part B premium within 60 days from the date of retirement.	Retirement date.	N/A

Common Qualifying Events – Deletions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Acquisition of Coverage (Employee or dependent gets coverage from another plan and wishes to cancel EUTF or HSTA VB plans)	<u>EC-1/EC-1H</u> form within 45 days of acquisition of coverage. <u>Letter from carrier or employer</u> detailing type of coverage enrolled in (i.e., medical, drug, dental, vision), effective date of coverage, and names of covered dependents within 45 days from the date of acquisition.	If coverage is gained 1st of month, EUTF coverage ends day before 1st. If coverage is gained 16th of month, EUTF coverage ends 15th.	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)	<u>EC-1/EC-1H</u> form as soon as the dependent child is no longer a full-time student.	Coverage ends the last day of pay period of school end date.	No
Court Order (to cover child)	EUTF receives the order directly from the Child Support Enforcement Agency (CSEA). No EC-1/ EC-1H is required if employee is already enrolled in EUTF plans.	Effective date on CSEA notice.	Plan changes allowed if required by court order. May enroll in plans if not already enrolled or may add dependents if already enrolled.
Death of Dependent	<u>EC-1/EC-1H</u> form as soon as reasonably practical. <u>Death certificate</u> or <u>copy of obituary</u> as soon as available.	Date of death or last day of pay period in which death occurs for dependents.	N/A
*Divorce (Employee must terminate coverage for former spouse or civil union partner)	<u>EC-1/EC-1H</u> form within 45 days of divorce. Submit <u>pages 1 and 2 of divorce decree along with the signature page and any pages that outline health benefits for children</u> within 45 days from the date of the divorce.	Coverage ends last day of pay period in which divorce date occurs.	No
*Legal Separation (Employee may terminate coverage for former spouse)	<u>EC-1/EC-1H</u> form within 45 days of date of legal separation. <u>Court documents</u> establishing legal separation including any pages outlining health benefits for children within 45 days from separation date.	Coverage ends last day of pay period following the legal separation.	No
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)	<u>EC-1/EC-1H</u> within 45 days from beginning of LWOP to waive plans. To reenroll after LWOP, EC-1/EC- 1H must be submitted within 45 days of return from LWOP.	If employee cancels plans, last day of pay period in which LWOP occurs.	No
*Termination of Domestic Partnership (Employee must terminate domestic partner and domestic partner's dependents)	Declaration of Termination of Domestic Partnership (available on the EUTF website) within 45 days of termination of partnership.	Coverage ends last day of pay period in which termination of domestic partnership occurred.	No

Note: For termination and transfer of employment, bargaining unit changes or death, the employer is required to notify EUTF immediately.

*Employees may be responsible for paying premiums and claims for ineligible dependents if EUTF is not notified in a timely manner.

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 the following documents to the EUTF in order to obtain retiree health and life insurance benefits:

- ERS Retirement Estimate Letter
- EC-2 Enrollment Form (due within 60 days of retirement date)
- Check with your employer if an EC-1 form for retirement has been submitted to EUTF

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)
- Direct Deposit Agreement Form
- Social Security Administration or Centers for Medicare and Medicaid Services letter for you and/or your spouse/partner indicating the Medicare Part B premium amount

Additional resources, including a Pre-Retirement Checklist, Medicare Checklist and required EUTF forms are available on our website at eutf.hawaii.gov. The EUTF also conducts Pre-Retirement workshops monthly at the EUTF office on Oahu and 2 to 3 times a year on the outer islands. Please visit our website for more information on upcoming workshops and how to register.

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 EC-2 enrollment application is received by the EUTF within sixty (60) days of retirement or within sixty

(60) days of certification from the ERS if a disability retirement. Retired employee-beneficiaries 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, 2019, Jane meets her \$2,000 calendar year maximum out-of-pocket under the plan. She incurs additional medical expenses of \$100 in August 2019, which are paid at 100% since her maximum out-of-pocket was satisfied. Jane retires on September 1, 2019 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 2019. 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% of those expenses because she has not met the \$2,500 maximum out-of-pocket under her retiree plan.

Medical Deductible Example:

On January 1, 2019, 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 2019. Jill retires on June 1, 2019 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 2019.

