Hawaii
Employer-Union Health
Benefits Trust Fund (EUTF)

REFERENCE GUIDE
Plan Year 2010

FOR ACTIVES
Effective January 1, 2010

Disclaimer: This Reference Guide offers general information on your health and other benefits plans. Your health benefits are exclusively governed by Hawaii Statutes and the EUTF Administrative Rules, as they are amended from time to time. Nothing in this Guide is intended to amend, change, or contradict the Hawaii Statutes and the EUTF Administrative Rules. This Guide is not a legal document or contract and the information in the Guide is not intended as legal advice or to create any legal or contractual liabilities.

It's Easy to enroll in Your Plan Year 2010 Benefits

Your benefits program has been designed to work for you. The benefit options and coverage choices provide you with the flexibility you need to make enrollment decisions based on your individual and family needs.

With annual open enrollment approaching, it's time for you to start thinking about the coverages you would like to enroll in for this period. There are several important steps you should take to make your benefit selections, and this reference guide is provided to assist you:

- **Read this Reference Guide carefully** to understand the Plans that are offered and the action steps required for you to enroll for the remainder of Plan Year 2010. ***A new 80/20 PPO plan will be administered by HMSA.***
- **Review your personalized enrollment notice** to ensure all pertinent information about you is correct. ***If you currently have a 90/10 PPO Plan with HMSA, this plan will change to a 90/10 Plan with HMA.***
- **If you are satisfied with your current benefit plan options (i.e., 90/10 PPO, HMO, HDHP, etc.)** then you are not required to fill out a Form EC-1, Enrollment Form for Active Employees (page 41).

Please refer to page 5 for more detailed information on how to enroll.

What's Inside

The EUTF provides this Reference Guide to help you make informed decisions about health care for you and your family.

In this guide you will find important highlights of:

- Medical Plan Options – ***new plan offered effective January 1, 2010!***
- Chiropractic benefits
- Prescription Drug benefits
- Vision benefits
- Dental benefits
- Life Insurance benefits

Please read through this entire Guide carefully and share the information with your family.

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. The EUTF sponsored prescription drug plan, except for the supplemental plans, offers benefits that are as good, or better, than the standard Medicare Part D plan coverage. Your Notice of Creditable Coverage is on page 27.

If you are enrolled in the supplemental medical plan, your prescription drug coverage is considered to be non-creditable when compared to the standard Medicare Part D plan. Please refer to the Notice of Non-Creditable Coverage that begins on page 28.

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Your Role in the Value of Your Health Care

If you've watched the news or read the paper lately, chances are you know that today's world is one of constantly rising health care costs. So what can you do?

Whether you choose a Plan offered by the EUTF or not, consider taking these steps as a start to becoming a better health care consumer and ensuring your long-term health and wellness:

- **Partner with your doctor.** Finding a doctor you trust and feel comfortable with is the first step toward ensuring good health. But once you've found that person, how can you work together to get the best care? Prepare for your office visits, listen and ask questions, learn all you can about your medical issues, and learn about wellness and preventive care.
- **Understand your treatment options**. Research shows that millions of people receive medical treatments or surgeries that are unnecessary and even harmful to their health. At the same time, many people don't get the treatment or surgery they need. When your doctor makes a recommendation, be sure you voice your questions, concerns, and preferences.
- **Learn more about your condition.** If you use the Internet to find health information, start by searching specialized sites connected with certain diseases. For example, if you're interested in heart disease research, visit the American Heart Association website (www.americanheart.org); asthma and allergies, visit the American Academy of Allergy, asthma and Immunology (www.aaaai.org); or cancer, visit the American Cancer society (www.cancer.org)
- **Get the most value from your prescription drug benefit.** While many factors of prescription drug increases are out of our control, there are steps you can take to save money. For an occasional minor ailment such as joint pain, heartburn, or allergies, ask your doctor if you can try an over-the-counter treatment first. Request generic or preferred drugs when possible. Use a participating retail pharmacy, or better yet, use the mail-order option to reduce your costs even more.
- **Stay well.** If you want to stay healthy and live a longer, healthier life, it is helpful to know your health risks and how to manage them. Get regular checkups, monitor your blood pressure, tell your doctor about all of the medications you're taking, and get the recommended screenings for your age and gender. Also consider exercising regularly and quitting smoking.

By taking care of your health today, you will be preparing for your health later in life and in retirement. By actively taking a role in managing your own health, and by enrolling in the appropriate health benefit plans, together we can find the balance between individual and institutional wellness.

NEW PLAN OFFERED – EUTF 80/20 PPO Plan

Effective January 1, 2010, Active participants have another option. The Board of Trustees has added a new PPO medical plan option. The current 90/10 PPO plan will be administered only by HMA (Health Management Associates). The new 80/20 PPO Plan with lower premiums will be administered by HMSA. **Note: "90/10" or "80/20" refers to most benefits; see page 16 or Guide to Benefits for details.** ***Study your options before making a choice. Here are several scenarios:***

	What if:	Then:
Current Benefit Plan		**Your Plan Effective January 1, 2010**
EUTF 90/10 PPO - HMSA	**I do not submit the Form EC-1?**	EUTF 90/10 PPO - HMA
EUTF 90/10 PPO - HMA	**I do not submit the Form EC-1?**	EUTF 90/10 PPO - HMA

	What if:	Then:
Current Benefit Plan	**You want to change your Plan to:**	**Do I need to submit the Form EC-1?**
EUTF 90/10 PPO - HMSA	EUTF 80/20 PPO - HMSA	Yes
EUTF 90/10 PPO - HMA	EUTF 80/20 PPO - HMSA	Yes

	What if:	Then:
Current Benefit Plan	**You want to keep your same benefits:**	**Do I need to submit the Form EC-1?**
EUTF 90/10 PPO - HMSA	EUTF 90/10 PPO - HMA	No
EUTF 90/10 PPO - HMA	EUTF 90/10 PPO - HMA	No

OPEN ENROLLMENT INSTRUCTIONS

Step 1: Review the choices available to you and decide whether you want to change or keep your plans. If you decide to keep your current benefit plans, you are not required to complete Form EC-1.

Step 2: If you have questions about your plan choices, please attend an Open Enrollment Benefit Fair.

During Open Enrollment, all active employees are invited to explore healthcare and insurance options at the Benefit Fairs. See the schedule on page 8. The following insurance carriers and administrator representatives will be on hand to answer your questions about their benefit plans.

Medical plans:	HMA	HMSA	Kaiser	Royal State National
Prescription Drug plan:	informedRx		Kaiser	Royal State National
Dental plan:	HDS			
Vision plan:	VSP			
Life insurance:	Standard Insurance Company			
Chiropractic plan:	Royal State National			

Step 3: Review your Open Enrollment materials. If you want more specific information regarding the different plans, please contact the applicable insurance carrier for your personal copy of their plan details. You can access the EUTF website, eutf.hawaii.gov for the latest information regarding the open enrollment.

You can add dependents, including a spouse, or domestic partner (DP), and children to your plan during open enrollment. To add a DP, please contact the EUTF to obtain the appropriate forms required to enroll a DP or go to the EUTF website, eutf.hawaii.gov, to download those forms.

Step 4: **Make your selections on the Form EC-1, Enrollment Form for Active Employees, and submit the completed and signed form to your identified open enrollment designee no later than November 30, 2009.**

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

A: To make changes to your personal information, complete the information on the Form EC-1.

B: To make changes to your plans or coverages, make your selections on the Form EC-1.

C: To add a dependent, enter the information in the dependents section on the Form EC-1.

NOTE: You will find that your benefit notice does not include your social security number. The HB number is your EUTF ID number. You will need to provide this ID number when communicating with the EUTF. If you are adding a new dependent, you are required to submit your dependent's social security number at the initial enrollment.