Medicare



Medicare is the federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or kidney transplant).

Medicare has four parts:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)
- Medicare Part C (Medicare Advantage)
- Medicare Part D (Prescription Drug)

Medicare Part B Enrollment for Medicare Eligible Employees Considering Retirement

The HRS 87A-23(4) requires that State and county retirees and their eligible dependents who are enrolled in EUTF retiree medical and/or prescription drug plans, enroll in Medicare Part B when they become eligible. Active employees considering retirement who are eligible for Medicare should enroll in Medicare Part B prior to retirement in order to participate in EUTF retiree medical and/or prescription drug plans. If you do not provide proof of Medicare Part B enrollment to the EUTF within 60 days of becoming eligible or enrolling into an EUTF retiree medical and/or prescription drug plan, your and/or your dependent's EUTF retiree medical and/or prescription drug plans will be cancelled or may not become effective until the Medicare Part B coverage becomes effective. Please note that your spouse/partner must be enrolled in Medicare Part B when eligible in order to be covered under the EUTF retiree medical and/or prescription drug plan regardless of whether they are retired or actively working.

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

Medicare Part B Premium Reimbursement

As a retiree, you and your eligible spouse/partner qualify for reimbursement of your Medicare Part B premiums, provided you are paying for your Medicare Part B premium and it is not being paid by another entity such as the Medicare Savings Program or Medicaid. In order to receive reimbursement, you must provide the EUTF with proof of your Medicare Part B enrollment, a copy of the

letter from the Social Security Administration showing the Medicare Part B premium that you pay, and a completed Medicare Part B Reimbursement Direct Deposit Agreement Form (available on the EUTF website at eutf.hawaii.gov/forms). If you are paying above the Medicare standard amount, you must notify the EUTF of the amount you are paying (minus any penalties) every year in order to receive full reimbursement.

If you or your dependent are currently Medicare eligible and not covered under an EUTF retiree medical and/or prescription drug plan, EUTF does not require you or your dependent to enroll in Medicare.

How to Enroll in Medicare

Enrollment in Medicare is done through the Social Security Administration:

- By phone at 1-800-772-1213
- Online at www.SSA.gov
- In person at the Social Security Administration office

Medicare Enrollment Periods:

- **Initial Enrollment Period**
Individuals eligible for Medicare due to age may enroll as early as three months prior to their 65th birthday, the month they turn 65 or three months after their 65th birthday (seven-month period). This seven-month period is called the Initial Enrollment Period (IEP). Individuals who are collecting Social Security at the time they reach age 65 will usually be enrolled into Medicare Part A and B automatically.
- **Special Enrollment Period**
Individuals covered under an active employer group plan may enroll in Medicare after the Initial Enrollment Period under a Special Enrollment Period (SEP) at any time while covered by the employer group plan. They may also enroll in the eight-month period beginning the month after employment ends or the employer group coverage ends. Please be advised that COBRA coverage is not considered coverage under an active employee group plan and therefore does not extend the SEP.
- **General Enrollment Period**
This enrollment period occurs annually from January 1st to March 31st with Medicare coverage effective July 1st. Individuals who miss their Initial Enrollment Period or

Special Enrollment Period may enroll during the General Enrollment Period (GEP).

More information on Medicare and details on enrollment is available online at www.medicare.gov.

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 67. The Notice of Creditable Coverage is also available at the EUTF website at eutf.hawaii.gov.

considered creditable coverage and EUTF's prescription drug plans for Medicare retirees are considered a Medicare Part D prescription drug plan.

The cost of the LEP depends on how long you did not have creditable prescription drug coverage. Currently, the LEP is calculated by multiplying 1% of the "national base beneficiary premium" (\$33.19 in 2019) times the number of full, uncovered months that you were eligible but didn't join a Medicare drug plan and went without other creditable prescription drug coverage. The final amount is rounded to the nearest \$.10 and added to your monthly premium. Since the "national base beneficiary premium" may increase each year, the penalty amount may also increase each year. You may have to pay this penalty for as long as you have a Medicare drug plan.