IT IS CRITICAL THAT YOU SUBMIT ANY CHANGES TO YOUR OPEN ENROLLMENT DESIGNEE NO LATER THAN November 30, 2009. Forms submitted after November 30, 2009 may be rejected.

Step 5: The EUTF will send your enrollment confirmation notice after processing is completed. The confirmation notice allows you to ensure that the changes you submitted were entered correctly. If you note an error, you should notify the EUTF immediately. **NO CHANGES TO YOUR ORIGINAL SELECTIONS WILL BE ALLOWED AFTER November 30, 2009**, only corrections to your information and selections!

IMPORTANT: If any of your dependents should be terminated from coverage due to a divorce, or becoming ineligible due to age or loss of student status, do not wait for open enrollment to submit these terminations. You are required to notify the EUTF and make these terminations when these events occur.

Total Monthly Premiums[1] (All Bargaining Units except BU 12[2])

Carrier or Administrator	Type of Plan	Coverage	Total Contributions Effective 1/1/2010	7/1/09 - 12/31/09 Premium		Difference	
				HMSA	HMA	HMSA	HMA
EUTF PPO (HMA) RSN Chiropractic	90/10 PPO Medical and Chiropractic	Self	$283.36	$283.36	$276.46	$0.00	$6.90*
		Two Party	$687.70	$687.70	$670.96	$0.00	$16.74*
		Family	$877.04	$877.04	$855.66	$0.00	$21.38*
EUTF PPO (HMSA) RSN Chiropractic	80/20 PPO Medical and Chiropractic	Self	$274.16	N/A		N/A	
		Two-Party	$665.34	N/A		N/A	
		Family	$848.52	N/A		N/A	
EUTF Prescription Drugs Only (informedRx)	Prescription Drugs Only	Self-only	$63.86	$63.86		$0.00	
		Two-Party	$155.06	$155.06		$0.00	
		Family	$197.96	$197.96		$0.00	
EUTF HMO (HMSA) Prescription Drug RSN Chiropractic	HMO Medical, Drugs, and Chiropractic	Self	$384.32	$384.32		$0.00	
		Two-Party	$932.84	$932.84		$0.00	
		Family	$1,189.90	$1,189.90		$0.00	
Kaiser Comprehensive Prescription Drug RSN Chiropractic	HMO Medical, Drugs, and Chiropractic	Self	$311.94	$307.66		$4.28	
		Two-Party	$756.44	$746.08		$10.36	
		Family	$965.44	$952.24		$13.20	
Kaiser Basic Prescription Drug RSN Chiropractic	HMO Medical, Drugs, and Chiropractic	Self	$276.26	$272.50		$3.76	
		Two-Party	$669.80	$660.64		$9.16	
		Family	$854.92	$843.24		$11.68	
EUTF Supplemental (HMSA) Prescription Drug RSN Chiropractic	Supplemental Medical, Drugs and Chiropractic	Self	$203.00	$203.00		$0.00	
		Two-Party	$492.80	$492.80		$0.00	
		Family	$628.56	$628.56		$0.00	
Royal State Supplemental RSN Drug RSN Chiropractic	Supplemental Medical, Drugs, and Chiropractic	Self	$56.62	$56.62		$0.00	
		Two-Party	$139.74	$139.74		$0.00	
		Family	$157.40	$157.40		$0.00	
EUTF High Deductible Health Plan (HMSA) Prescription Drug	PPO Medical and Drugs	Self	$260.32	$260.32		$0.00	
		Two-Party	$632.56	$632.56		$0.00	
		Family	$807.42	$807.42		$0.00	
HDS	Dental	Self	$30.78	$30.78		$0.00	
		Two-Party	$61.58	$61.58		$0.00	
		Family	$101.34	$101.34		$0.00	
VSP	Vision	Self	$6.04	$6.04		$0.00	
		Two-Party	$11.18	$11.18		$0.00	
		Family	$14.62	$14.62		$0.00	
Standard Insurance	Life Insurance	Employee	$4.16	$4.16		$0.00	

[1]Employer and Employee contributions are subject to Collective Bargaining.

[2]BU 12 employees should contact their employer or go to the EUTF website (eutf.hawaii.gov) for information regarding their premiums and contributions.

***Those employees currently in the PPO plan with HMSA are already at the higher rates and will not have an increase if they stay in the 90/10 plan with HMA.**

Schedule of Open Enrollment Benefit Fairs

Schedule for Actives			
Date	**Location**	**Room**	**Time**
Nov. 3	University of Hawaii	Kuykendall Auditorium	8:30 - 10:00, 10:30 – 12:00, 1:30 - 3:00
Nov. 4	Windward Comm. College	Akoakoa 101-105	10:30 - 12:00, 1:30 - 3:00
Nov. 6	Maui	Wailuku Comm. Center	12:00 - 1:30, 2:00 - 3:30
Nov. 9	State Capitol	Auditorium	10:30 - 12:00, 1:30 - 3:00
Nov. 10	Leeward Comm. College	GT 105	8:30 - 10:00, 10:30 - 12:00, 1:30 - 3:00
Nov. 12	Hilo	Aunt Sally's Luau Hale	12:00 - 1:30, 2:00 - 3:30
Nov. 13	Maui	Kahului Comm. Center	12:00 - 1:30, 2:00 - 3:30
Nov. 16	Kapolei Hale	Conf. Rm. B & C	10:30 - 12:00, 1:30 - 3:00
Nov. 17	Kauai	War Memorial	12:00 - 1:30, 2:00 - 3:30
Nov. 18	Molokai	Mitchell Pauole Cntr.	11:00 - 12:00
Nov. 19	Hilo	Aunt Sally's Luau Hale	12:00 - 1:30, 2:00 - 3:30
Nov. 20	Lanai	Lanai Comm. Cntr	1:00 - 2:00
Nov. 23	Kauai	War Memorial	12:00 - 1:30, 2:00 - 3:30
Nov. 24	Leeward Comm. College	GT105	8:30 - 10:00, 10:30 - 12:00, 1:30 - 3:00
Nov. 25	University of Hawaii	Kuykendall Auditorium	8:30 - 10:00, 10:30 - 12:00, 1:30 - 3:00
Nov. 30	State Capitol	Auditorium	10:30 - 12:00, 1:30 - 3:00

Benefit Fair Locations

OAHU

Kapolei Hale
1000 Uluohia Street
Kapolei, HI 96707

Leeward Community College
96-045 Alaike Street
Pearl City, HI 96782

State Capitol Auditorium
415 South Beretania Street
Honolulu, HI 96813

U.H. Kuykendall Auditorium
2445 Campus Road
Honolulu, HI 96822

Windward Community College
45-720 Keaahala Road
Kaneohe, HI 96744

MAUI

Kahului Community Center
275 Uhu Street
Kahului, HI 96732

Wailuku Community Center
395 Waena Place
Wailuku, HI 96793

KAUAI

War Memorial Convention Center
4191 Hardy Street
Lihue, HI 96766

LANAI

Lanai Community Center
8th Street
Lanai City, HI 96763

HAWAII

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

MOLOKAI

Mitch Pauole Center
90 Inoa Street
Kaunakakai, HI 96748

Is your Dependent Really Your Dependent?

Before, during and after the 2010 Open Enrollment period, the EUTF is conducting a separate verification of dependent eligibility. If you have one or more dependents enrolled in EUTF benefit plans, you already have received correspondence from Secova, the company contracted by the EUTF for this project. If you have any questions about the dependent eligibility verification project, contact Secova at 808-566-0868 or 1-888-541-8094, or visit the special web site at https://verify.secova.com/EUTF.

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

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

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 Hawaii Revised Statutes;
- 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.

Enforcement Actions of the EUTF

Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the EUTF. The notice shall be sent within fifteen days of the date on which the required semi-monthly contribution payment was due. The notice shall require the employee-beneficiary to make full payment of the contribution shortage prior to the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due. Regardless of whether or not the notice of contribution shortage is received by the employee-beneficiary, if the employee-beneficiary fails to make full payment by the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due, the employee-beneficiary's enrollment in the benefit plans offered or sponsored by the EUTF and all coverages for dependent-beneficiaries under such enrollment shall be canceled as set forth in Rule 4.12(c). Cancellation of an employee-beneficiary's coverage pursuant to this rule shall not affect the EUTF's right to collect any and all contribution shortages from the employee-beneficiary.

Other Actions

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

Employee-Beneficiary Eligibility

Eligibility for coverage is determined by the Administrative Rules adopted by the EUTF Board of Trustees. Enrollments, terminations, and other changes must be presented to the EUTF. If you have any questions concerning eligibility provisions, you should call the EUTF Customer Service at 808-586-7390 or reference the Administrative Rules posted on the EUTF website, eutf.hawaii.gov.

Health Plans

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

- An employee, including an elective officer of the State, county or legislature
- A retired employee
- The surviving spouse or domestic partner (DP) of an employee killed in the performance of duty, provided the spouse or DP does not remarry or enter into another domestic partnership
- The surviving spouse or DP of a deceased retired employee, provided the spouse or DP does not remarry or enter into another domestic partnership
- The unmarried child of an employee killed in the performance of duty, provided the child is under age 19 and has no surviving parent
- The unmarried child of a deceased retired employee, provided the child is under age 19 with no surviving parent

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

- Spouse or domestic partner (DP)
- Unmarried children under age 19 or full-time student under the age of 24
- Unmarried child incapable of self-support due to mental/physical incapacity that existed prior to age 19
- Child covered by terms of a qualified medical child support order (QMCSO).

Group Life Insurance

Employees and retired employees are eligible for any group life insurance plans offered or sponsored by the EUTF, provided that they comply with the age, enrollment, underwriting, and contribution requirements of such plans.

Special Eligibility Requirements

Student: A child over age 19 and under 24 is eligible if attending an accredited college, university or technical school as a full-time student. This includes children who are away at school and dependent upon you for support.

Domestic Partner: 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 declaration of domestic partnership (affidavit) with the EUTF

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 your W-2. Consult your tax advisor to determine your domestic partner's status. If you determine that your domestic partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available along with information/instructions on the EUTF website, eutf.hawaii.gov) to the EUTF.

Enrollment

To enroll, you must complete Form EC-1, Enrollment Form for Active Employees. If you do not enroll eligible members of your family within 30 days of when you or they first become eligible, you must wait until the next Open Enrollment period to do so. The plan year for active employees begins July 1 and ends June 30 of the following year.

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

- HMSA, HMA, and HDS will issue two identical ID cards showing the name of the subscriber.
- Kaiser and informedRx issue an ID card for each enrolled member of a family upon initial enrollment.
- VSP does not issue ID cards.

If you do not change any of your current elections, you may not receive new ID cards.

Dual Enrollment (Two EUTF Enrollments) Is Not Allowed
Dual enrollment in EUTF plans is not allowed under EUTF Administrative Rule 4.03. If both you and your spouse/domestic partner (DP) are employee-beneficiaries, only one of you may enroll in a EUTF Family plan, or if no other dependents are involved, both may enroll in EUTF Self plans. If your spouse/DP has coverage outside of the EUTF that provides a family coverage, this rule does not preclude you from also enrolling in a family coverage plan to cover your spouse/DP. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

Medicare Part B Premium Reimbursement
Retirees and their spouses or domestic partners who are enrolled in a EUTF retiree medical plan are eligible for Medicare Part B premium reimbursements. If you are enrolled in a EUTF active employee medical plan, you are not eligible for Medicare Part B reimbursement. However, if you are an active employee, enrolled in Medicare Part B and covered by the EUTF retiree medical plan through your spouse/DP, your spouse/DP is entitled to Medicare Part B reimbursement for you.

Change of Coverage
To change your coverage, you should complete Form EC-1. Common situations resulting in a change of coverage outside the Open Enrollment period are:

1. You marry and want to enroll your spouse/DP and newly eligible dependent children.
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.
3. You have a change in family status involving the loss of eligibility of a family member (e.g., separation, divorce, death, child marries, no longer lives with you, or turns age 19 or 24 for student).
4. Your spouse's/ DP's or eligible dependent's employment status changes resulting in a loss of health coverage.
5. You move out of your plan's service area.

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

1. You voluntarily terminate coverage.
2. You do not make required premium payments (if applicable).
3. You die, subject to exceptions for your surviving spouse or DP and unmarried children under age 19.
4. The EUTF is discontinued by the Legislature.

Coverage for your dependents will end if:

1. Your dependent is no longer eligible for coverage.
2. Your dependent enters the uniformed services.
3. Failure to comply with the EUTF Administrative Rules.
4. Filing of fraudulent claims.

Effective Dates of Coverage
For new hires, the effective date of coverage is the first day of work. There is no waiting period following your date of hire before your health benefits coverage begins, provided you submit a completed Form EC-1 to your employer within 30 days of your hire date. Your enrolled eligible dependents' coverage is effective the same date as yours.

Although **your coverage begins immediately**, payroll deductions for your premiums are not assessed sooner than the first day of the second pay period after your hire date. Regardless of when your payroll deductions begin, if you need to obtain services from any of the carriers, **you do not need to wait until you receive your ID cards**. The EUTF can arrange for you to receive them or you can ask your provider to delay submitting the claim for payment

until your application has been processed and the carrier has recorded your enrollment. If your payroll deductions do not begin with your second pay period, they will be retroactive to your second pay period when they do begin.

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

Coverage changes involving the addition of dependents are effective retroactive to the date of the event or the date the EUTF receives proper notification, depending on the event and providing that the application is filed within 30 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the EUTF. Dependent children are automatically terminated as of the end of the pay period they attain age 19 or 24, in the case of full-time students, and do not require the completion of an application to delete coverage. If your student graduates or drops out of school before age 24, your student becomes ineligible and you must submit the Form EC-1 to remove the student from coverage.

Transfer of Employment
If you transfer from one EUTF employer to another, including transfers within State and/or County employment, coverage will be continued provided that you are still covered by the EUTF (COBRA coverage excluded) when you begin in your new position.

If you transfer employment within 90 calendar days of the last day of employment with the previous employer, you will not be subject to sections 87A-35 and 87A-36, Hawaii Revised Statutes. These paragraphs define the manner in which an employee's years of service are to be computed to determine the employer contributions for retiree benefits.

Effective Date of Termination
In general, when an event causes your 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 partnership, death, surviving spouse/DP remarries, or child ceases to be eligible for coverage. There may be certain instances in which the effective date of termination is different. You may obtain additional information by referring to the EUTF Administrative Rules that are posted on the EUTF website, eutf.hawaii.gov.

Enrollment in EUTF benefit plans is contingent on meeting all eligibility criteria detailed in the EUTF Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.
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 rules;
3. The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
4. The employee-beneficiary 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 of the rejection of any enrollment application.

Administrative Appeals

Under EUTF Administrative Rule 2.04, a person aggrieved by one of the following decisions by the EUTF may appeal to the EUTF Board of Trustees (Board) for relief from that decision:
1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;

3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF.

The first step in the appeal process is an appeal to the EUTF administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the EUTF's office within thirty days of the date of the 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 thirty-day period has expired. The written appeal need not be in any particular form but should contain the following information:

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

If the aggrieved person is dissatisfied with the EUTF administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety 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. 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 a reasonable amount of time. The Board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the Board may set such hearing before the Board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the Board to hear the matter in question. Please note that nothing in the EUTF Administrative Rules requires the Board to hear or decide any matter that can be lawfully delegated to another person or entity for a hearing and decision.

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

For emergency appeals regarding the EUTF PPO Plan or EUTF Prescription Drug Plan, please refer to the EUTF Administrative Rule 2.05 for information on this appeal process.