Medicare Prescription Drug

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

LATE ENROLLMENT PENALTY (LEP)

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

For your information, EUTF's prescription drug plans for active employees through CVS/caremark and Kaiser are

Important Notices

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

CHANGES DURING THE PLAN YEAR TO YOUR HEALTH CARE BENEFIT ELECTIONS

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

- **Special Enrollment Event:**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 45 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 45 days after the marriage, adoption, or placement for adoption, or in the event of a birth of a child in which case the enrollment application shall be filed within 180 days of the birth of the child or newly adopted newborn child.

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

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

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

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

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

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

- Changes consistent with Special Enrollment rights and FMLA leaves.

You must notify your Designated Personnel Office by submitting an EC-1/EC-1H Enrollment Change form within 45 days of the mid-year change.

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

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

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

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

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

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalsev/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenhippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person

shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

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

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; 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.

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

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

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the Summary of Benefits and Coverage (SBC), summarizes and compares important information in a standard format.

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

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

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

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

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

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

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

COBRA COVERAGE REMINDER

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

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

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

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

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

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
201 Merchant Street, Suite 1700, Honolulu, Hawaii 96813

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

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

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

Direct Access to OB/GYN Providers:

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

GENERAL STATEMENT OF NONDISCRIMINATION (DISCRIMINATION IS AGAINST THE LAW)

Hawaii Employer-Union Health Benefits Trust Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Hawaii Employer-Union Health Benefits Trust Fund does

not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Hawaii Employer-Union Health Benefits Trust Fund:

- a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- b) Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

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

If you believe that the Hawaii Employer-Union Health Benefits Trust Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator for EUTF
201 Merchant Street, Suite 1700, Honolulu, HI 96813
Telephone 1-808-586-7390, Toll-Free 1-800-295-0089, Fax: 808-586-2161, Email: eutf@hawaii.gov.

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/filing-with-ocr/index.html>.

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

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	Message About Language Assistance
1. Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-808-586-7390 (TTY: 1-808-587-5538).
2. Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-808-586-7390 (TTY: 1-808-587-5538)。
3. French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-808-586-7390 (TTY: 1-808-587-5538).
4. German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-808-586-7390 (TTY: 1-808-587-5538).
5. Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-808-586-7390 (TTY: 1-808-587-5538).
6. Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-808-586-7390 (TTY: 1-808-587-5538).
7. Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-808-586-7390 (TTY: 1-808-587-5538) 번으로 전화해 주십시오.
8. Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-808-586-7390 (TTY: 1-808-587-5538) まで、お電話にてご連絡ください。
9. Ilocano	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-808-586-7390 (TTY: 1-808-587-5538).
10. Samoan	MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se tofogi, mo oe, Telefoni mai: 1-808-586-7390 (TTY: 1-808-587-5538).
11. Marshallese	LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jerbal in jipañ ilo kajin ñe am ejjelok wōñāān. Kaalok 1-808-586-7390 (TTY: 1-808-587-5538).
12. Trukese	MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1-808-586-7390 (TTY: 1-808-587-5538).
13. Tongan	FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-808-586-7390 (TTY: 1-808-587-5538).
14. Hawaiian	E NĀNĀ MAI: Inā ho'opuka 'oe i ka 'ōlelo [ho'okomo 'ōlelo], loa'a ke kōkua manuahi iā 'oe. E kelepona iā 1-808-586-7390 (TTY: 1-808-587-5538).
15. Pohnpeian	Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-808-586-7390 (TTY: 1-808-587-5538).



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
Expires 5-31-2020

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Hawaii Employer-Union Health Benefits Trust Fund (EUTF)		4. Employer Identification Number (EIN) 14-2014628	
5. Employer address 201 Merchant Street, Suite 1700		6. Employer phone number 808-586-7390 or toll-free at 800-295-0089	
7. City Honolulu	8. State Hawaii	9. ZIP code 96813	
10. Who can we contact about employee health coverage at this job? EUTF Member Services Branch Manager			
11. Phone number (if different from above)		12. Email address eutf@hawaii.gov	

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

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

All employees.

Some employees. Eligible employees are:

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

- With respect to dependents:

We do offer coverage. Eligible dependents are:

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

We do not offer coverage.

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

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

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

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

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

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

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

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

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

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

- 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 HMO plans (as administered by Kaiser).