State of Hawaii Employees Only

By electing to participate in the Premium Conversion Plan (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 (marriage, birth or adoption of children, divorce, etc.), you must complete/file all the required PCP forms within 90 days of the event, to change or cancel your reduction in pay

(otherwise, changes can be made only during the Open Enrollment period). Please note that you must notify the EUTF within 30 days of the event in order to make the change in coverage.

3. Allowable changes/cancellations will generally take effect the month after you file, so 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 form; never retroactively.
4. Your election, in the absence of an 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 authorization will still 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.

Medical Plan Options

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

- Preferred Provider Organization (PPO) 90/10 Plan
- Preferred Provider Organization (PPO) 80/20 Plan
- Health Maintenance Organization (HMO) Plans
- Supplemental Medical Plans
- High Deductible Health Plan (HDHP)/Health Savings Account (HSA)

Understanding the Plan Designs

- **Under either PPO plan,** you can receive services from any provider, without coordinating your care through a primary care physician (PCP). A PPO gives you the flexibility to visit the providers you choose – inside or outside of the Plan's network. However, the Plan pays greater benefits if you receive care from an in-network provider or facility. It's important to note that when you participate in a PPO, you are responsible for ensuring that the services and care you receive are covered by your Plan. If you use an out-of-network provider, you'll often be responsible for submitting your own claims.

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

- **Under a Supplemental Medical Plan,** expenses that are not covered by another, primary medical plan are paid under this plan. If you have a medical plan through your spouse/DP or another source, you can choose these plans to cover any copayments or coinsurance charged by that plan. You can enroll in a supplemental plan **only** if you have another medical plan coverage not provided through the State or counties.

- **Under an HDHP/HSA,** your coverage consists of two components: a traditional health plan to protect you against health care expenses (High Deductible Health Plan) and an optional tax-advantaged savings vehicle (Health Savings Account).* With the exception of certain types of preventive care, the benefits from your health plan (HDHP) begin after you meet your annual deductible. Contributions to the HSA help you build savings for current and future medical expenses that fall within the deductible of the HDHP. Today, only HMSA offers the HDHP Plan. It has partnered with Sterling HSA to administer your account (funds are held at First Hawaiian Bank). It has also partnered with BlueHealthCare Bank to administer your account. If you enroll in the HDHP, you may choose whether or not to enroll in the HSA.

In order to understand the HDHP/HSA combination, it is important to see how its two components work:

- The **HDHP** works much like a PPO. You can receive services from any provider, and you do not have to coordinate your care through a PCP. While the HDHP covers services in and outside of the network, like the PPO, the HDHP provides very strong financial incentives for you to use network providers. Despite the high deductible requirements, an HDHP provides first-dollar coverage for certain preventive care services.
- The **HSA** is a savings account funded by you with a "tax-favored" status. That means, your contributions are tax-deductible, disbursements are tax-free if used for qualified expenses, and earnings grow tax-deferred. You can only open an HSA if you are enrolled in a qualified high deductible health plan. When you incur a medical expense, you can pay for it with your HSA funds or you can choose to pay for it out-of-pocket. If you do not use the money in your HSA, the balance continues to grow with tax-free earnings to use for future medical expenses. It is also important to note that the account is portable and can be used for medical expenses in retirement.

  Once the money is deposited in your HSA account, it's yours until you spend it. Unused dollars earn interest tax-free with certain restrictions. If you change employers or retire, you can take your HSA with you. Withdrawals from your HSA are tax-free as long as they are used to pay for qualified medical expenses. Therefore, it is important that you maintain records for tax-reporting purposes.

The HDHP/HSA combination allows you to take control of your day-to-day health care costs through a savings/reimbursement account with the protection of a traditional health plan that promotes preventive care.

**In general, you will not be eligible for the HDHP/HSA option if you have any other health coverage that would apply to services covered by the HDHP/HSA. For example, if your spouse has other health coverage through his or her employer, your spouse may not be eligible for coverage under the HDHP/HSA option. Also, participation in a flexible spending account (FSA) arrangement may limit your ability to obtain coverage under the HDHP/HSA option.*

Benefit Plan Summaries

The summary chart on the following pages (pages 16-18) is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions apply. For complete information on plan benefits, please refer to the HMA, HMSA, Kaiser or Royal State Guide to Benefits, which may be obtained from HMA, HMSA, Kaiser or Royal State directly or from the EUTF website, eutf.hawaii.gov. In the case of a discrepancy between the summary, charts and other information below and the language contained in the Guide to Benefits, the language in the Guide to Benefits will take precedence.

Chiropractic Plan Benefits (Royal State National)

Royal State National Insurance Company, Ltd., through ChiroPlan Hawaii, Inc. is the provider of the chiropractic benefits. The chiropractic benefit is packaged with all active medical plans except the EUTF High Deductible Health Plan.

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

Medical Plan Coverage Chart (HMA, HMSA, Kaiser, RSN)

Plan Design	EUTF 90/10 PPO Plan		EUTF 80/20 PPO Plan	
Carrier	**HMA**		**HMSA**	
General	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Single/Family	None[1]	$100 per person; $300 per family	None	
Out-of-pocket limit Single/Family	$2,000/ $6,000		$2,500/ $7,500	
Lifetime Benefit Maximum	Unlimited		Unlimited	
Policy Year Benefit Maximum	None		None	
Physician Services	**YOU PAY:**		**YOU PAY:**	
Primary Care Office Visit	10%	30%	$14	$14
Specialist Office Visit	10%	30%	$14	$14
Routine physical exams	No Charge	Balance after 100% of EC Paid by HMA*	No Charge	No Charge
Screening Mammography	10%	30%*	No Charge	No Charge
Immunizations	No Charge	Balance after 100% of EC Paid by HMA*	No Charge	No Charge
Well Baby Care Visits	No Charge	30%*	No Charge	No Charge
Maternity	Same as any other condition	Same as any other condition	10%	10%
Second opinion – surgery	10%	30%	$14	$14
Emergency Room (ER care)	10%	10%*	$20	$20
Ambulance	10%	30%	20%	20%
Inpatient Hospital Services				
Room & Board	10%	30%	20%	20%
Ancillary Services	10%	30%	20%	20%
Physician services	10%	30%	$20	$20
Surgery	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%	30%	20%	20%
Surgery	10%	30%	20%	20%
Diagnostic Lab	10%	30%	No Charge	No Charge
Diagnostic X-ray	10%	30%	20%	20%
Anesthesia	10%	30%	20%	20%
Mental Health Services				
Inpatient Care	10%	30%	20%	20%
Outpatient Care	10%	30%	20%	20%
Other Services				
Durable Medical Equipment	10%	30%	20%	20%
Home Health Care	No Charge	30%	20%	20%
Hospice Care	No Charge	Not Covered	No Charge	No Charge
Nursing Facility - Skilled Care	10%, 120 days / CY	30%, 120 days/ CY	20%	20%
Physical & Occupational Therapy	10%	30%	20%	20%
Notes:	[1]Except for Nutritional Counseling *Deductible does not apply EC = Eligible Charge			

Medical Plan Coverage Chart (HMA, HMSA, Kaiser, RSN) - continued

Plan Type	HMO		
Plan Design	**Comprehensive**	**Basic**	**EUTF HMO**
Carrier	**Kaiser***	**Kaiser***	**HMSA**
General			
Deductible Single/Family	None/None	None/None	None/None
Out-of-pocket limit Single/Family	$2,000/ $6,000	$2,000/$6,000	$1,500/ $4,500
Lifetime Benefit Maximum	None	None	None
Policy Year Benefit Maximum	None	None	None
Physician Services	**YOU PAY:**	**YOU PAY:**	**YOU PAY:**
Primary Care Office Visit	$15	$25	$15
Specialist Office Visit	$15	$25	$15
Routine physical exams	$15	$25	$15
Screening Mammography	No Charge	No Charge	No Charge
Immunizations	No charge or $10	No charge or $10	No Charge
Well Baby Care Visits	$15	$25	$15
Maternity	Routine OB care: no charge, after confirm of pregnancy	No Charge, after confirmation of pregnancy	No Charge, Routine Pre/Post Natal Care & Delivery
Second opinion – surgery	$15	$25	$15
Emergency Room (ER care)	$50	$75	$25 (in-state); $25 (Bluecard); 20% (worldwide)
Ambulance	20%	20%	20%
Inpatient Hospital Services			
Room & Board	No Charge	$100/ day (exc. routine post-partum days)	No Charge
Ancillary Services	No Charge	No Charge	No Charge
Physician services	No Charge	No Charge	No Charge
Surgery	No Charge	No Charge	No Charge
Anesthesia	No Charge	No Charge	No Charge
Outpatient Services			
Chemotherapy/ Radiation Therapy	$15	$25	$15
Surgery	$15	$25	$15
Diagnostic Lab	$15/ department/ day	50%	No Charge
Diagnostic X-ray	$15/ department/ day	50%	$15 per X-ray
Anesthesia	No Charge	No Charge	$15
Mental Health Services			
Inpatient Care	No Charge	20%	No Charge
Outpatient Care	$15	20%	$15
Other Services			
Durable Medical Equipment	20%	Not Covered	20%
Home Health Care	No Charge	No Charge	No Charge
Hospice Care	No Charge	No Charge	No Charge
Nursing facility - Skilled Care	No Charge, 100 days/ CY	No Charge, 60 days/ CY	No Charge, 100 days/ CY
Physical & Occupational Therapy	$15	$25	$15 (Outpatient)

*For Kaiser members only:

1. Except for certain situations outlined 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 give up the right to jury or court trial. For a complete description of arbitration information, please see your *Group Medical and Hospital Service Agreement*.
2. Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgement, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.

Medical Plan Coverage Chart (HMA, HMSA, Kaiser, RSN) - continued

Plan Type	HDHP		Supplemental	
Carrier	**HMSA**		**Royal State**	**HMSA**
General	In-Network	Out-of-Network		
Annual Deductible Single/Family	$1,500 /$3,000		None/None	None/None
Annual Out-of-pocket limit Single/Family	$4,000/ $8,000		None	$10,000
Lifetime Benefit Maximum	$2,000,000		None	$1,000,000
Policy Year Benefit Maximum	None		Medical svcs: $3,000; Rx: $100/$300	None
Physician Services	**YOU PAY:**		**YOU PAY:**	**YOU PAY:**
Primary Care Office Visit	10%*	30%*	Co-pay covered	50%
Specialist Office Visit	10%*	30%*	Co-pay covered	50%
Routine physical exams	No Charge[1]	No Charge	Co-pay covered	Not Covered
Screening Mammography	No Charge	30%	Co-pay covered	No Charge (In-network: 50% (Out-of-Network)
Immunizations	No Charge	No Charge	Co-pay covered	50%
Well Baby Care Visits	No Charge	30%	Co-pay covered	No Charge (In-network: 50% (Out-of-Network)
Maternity	Same as any other condition	Same as any other condition	Co-pay covered	Same as any other condition
Second opinion – surgery	10%*	30%*	Co-pay covered	50%
Emergency Room (ER care)	10%*	10%*	Co-pay covered	50%
Ambulance	10%*	30%*	Co-pay covered	50%
Inpatient Hospital Services				
Room & Board	10%*	30%*	Co-pay covered	50%
Ancillary Services	10%*	30%*	Co-pay covered	50%
Physician services	10%*	30%*	Co-pay covered	50%
Surgery	10%*	30%*	Co-pay covered	50%
Anesthesia	10%*	30%*	Co-pay covered	50%
Outpatient Services				
Chemotherapy/ Radiation Therapy	10%*	30%*	Co-pay covered	50%
Surgery	10%*	30%*	Co-pay covered	50%
Diagnostic Lab	10%*	30%*	Co-pay covered	50%
Diagnostic X-ray	10%*	30%*	Co-pay covered	50%
Anesthesia	10%*	30%*	Co-pay covered	50%
Mental Health Services				
Inpatient Care	10%*	30%*	Co-pay covered	50%
Outpatient Care	10%*	30%*	Co-pay covered	50%
Other Services				
Durable Medical Equipment	10%*	30%*	Co-pay covered	50%
Home Health Care	0%*	30%*	Co-pay covered	50%
Hospice Care	0%*	Not Covered	Co-pay covered	50%
Nursing facility - Skilled Care	10%*,120 days/CY	30%*,120 days/CY	Co-pay covered	50%, 120 days / CY
Physical & Occupational Therapy	10%*	30%*	Co-pay covered	50%
Notes:	*Annual Deductibles apply [1]One Physical Exam / CY Up to $300 in cash incentives through the Rewards Program Optional: Health Savings Account			

PPO and HMO Prescription Drug Plans

The EUTF's prescription drug plan is administered by informedRx. This plan is the prescription drug coverage for the PPO options, administered by HMA and HMSA, and for stand-alone drug coverage. The Kaiser prescription drug coverage is included under the Kaiser Medical Program.

COVERAGE*	PPO Prescription Drug Plan (administered by informedRx) HDHP Prescription Drug Plan (administered by HMSA)		HMO Prescription Drug Plan	
			Kaiser	HMSA
RETAIL PRESCRIPTION PROGRAM (30 day supply)	**Participating Pharmacy**	**Nonparticipating Pharmacy**	**Copayment up to**	**Participating Pharmacy**
Generic	$5 copayment	$5 + 20% of eligible charges	$15	$5
Preferred Brand Name	$15 copayment	$15 + 20% of eligible charges	$15	$15
Other Brand Name	$30 copayment	$30 + 20% of eligible charges	$15	$30
Injectables and Specialty Drug (Does not apply to HDHP)	20% of eligible charges; Up to $250 maximum; $2,000 out-of-pocket maximum per plan year	Not a benefit	$15	$15
Insulin				
Preferred Insulin	$5 copayment	$5 + 20% of eligible charges	$15	$5
Other Insulin	$15 copayment	$15 + 20% of eligible charges	$15	$15
Diabetic Supplies				
Preferred Diabetic Supplies	No copayment	No copayment	$15	No copayment
Other Diabetic Supplies	$15 copayment	$15 + 20% of eligible charges	$15	$15
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	**Participating Pharmacy**	**Nonparticipating Pharmacy**	**Kaiser**	**HMSA**
Generic	$10 copayment	Not a benefit	$30	$10
Preferred Brand Name	$35 copayment	Not a benefit	$30	$35
Other Brand Name	$60 copayment	Not a benefit	$30	$60
Insulin				
Preferred Insulin	$10 copayment	Not a benefit	$30	$10
Other Insulin	$35 copayment	Not a benefit	$30	$35
Diabetic Supplies				
Preferred Diabetic Supplies	No copayment	Not a benefit	$30	No copayment
Other Diabetic Supplies	$35 copayment	Not a benefit	$30	$35

* For **Royal State Supplemental Plan**, reimbursement for prescription drug co-payments charges shall not exceed $10 per prescription drug (RX) up to $100 if enrolled in single coverage or $300 if enrolled in family coverage per policy year. Reimbursement for prescription drugs co-payment count towards the Policy Year Maximum Benefit Payable.
For **EUTF Supplemental Plan**, reimbursement for prescription drug co-payments charges shall not exceed $20 per prescription drug (RX) for generic and preferred brand name. For 90-day mail order, reimbursement for prescription drug co-payments charges shall not exceed $35 per prescription drug (RX).
For **HDHP Medical Plan**, it includes prescription drug benefits (administered by HMSA). Copayments are not applicable for the HDHP plan until the deductible is met. Please refer to the Guide to Benefits brochure.