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

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, you can elect or keep prescription drug coverage under the 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 HMO plans (as administered by Kaiser) you will not pay extra if you later decide to enroll in Medicare prescription drug coverage. You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

YOUR RIGHT TO RECEIVE A NOTICE

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

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

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next October to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any one of the following options:

Your Choices:	What you can do:	What this option means to you:
Option 1	<p>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 HMO plans (as administered by Kaiser) and you do not have to enroll in a Medicare prescription drug plan.</p>	<p>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 HMO plans (as administered by Kaiser).</p> <ul style="list-style-type: none"> You may, in the future, enroll in a Medicare prescription drug plan during Medicare’s annual enrollment period (during October 15th through December 7th of each year). As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	<p>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 HMO plans (as administered by Kaiser) and also enroll in a Medicare prescription drug plan.</p> <p>If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.</p>	<p>Your current coverage pays for other health expenses in addition to prescription drugs.</p> <p>If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows:</p> <ul style="list-style-type: none"> 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. <p>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 HMO plans (as administered by Kaiser). That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan’s next Open Enrollment period.</p> <p>Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:</p> <ul style="list-style-type: none"> PDPs may have different premium amounts; PDPs cover different brand name drugs at different costs to you; PDPs may have different prescription drug deductibles and different drug copayments; PDPs may have different networks for retail pharmacies and mail order services.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

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

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

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
 201 Merchant Street, Suite 1700
 Honolulu, Hawaii 96813
 Phone Number: 808-586-7390 or toll-free at 800-295-0089

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

HIPAA Notice: Notice of Privacy Rules

Effective date of this notice is December 16, 2014.

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



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

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

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

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

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

information, if they fall under HIPAA's definition of "Covered Entities."

By law, the EUTF MUST:

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

HIPAA also requires the EUTF to tell you about:

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

How the EUTF May Use and Disclose Your Medical Information

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

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

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

- **For Treatment:** the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under the your insurance plan. For example, the EUTF might disclose the name of your child's dentist to your child's orthodontist so that the orthodontist may ask the dentist for your child's dental X-rays.
- **For Payment:** the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health plan to coordinate benefit payments.
- **For EUTF Operations:** the EUTF may use and disclose your medical information for health care operations and other EUTF operations. These uses and disclosures are necessary to administer the EUTF benefit plans. For example, the EUTF may use and disclose your medical information to conduct or facilitate quality assessments and improvement activities, patient safety activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, enrollment, premium rating and other activities

related to creating, renewing or replacing insurance contracts or benefit plans, claims review and appeals, legal functions and services, business planning and development, and other activities related to business management and administration. In connection with the foregoing, the EUTF may disclose your medical information to third parties who perform various health care operations or EUTF operations on its behalf.

- **As Required By Law:** the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF's compliance with federal privacy regulations (this notice).
- **To Avert a Serious Threat to Health or Safety:** the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

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

Disclosure to Health Insurance Companies or Health Maintenance Organizations: In carrying out treatment, payment or health care operations, the EUTF may disclose your medical information to health insurance companies or health maintenance organizations (HMOs) that it contracts with to provide services or benefits under its health benefits plans. For example, the EUTF may disclose your medical information to the Hawaii Medical

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

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

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

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

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

facilitate organ or tissue donation and transplantation.

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

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

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

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

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

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

Coroners, Medical Examiners and Funeral Directors: the EUTF may release your medical information to a

coroner or medical examiner. This might be necessary, for example, to identify a deceased person or determine the cause of death.

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

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

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

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

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

- **Family or Friends Involvement:** the EUTF may disclose your medical information to family members, other relatives, or your friends without your written consent or authorization if:
 - The medical information is directly relevant to the family or friend's involvement with your

care or payment for that care, and

- You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

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

Your Rights Regarding Your Medical Information
You have the following rights regarding your medical information maintained by the EUTF:

Right to Inspect and Copy Your Medical Information:

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

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

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

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

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

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

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

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

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

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

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

- Is not part of the medical information kept by or for the EUTF,

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

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

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

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

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

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

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

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

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

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

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

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

A Note about Personal Representatives

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

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

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this

will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

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

Changes to This Notice

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

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

Minimum Necessary Standard

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

- Disclosures to or requests by a health care provider for treatment,
- Uses by you or disclosures to you of your own medical information,

- Disclosures made to the Secretary of the Department of Health and Human Services,
- Uses or disclosures that may be required by law,
- Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- Uses and disclosures for which the EUTF has obtained your authorization.