The EUTF has approved benefit changes to the PPO Prescription Drug program for all **Active** Eligible participants effective July 1, 2009. It is important to note that many of these programs offer a financial incentive for participants to use the generic equivalent or Preferred Brand medication without compromising care as these medications have the same efficacy and are priced lower than Non-Preferred brand name medications.

informedRx recognizes that some participants have a clinical need for a Non-Preferred product. In these cases, a prior authorization (PA) process is available for those who require Non-Preferred medications. For the PA process, the prescribing physician must document a clinical failure or drug allergy to the generic or Preferred medication in question.

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

informedRx has implemented the following changes on behalf of the EUTF:

Generic Drug Incentive Program Effective July 1, 2009
The Generic Drug Incentive Program requires participants to use a generic equivalent medication, when available, in place of the associated brand name medication. When a generic medication is utilized, the standard generic co-payment will apply. However, if a participant chooses to use a brand medication rather than the generic equivalent, then the co-payment becomes the standard generic co-payment plus the difference in the cost of the generic and brand.

A prior authorization (PA) process is available for those participants who require a Non-Preferred medication. For the PA process, the prescribing physician must document a clinical failure or drug allergy to the generic medication in question.

Removal of Formulary Grandfathering Effective July 1, 2009
To ease the transition from the HMSA Prescription Drug Plan to the EUTF informedRx (then known as NMHC) Prescription Drug Plan in 2007, the EUTF allowed participants that were utilizing an HMSA Preferred drug (but categorized as an informedRx Non-Preferred drug) to be "grandfathered" at the informedRx Preferred drug tier co-payment level. This "grandfathering" allowed participants to pay a lower co-payment for their medication with the informedRx Prescription Drug Plan.

Effective July 1, 2009, the "grandfathering" of HMSA Preferred drugs expired. All Non-Preferred medications now require the applicable co-payment according to the current plan design regardless of the co-payment previously charged.

Utilization Management Guidelines Effective July 1, 2009
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 informedRx National Pharmacy and Therapeutics (P&T) Committee.
2. ***Step Therapy*** – Requires the use of lower-cost alternatives (First-Line Agents) prior to gaining access to more costly brand name products.
3. ***Contingent Therapy Protocol*** – Ensures medications are being used as approved by the FDA.

Maintenance Mail Order Program for Maintenance Medication Effective July 1, 2009
For maintenance medications, the Maintenance Mail Order Program requires participants to obtain these medications through informedRx's mail service pharmacy, informedMail after three (3) 30-day fills at a retail pharmacy. Mail order provides a 90-day supply of medication at one low co-payment. As part of the Maintenance mail Order Program, participants are allowed three (3) 30-day fills at a retail pharmacy in order to determine if a new medication or dosage is right for you. Each new maintenance medication or change in dosage will allow for the retail fills prior to utilizing mail order. The informedRx mail order benefit provides you cost savings through lower co-payments and the convenience of home delivery. Examples of maintenance medications are prescription drugs that are prescribed for the treatment of ongoing or chronic conditions such as high blood pressure, diabetes, heart disease or thyroid condition.

Non-Specialty medications requiring refrigeration are not subject to the Maintenance Mail Order Program. Participants using insulin or other non-specialty drugs needing refrigeration have the option of obtaining those drugs through a local pharmacy or through this program.

Reference-Based Pricing Program Effective January 1, 2010
The EUTF informedRx Prescription Drug Plan includes a Reference-Based Pricing Program. With this program, the most cost-effective FDA-approved drug will be designated as the Preferred drug within three (3) drug categories or classes.

The Reference-Based Pricing Program applies to the following three drug classes:

1. Cholesterol lowering drugs known as Statins
2. Anti-heartburn/ulcer medications known as Proton Pump Inhibitors or PPIs
3. Allergy medications known as Low or Non-Sedating Antihistamines

For each drug that is included in the Reference-Based Pricing Program, a therapeutic alternative drug exists that is approved by the FDA to treat the same condition. With this program, participants have an opportunity to save a significant amount of money by using the therapeutic alternative drug (also known as the Preferred drug).

Participants prescribed and taking a Preferred drug will pay the generic co-payment for the drug. However, when participants choose to take or continue to take a Non-Preferred drug (the more costly drug) in one of the three drug classes; their co-payment will no longer be a fixed amount, but will vary based on the difference in price of the most cost effective drug (the Preferred drug) and the more costly product (Non-Preferred Drug).

Ascend SpecialtyRx and Specialty Drug Tier Effective July 1, 2009
The EUTF has moved plan coverage and management of self-administered injectable specialty drugs from the HMSA and HMA PPO medical plans to the informedRx Prescription Drug Plan. The EUTF informedRx Prescription Drug Plan requires participants to obtain specialty medications through Ascend SpecialtyRx.

Ascend SpecialtyRx uses evidence-based care plans and medication management outreach programs to help participants use these complex medications properly. Medications for the treatment of the following conditions are available through Ascend SpecialtyRx:

- Arthritic Disorders
- Blood Disorders
- Crohn's Disease
- Cystic Fibrosis
- Fabry Disease
- Gaucher's Disease
- Growth Hormone Deficiency
- Hemophilia
- Hepatitis-C
- HIV/AIDS Wasting
- Infertility
- Immune Deficiency
- Multiple Sclerosis
- Oncology (Cancer)
- Organ Transplant
- Osteoporosis
- Pompe's Disease
- Psoriasis
- Respiratory Syncytial Virus

A fourth tier has been added to the Plan's Formulary to include specialty drugs.

Medications that fall within the Tier 4 (specialty drugs) will be subject to a 20% participant co-insurance. All Tier 4 specialty drugs will have a $250 co-payment maximum per fill and a $2,000 out-of-pocket maximum per plan year. ***Exception:*** Oral oncology medications provided under the Ascend SpecialtyRx will have a Tier 3 copayment instead of Tier 4 copayment.

Note: informedRx, the vendor of prescription drug and pharmacy services for the EUTF since July 1, 2007, was formerly known as NMHC. During the past year, the company was re-named informedRx. The cost saving features of the EUTF prescription drug plan described in this section were approved by the EUT Board of Trustees and have nothing to do with the name change. If you still have an NMHC prescription drug ID card, it is still valid.

If you have questions about your prescription drug benefits or informedRx you can call 1-866-533-6977. Representatives are available 24-hours a day to assist with your questions. You can also visit the SXC website at www.sxc.com for additional information on the company.

Dental Plan Benefits (Hawaii Dental Services (HDS))

Your Plan provides:

BENEFIT	PLAN COVERS
PLAN MAXIMUM per person per plan year (July 1 – June 30)	$2,000
DEDUCTIBLE per plan year (July 1 – June 30) (does not apply to benefits covered at 100%)	$50/person
DIAGNOSTIC	
Examinations - twice per calendar year	100%
Bitewing X-rays - twice per calendar year through age 14; once per calendar year thereafter	100%
Other X-rays (full mouth X-rays limited to once every 5 years)	100%
PREVENTIVE	
Cleanings – twice per calendar year	100%
• Diabetic Patients – four cleanings or *periodontal maintenance	
• Expectant Mothers – three cleanings or *periodontal maintenance *Periodontal maintenance benefit level	*80%
Topical fluoride (once per calendar year through age 19)	100%
• Fluoride Varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions as documented by the dentist.	
Space maintainers (through age 17)	100%
Sealants (through age 18) – one treatment application, once per lifetime only to permanent molar and bicuspid teeth with no cavities and no occlusal restorations, regardless of the number of surfaces sealed.	100%
RESTORATIVE	
Amalgam (silver-colored) fillings	80%
Composite (white-colored) fillings – limited to the anterior (front) teeth	80%
Crowns and gold restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	60%
Note: Composite restorations or porcelain (white) crowns on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the Amount Charged by the dentist.	
ENDODONTICS	80%
Pulpal therapy; Root canal filling	
PERIODONTICS	80%
Surgical and non-surgical treatment of diseases of the gums and bones	
PROSTHODONTICS	60%
Fixed bridges (once every 5 years; ages 16 and older)	
Removable Dentures (complete and partial – once every 5 years; ages 16 and older)	
Implants (covered as alternate benefit) when one tooth is missing between two natural teeth	
ORAL SURGERY	80%
Extractions; Other oral surgery procedures to supplement medical care plan	
ADJUNCTIVE GENERAL SERVICES	80%
Consultations (by Specialist not performing services); Office Visits (injury related); Sedation: General & IV	
Palliative (emergency) treatment (for relief of pain but not to cure)	100%
ORTHODONTICS Maximum amount payable by HDS for an eligible patient shall be $1,000 lifetime per case paid in 8 quarterly payments of $125. Orthodontic services are not covered: * If you received orthodontic services prior to the effective date of this benefit, no payment will be made for such orthodontic services even if the orthodontic services are not completed or there are still outstanding bills for the services. *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 payment schedule, payments will not continue. *If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.	50%