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

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

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

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice. You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and

Human Services by contacting their nearest office as listed in your telephone directory or at this website (<http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html>) or this website: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html> or contact the Privacy Officer for more information about how to file a complaint. You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

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

You should understand that the EUTF is unable to take back any disclosures that have already been made with your authorization, and that the EUTF is required to retain any records regarding any care or services provided to you. EUTF may not (and does not) use your genetic information that is PHI for underwriting purposes.

Questions?

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

Governing Law

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

You may contact the EUTF Privacy Officer at the following address:
 201 Merchant Street, Suite 1700, Honolulu, HI 96813
 Telephone number: 1-808-586-7390, Toll-Free number: 1-800-295-0089

Administrative Appeals

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



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

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long-term care, offered or sponsored by the EUTF.
5. In addition to the appeal rights outlined in this section, an aggrieved person may be 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 and eighty days (180) of the date of the adverse decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the EUTF administrator nor the Board shall be required to hear any appeal that is filed after the one hundred and eighty-day (180) period has expired. The written appeal need not be in any particular form but should contain the following information:

1. The aggrieved person's name, address, and telephone number;

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

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

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

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

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

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

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

For emergency appeals of eligibility, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

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

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

COBRA



The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that gives workers and their families who lose health benefits the right to continue coverage provided by their group health plan for limited periods of time under certain circumstances. These include voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. The amount a qualified beneficiary may be required to pay in most cases may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. For more information about COBRA, visit the U.S. Department of Labor COBRA information page at <http://www.dol.gov/dol/topic/health-plans/cobra.htm>.

COBRA Open Enrollment

In compliance with federal law, the EUTF offers all eligible employees and their covered dependents (known as qualified beneficiaries) the opportunity to make changes to their coverage just as regular actively employees are.

The open enrollment period for members enrolled in the EUTF or HSTA VB COBRA employee health plans is from **April 1** through **April 30, 2019**. During open enrollment (OE) you can:

- Add, change or drop a plan
- Add or remove a dependent
- Change coverage tiers, such as changing from Self to Family or Family to Two-party
- There is no action required for COBRA enrollees who do not wish to make changes

A COBRA packet will be sent to your address on file with the EUTF COBRA OE Enrollment Form or HSTA VB COBRA OE Enrollment Form to provide you an opportunity to make changes to your COBRA health plans. Plan changes properly submitted during this open enrollment period will be effective *July 1, 2019*.

Your completed EUTF COBRA OE Enrollment Form or HSTA VB COBRA OE Enrollment Form must be postmarked to the EUTF on or before *April 30, 2019*. Enrollment forms postmarked after *April 30, 2019* will NOT be accepted.

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

The following premium rates for EUTF and HSTA VB COBRA members are approved for the period of *July 1, 2019* through *June 30, 2020*. Separate invoices will be billed by each carrier selected. COBRA rates listed do not include the COBRA administration fee.

EUTF Monthly COBRA Premiums

Hawaii Employer-Union Health Benefits Trust Fund EUTF Monthly COBRA Rates

Benefit Plan	Type of Enrollment	Regular COBRA
		7/1/2019 - 6/30/2020
<i>MEDICAL PLANS</i>		
PPO - 90/10 Plan - HMSA Medical	Self	\$619.22
	Two Party	\$1,504.03
	Family	\$1,918.04
PPO - 80/20 Plan - HMSA Medical	Self	\$482.70
	Two-Party	\$1,172.28
	Family	\$1,494.87
PPO - 90/10 and 80/20 Plans - CVS Caremark Prescription Drug	Self	\$163.46
	Two-Party	\$397.18
	Family	\$506.04
PPO - 75/25 Plan - HMSA Medical	Self	\$318.93
	Two-Party	\$774.32
	Family	\$987.17
PPO - 75/25 Plan - CVS Caremark Prescription Drug	Self	\$87.39
	Two-Party	\$212.34
	Family	\$270.54
HMO - HMSA Medical	Self	\$727.34
	Two-Party	\$1,766.74
	Family	\$2,253.22
HMO - CVS Caremark Prescription Drug	Self	\$163.46
	Two-Party	\$397.18
	Family	\$506.04
HMO - Kaiser Comprehensive Medical and Prescription Drug	Self	\$636.43
	Two-Party	\$1,546.56
	Family	\$1,972.98
HMO - Kaiser Standard Medical and Prescription Drug	Self	\$412.22
	Two-Party	\$1,001.72
	Family	\$1,277.91
<i>DENTAL PLAN</i>		
HDS Dental	Self	\$35.33
	Two-Party	\$70.66
	Family	\$116.23
<i>VISION PLAN</i>		
VSP Vision	Self	\$5.99
	Two-Party	\$11.11
	Family	\$14.54

HSTA VB Monthly COBRA Premiums

Hawaii Employer-Union Health Benefits Trust Fund HSTA VB Monthly COBRA Rates

Benefit Plan	Type of Enrollment	Regular COBRA
		7/1/2019 - 6/30/2020
<i>MEDICAL PLANS</i>		
PPO - 90/10 Plan - HMSA Medical	Self	\$532.80
	Two Party	\$1,292.27
	Family	\$1,647.34
PPO - 80/20 Plan - HMSA Medical	Self	\$418.79
	Two-Party	\$1,015.63
	Family	\$1,294.35
PPO - 90/10 and 80/20 Plans - CVS Caremark Prescription Drug	Self	\$148.30
	Two-Party	\$360.34
	Family	\$459.12
HMO - Kaiser Comprehensive Medical and Prescription Drug	Self	\$560.77
	Two-Party	\$1,362.67
	Family	\$1,738.40
<i>DENTAL PLANS</i>		
HDS Dental	Self	\$38.57
	Two-Party	\$77.15
	Family	\$126.92
HDS Supplemental Dental	Self	\$19.95
	Two-Party	\$39.90
	Family	\$59.85
<i>VISION PLAN</i>		
VSP Vision	Self	\$5.99
	Two-Party	\$11.11
	Family	\$14.54

Contact Information

For Questions About...	Please Contact...
<p style="text-align: center;">Eligibility & EUTF Information</p>	<p>eutf.hawaii.gov EUTF Customer Service 1-808-586-7390 (Oahu) or Toll-Free: 1-800-295-0089 Monday through Friday, 7:45 a.m. – 4:30 p.m. HST</p>
<p style="text-align: center;">Hawaii Medical Service Association (HMSA)</p>	<p>www.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. Saturday: 9 a.m. – 1 p.m.</p> <p>In person: HMSA Center @ Honolulu HMSA Building 818 Keeaumoku St. Honolulu, HI 96814 Monday through Friday: 8 a.m. – 6 p.m. Saturday: 9 a.m. – 2 p.m.</p> <p>HMSA Center @ Pearl City Pearl City Gateway 1132 Kuala St., Suite 400 Pearl City, HI 96782 Monday through Friday: 9 a.m. – 7 p.m. Saturday: 9 a.m. – 2 p.m.</p> <p>HMSA Center @ Hilo Waiakea Center 303A E. Makaala St. Hilo, HI 96720 Monday through Friday: 9 a.m. – 7 p.m. Saturday: 9 a.m. – 2 p.m.</p>
<p style="text-align: center;">Kaiser Permanente</p>	<p>www.kp.org/eutf 1-808-432-5250 (Oahu) or Toll-Free: 1-844-276-6628 (Neighbor Islands) Monday through Friday: 7:00 a.m. – 7:00 p.m. HST Saturdays: 8:00 a.m. – 1:00 p.m. HST</p> <p>Walk-in Service: 711 Kapiolani Blvd</p>