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

HDS recently updated its public Web site with a fresh, new look that now includes a section exclusively for EUTF members at www.deltadentalhi.org. This section includes a copy of the active dental benefits brochure which includes a summary of the dental benefits. HDS members can also check on their eligibility, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, and view oral health and wellness information.

Vision Plan Benefits (Vision Service Plan (VSP))

Your coverage from a VSP Doctor:

Exam covered in full ..... every plan year[1], after $10 Copay

Prescription Glasses

Lenses covered in full ..... every plan year[1], after $25 Copay

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

Frame ..... every other plan year[1]

- $120 allowance, plus 20% off any out-of-pocket costs

~OR~

Contact Lenses ..... every plan year[1]

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

[1]Plan year begins July 1

Extra Discounts and Savings

Glasses & Sunglasses

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

Contact Lenses

- New and current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of lenses. Ask your VSP doctor if you qualify.

Laser Vision Correction

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

You get the best value from your VSP benefit when you visit a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 6 months to submit a claim to VSP for partial reimbursement, less copays according to the following schedule:

Out-of-Network Reimbursement Amounts

Exam ..... Up to $45.00

Single Vision Lenses ..... Up to $45.00

Lined Bifocal Lenses ..... Up to $65.00

Lined Trifocal Lenses ..... Up to $85.00

Frame ..... Up to $47.00

Contacts ..... Up to $105.00

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

[1]Plan year begins in July.

Life Insurance (Standard Insurance Company)

Your life insurance benefit remains at $36,225, for active participants. Since this benefit is only for beneficiaries and the coverage is the same for everyone, you do not need to make an election for this coverage.

- Your benefit will reduce once you reach age 65 and continue to reduce as follows:
    - $23,546 for participants age 65 through 69
    - $16,301 for participants age 70 through 74
    - $10,868 for participants age 75 through 79
    - $7,245 for participants age 80 and over

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

- Portability - this provision allows a terminated participant to continue their life insurance at a group discounted rate instead of an individual rate, provided they meet the eligibility requirements.
- Accelerated Benefit – allows you to receive an early payment of a portion of your life insurance if you have a Qualified Medical Condition and meet certain requirements.
- Repatriation of remains benefit – this benefit reimburses an individual who incurs expenses related to transporting your remains back to a mortuary near your primary place of residence if you pass away 200 miles or more away from home.
- Travel assist benefit – helps you respond to medical care situations when you are 100 miles or more away from home. Form is provided on the following page.
- MEDEX® Travel Assist program. This benefit is designed to help you and eligible family members respond to medical care situations, and many other emergencies, when you are traveling for business or pleasure 100 miles or more away from home.

Below are some key features of the MEDEX program that you should be aware of:

- All services must be arranged by MEDEX Assistance Corporation. No claims for reimbursement will be accepted.
- MEDEX does not cover traveling for the purpose of obtaining medical services or treatment.
- International travel is only covered for up to 180 days for any one trip.
- When calling MEDEX, please reference Group #9061. The policyholder is Standard Insurance Company.

Please see the MEDEX Travel Assist insert located on the following page for more details about the services available, plan restrictions, as well as your identification card. Your identification card contains the phone numbers and email address you'll need to contact MEDEX, so keep it with you when you travel.

MEDEX® Travel Assist

Security That Travels With You

MEDEX® Travel Assist is a comprehensive program of information, referral, assistance, transportation and evacuation services designed to help you respond to medical care situations and many other emergencies that may arise during travel.

You do not need to enroll. As a participant in the Hawaii Employer-Union Health Benefits Trust Fund Group Life Insurance Policy issued by Standard Insurance Company, you are automatically covered.

MEDEX Provides the Following Services

- **Pre-Trip Assistance** including consulate and embassy locations, currency exchange information, health hazards advice and inoculation requirements, passport and visa information, weather information and travel locator services.
- **Medical Assistance Services** including locating medical care, case communications, translation and interpreter services, hotel convalescences arrangements, medical insurance assistance and prescription drug assistance.
- **Emergency Transportation Services** including emergency evacuations for medical treatment, medically necessary repatriation, repatriation of remains, family or friend travel arrangements, return of dependent children and vehicle return.
- **Travel Assistance Services** including emergency credit card and ticket replacement, emergency passport and document replacement, emergency cash and payment assistance, emergency message service, missing baggage assistance, locating legal services and bail bond services.
- **Personal Security Services** including real-time security intelligence and security evacuation services.

What MEDEX Travel Assist Does Not Cover

While MEDEX assists with most emergencies you may have away from home, it does not cover costs or expenses incurred because of:

- Involvement in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, and insurrection, military or usurped power
- Traveling against the advice of a physician
- Traveling for the purpose of obtaining medical services or treatment
- The commission of, or attempt to commit, an unlawful act
- Injury or illness caused by or contributed to by use of drugs or intoxicants, unless prescribed by a physician
- Psychiatric, psychological or emotional disorders, unless hospitalized
- Pregnancy and childbirth, except for complications of pregnancy
- Participation as a professional in athletics
- Expenses incurred for emergency evacuation or repatriation services as a result of injury or sickness while traveling within 100 miles of your place of residence
- Traveling outside your home country for more than 180 days for any one trip

How to Access Services

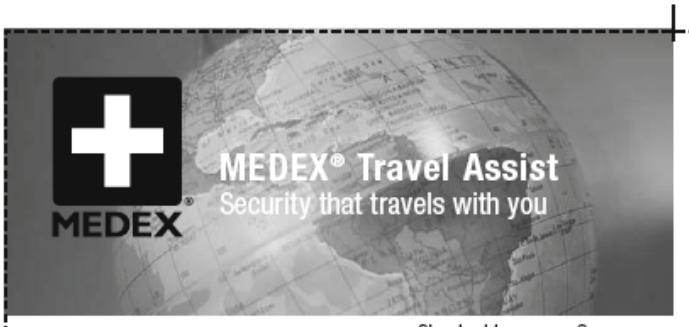
Simply cut out and sign the identification card below and keep it with you when you travel.

For additional information please visit **www.standard.com/mybenefits/hawaiieutf**.

All services must be arranged by MEDEX Assistance Corporation. No claims for reimbursement will be accepted.

The MEDEX Travel Assist program is available to participants in the Hawaii Employer-Union Health Benefits Trust Fund Group Life Insurance Policy issued by Standard Insurance Company. The program is subject to the terms and conditions, including exclusions and limitations, of the Employer Emergency Medical Assistance Service Certificate issued to participating policyholders by MEDEX Assistance Corporation, which is not affiliated in any way with Standard Insurance Company.

FOLD



Standard Insurance Company
Group #9061

NAME

The participant named is eligible for MEDEX® Travel Assist when traveling at least 100 miles from home or in a foreign country.