	<p>Honolulu, HI 96813 Monday through Friday: 8:00 a.m. – 4:30 p.m. excluding State observed holidays.</p>
<p>CVS Caremark (For HMSA members)</p>	<p>CVS Caremark Prescription Drug Plan www.caremark.com 1-855-801-8263 TTY - 711 (24 hours a day, 7 days a week)</p> <p>Walk-in Service: Pauahi Tower 1003 Bishop Street, Suite 704 Monday through Friday, 7:45 a.m. – 4:30 p.m. HST</p>
<p>Hawaii-Mainland Administrators (HMA)</p>	<p>www.hma-hi.com/eutf Oahu: 1-808-951-4643 Toll-Free: 1-866-437-1992 For phone calls, the hours are: Monday through Friday 7:30 a.m. – 7:00 p.m. HST, Saturday 9:00 a.m. – 1:00 p.m. HST For walk-ins, the hours are: Monday through Friday 7:30 a.m. – 5:00 p.m. HST</p>
<p>Hawaii Dental Service (HDS)</p>	<p>www.hawaiidentalsservice.com 1-808-529-9310 or Toll-Free: 1-866-702-3883 Over the phone: Monday through Friday, 7:30 a.m. – 6:00 p.m. HST, except Federal and State observed holidays and the day after Thanksgiving Walk In Hours: Monday through Friday, 8:00 a.m. – 4:30 p.m., except Federal and State observed holidays and the day after Thanksgiving Office located: Topa Financial Center, Bishop Street Tower, 700 Bishop Street, Suite 700</p>
<p>Vision Service Plan (VSP)</p>	<p>www.vsp.com Toll-Free: 1-866-240-8420</p> <p><u>As of Sunday 3/11/18 – Daylight Saving BEGINS:</u> Monday through Friday, 2:00 a.m. – 5:00 p.m. HST Saturdays 4:00 a.m. – 5:00 p.m. HST Sundays 4:00 a.m. – 4:00 p.m. HST</p> <p><u>Effective Sunday 11/4/18 – Daylight Saving ENDS:</u> Monday through Friday, 3:00 a.m. – 6:00 p.m. HST Saturdays 5:00 a.m. – 6:00 p.m. HST Sundays 5:00 a.m. – 5:00 p.m. HST</p>

	<p>Oahu: 1-808-532-1600 or Toll-Free: 1-800-522-5162 Monday through Friday, 7:30 a.m. – 4:30 p.m. HST</p> <p>Walk-in Service: 1003 Bishop St., #890 Honolulu, HI 96813</p>
<p>American Specialty Health Group, Inc. (ASH)</p>	<p>www.ashlink.com Toll-Free: 1-888-981-2746 Monday through Friday, 3:00 a.m. – 6:00 p.m. HST* Saturdays, 10:00 a.m. – 6:00 p.m. HST*</p> <p>*Hours will be adjusted to Monday through Friday, 2:00 a.m. – 5:00 p.m. HST and Saturdays, 9:00 a.m. – 5:00 p.m. HST during Daylight Saving Time</p>
<p>Securian</p>	<p>www.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</p> <p>Email: lifebenefits@securian.com</p>
<p>Medicare enrollment</p>	<p>www.SSA.gov Toll-Free: 1-800-772-1213</p>

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EC-1 Enrollment Form Instructions

Submit your completed EC-1 form to your personnel office or enrollment designee for verification, signature and routing to the EUTF within 45 days (180 days for newborns) of the event date. For DOE employees, you must submit your EC-1 form to the DOE-EBU.

Enrollment Type

Select the event for which you are submitting the enrollment form. Mark the New Hire box if you're newly hired, 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: Acquisition of Coverage, Adoption, Birth, Civil Union Partner, Court Order, Death, Divorce, Domestic Partnership, Foster Child, 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.

I. Employee Data

Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

This section only needs to be completed if filing for new hire/newly eligible employee, adoption/placement for adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled). Select one of the three choices for when your coverage and premium contributions will begin. If no selection is made, the first option will be the default option used.

III. Plan Selection

Mark all plans you wish to be enrolled in. You 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: Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at dhrd.hawaii.gov. Please inquire with your DPO or DHRD on completing a PCP-2 form. Mark Enroll or Cancel/Waive on the EC-1 form.

For County Employees Only: 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. Required supporting documents (e.g., marriage certificate, student certification letter, etc.) must be submitted to the EUTF within 60 days of the event date. If dependent children 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.

Use the following Relationship codes:

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

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.

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. Submit the completed EC-1H form to the DOE- EBU, P.O. Box 2360, Honolulu, HI 96804, or your Charter School Personnel Office for verification, signature and routing to the EUTF within 45 days (180 days for newborns) of the event date.

Enrollment Type

Select the event for which you are submitting the enrollment form. Mark 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: Acquisition of Coverage, Adoption, Birth, Civil Union Partner, Court Order, Death, Divorce, Domestic Partnership, Foster Child, 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.

I. Employee Data

Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

This section only needs to be completed if filing for adoption/placement for adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled). Select one of the three choices for when your coverage and premium contributions will begin. If no selection is made, the first option will be the default option used.

III. Plan Selection

Mark all plans you wish to be enrolled in. You 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. The Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pretax basis and is offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at dhrd.hawaii.gov. Please inquire with your DPO or DHRD on completing a PCP-2 form. Mark Enroll or Cancel/Waive on the EC-1 form.

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.

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. Required supporting documents (e.g., marriage certificate, student certification letter, etc.) must be submitted to the EUTF within 60 days of the event date. If dependent children 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.

Use the following Relationship codes:

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

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-1H form to DOE - EBU, P.O. Box 2360, Honolulu, HI 96804. To ensure proper processing, all required fields must be completed and proper documentation submitted timely.

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Hawaii Employer-Union Health Benefits Trust Fund

Submit this form to your personnel office.

ACTIVE EMPLOYEE EC-1 HEALTH BENEFITS ENROLLMENT FORM All Bargaining Units

DOE employees submit to: DOE-EBU PO Box 2360 Honolulu HI, 96804

EMPLOYEE DATA

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: Last First M.I. Social Security No. or EUTF ID No.:

Mailing Address: City State Zip Code Residence Address: 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: / /

COVERAGE START DATE

Complete this section if filing for new hire/newly eligible employee, adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled).

- [] Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs. (If no selection is made, this option will be used.)
[] Coverage and premium contributions start 1st day of the first pay period following event date (1st or the 16th of the month)
[] Coverage and premium contributions start 1st day of the second pay period following event date (1st or the 16th of the month)

PLAN SELECTION 7/1/19 THROUGH 6/30/20

PLEASE VISIT THE EUTF WEBSITE AT EUTF.HAWAII.GOV FOR PREMIUM & CONTRIBUTION AMOUNTS

Table with columns for plan names (Medical, Chiro, Prescription Drug, Dental, Vision, Life) and selection options (Cancel/Waive, Self, Two-Party, Family, Enroll).

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, Middle Initial	Birth date	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: (e.g. medical, dental)	Name of the Plan: (e.g. HMSA, Quest)	Subscribers 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:			



Hawaii Employer-Union Health Benefits Trust Fund

Submit this 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

EMPLOYEE DATA

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: Last First M.I.
Social Security No. or EUTF ID No.:

Mailing Address: City State Zip Code
Residence Address: 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: / /

COVERAGE START DATE

Complete this section if filing for new hire/newly eligible employee, adoption, birth, marriage, domestic partner, guardianship, newly eligible student, reinstatement of employment, or return from authorized leave of absence (if not currently enrolled).

- [] Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs. (If no selection is made, this option will be used.)
[] Coverage and premium contributions start 1st day of the first pay period following event date (1st or the 16th of the month)
[] 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 7/1/19 THROUGH 6/30/20

PLEASE VISIT THE EUTF WEBSITE AT EUTF.HAWAII.GOV FOR PREMIUM & CONTRIBUTION AMOUNTS

Table with columns for plan names (Medical, Chiro, Prescription Drug, Vision) and selection options (Cancel/Waive, Self, Two-Party, Family). Includes sections for Other Plans (Dental, Vision, Life) and Premium Conversion Plan.

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.

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, Middle Initial	Birth date	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: (e.g. medical, dental)	Name of the Plan: (e.g. HMSA, Quest)	Subscribers 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	School/Office	Bargaining Unit
Date EC-1H Received in DOE EBU/Charter School / /	DOE EBU/Charter School Phone No.	DOE EBU/Charter School Fax No.	
DOE EBU/Charter School (or employer designee) Printed Name		Date of DOE EBU/Charter School (or employer designee) Signature / /	
DOE EBU/Charter School (or employer designee) Signature			
By signing this EC-1H form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.			
Comments:			

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**FORMS SUBMITTED
TO YOUR
EMPLOYER'S OPEN
ENROLLMENT
DESIGNEE AFTER
APRIL 30, 2019
WILL NOT BE
PROCESSED**