In the United States, Canada, Puerto Rico, U.S. Virgin Islands, and Bermuda call toll-free 800-527-0218

In other locations worldwide, call collect 410-453-6330

MEDEX Travel Assist can also be reached at *operations@medexassist.com.*

MEDEX Travel Assist is not responsible for the availability or results of any medical, legal, or transportation services. You are responsible for obtaining all services not directly provided by MEDEX and for the expenses associated with them. All services must be arranged by MEDEX Assistance Corporation. No claims for reimbursement will be accepted.

FOLD

SI **12092-645545** (4/09) EE

For More Information

For Questions about…	You Should Contact…
EUTF	**eutf.hawaii.gov** EUTF Customer Service 808-586-7390 or Toll Free: 1-800-295-0089 (Monday through Friday, 7:45 a.m. – 4:30 p.m. HST)
HMA	**www.EUTF-HMA.com** 808-951-4643 or Toll Free: 1-866-437-1992 (Monday through Friday, 7:30 a.m. – 5:00 p.m. HST)
HMSA	**www.hmsa.com** 808-948-6499 or Toll Free: 1-800-776-4672 Hilo: 808-935-5441, Kailua-Kona: 808-329-5291 Kahului: 808-871-6295, Lihue: 808-245-3393 (Monday through Friday, 8:00 a.m. – 4:00 p.m. HST)
Kaiser Permanente	**www.kp.org/hi/EUTF's** 808-432-5955 (Oahu) or Toll Free: 1-800-966-5955 (Neighbor Islands) (Monday through Friday, 8:00 a.m. – 5:00 p.m. HST Saturdays 8:00 a.m. – 12:00 p.m. HST)
informedRx	**www.myinformedrx.com/eutf.asp** 1-866-533-6977 (24/7) (Monday through Friday, 8:00 a.m. – 4:30 p.m. HST) **informedMail** 1-866-533-6077 (24/7) Fax prescriptions to: 1-800-881-1889 (Physicians only) **Ascend SpecialtyRx** 1-800-850-9122 (Monday through Friday, 8:00 a.m. – 4:30 p.m. HST Saturdays 4:00 a.m. – 8:00 a.m. HST)
Royal State National	**Chiropractic Benefit** 808-621-4774 or Toll Free: 1-800-414-8845 **www.chiroplanhawaii.com** **Supplemental Medical Plan** 808-539-1621 or Toll Free: 1-888-942-2447 **www.rsninc.com** (Monday through Friday, 8:00 a.m. – 4:30 p.m. HST)
VSP	**www.vsp.com** 808-532-1600 or Toll Free: 1-800-522-5162 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST) Toll Free for Mainland: 1-800-877-7195 (Monday through Friday, 5:00 a.m. – 7:00 p.m. PST Saturdays 6:00 a.m. – 2:30 p.m. PST)
HDS	**www.deltadentalhi.org** 808-529-9310 or Toll Free: 1-866-702-3883 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST)
Standard Insurance	**www.standard.com/mybenefits/hawaiieutf/** Toll Free: 1-888-408-2298 (Monday through Friday, 7:30 a.m. – 4:30 p.m. HST)

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

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

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

Notice of Creditable Coverage (see page 27)

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

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

Notice of Non-Creditable Coverage (see page 28)

If you are enrolled in a supplemental medical plan, the EUTF has determined that your prescription drug benefits are not as good as or better than the standard Medicare Part D drug benefits. As a rule, you are enrolled in the supplemental medical plan because you are also enrolled in another prescription drug plan and you should have received a Notice of Creditable Coverage from that other plan. If your other plan's prescription drug benefits are also non-creditable coverage, you should consider enrolling in Medicare Part D when you first become eligible to do so. If you don't enroll in Part D when you are first eligible to do so, you may have to pay a penalty (a higher premium) for your Part D coverage when you later do enroll, and you may have to pay that penalty for as long as you are covered under Part D.

It is important to note that if you enroll in a Medicare Part D plan, the EUTF will not reimburse you for the premiums.

Notice of Creditable Coverage

Important Notice of Creditable Coverage from Hawaii Employer-Union Health Benefits Trust Fund (EUTF) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the EUTF and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The EUTF has determined that the prescription drug coverage offered by the informedRx (formerly NMHC) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current EUTF Prescription Drug Plan coverage will be affected. Your current medical coverage with the EUTF pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.
If you do decide to join a Medicare drug plan and drop your current EUTF Prescription Drug Plan coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the EUTF and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable 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 that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the EUTF's Customer Service listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the EUTF changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of 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.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage 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).

Date:	1/1/2010
Name of Entity/Sender:	Hawaii Employer-Union Health Benefits Trust Fund
Contact--Position/Office:	Customer Service
Address:	201 Merchant Street, Suite 1520, Honolulu, HI 96813
Phone Number:	808-586-7390

Notice of Non-Creditable Coverage

Important Notice of Non-Creditable Coverage from Hawaii Employer-Union Health Benefits Trust Fund (EUTF) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the EUTF and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The EUTF has determined that the prescription drug coverage offered in its supplemental plans is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the EUTF's Supplemental Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from the EUTF's Supplemental Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on

if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you decide to drop your current coverage with the EUTF, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the EUTF.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under the EUTF's Supplemental Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current EUTF coverage will not be affected. Your current medical coverage with the EUTF pays for other health expenses in addition to prescription drug expenses. 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 through EUTF's supplemental plans.

If you drop your current prescription drug coverage through EUTF's supplemental plans and enroll in Medicare prescription drug coverage through another plan, you may enroll back into an EUTF plan during the open enrollment period under the EUTF-sponsored plans.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the EUTF's Customer Service listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the EUTF changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of 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.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	1/1/2010
Name of Entity/Sender:	Hawaii Employer-Union Health Benefits Trust Fund
Contact--Position/Office:	Customer Service
Address:	201 Merchant Street, Suite 1520, Honolulu, HI 96813
Phone Number:	808-586-7390

Women's Health & Cancer Rights Act

Your health insurance plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services, including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Your plan will provide coverage in consultation with the attending physician and patient.

Coverage for breast reconstruction and related services will be subject to deductibles, co-payments, and coinsurance amounts that are consistent with those that apply to other benefits under the Plan. If you have any questions about the Women's Health and Cancer Rights Act, please call your insurance carrier or the EUTF at 808-586-7390.

Newborns' & Mothers' Health Protection Act

Generally, group health plans and health insurance issuers who offer group insurance coverage may not (under federal law) restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery, or
- Less than 96 hours following a caesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the Plan may still require pre-certification of any hospital admission in connection with childbirth, in order for you to obtain the maximum level of benefits available under the Plan.

Qualified Medical Child Support Order

Your health insurance plan honors qualified medical child support orders (QMCSOs). This means that if a QMCSO issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan. To be qualified, a medical child support order must include:

- Name and last known address of the parent who is covered under the health insurance plan,
- Name and last known address of each child to be covered under the health insurance plan,
- Type of coverage to be provided to each child, and
- Period of time coverage will be provided.

Send QMCSOs to the EUTF, which is your Plan Administrator. Upon receipt, the EUTF will notify you and give you the procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan.

National Medical Support Notices

The EUTF (your health benefits plan administrator) also honors qualified National Medical Support Notices (NMSNs). These Notices are similar to a QMCSO, but are issued by a state agency pursuant to a medical child support order. Upon receipt of the NMSN, the Employer will, within 40 business days, return the Notice to the state agency if the specified coverage is not available for one of the reasons set forth on the Notice, or forward the Notice to the EUTF, the Plan Administrator, if the specified coverage is available.

If the Employer forwards the Notice to the EUTF, the EUTF will, within 40 business days, return the Notice to the state agency and/or the parties concerned to inform them whether the Notice constitutes a QMCSO.

If the Notice qualifies, the EUTF will notify the state agency either that the child(ren) is/are currently enrolled or will be enrolled in the coverage available under the EUTF.

If you are not enrolled and there is more than one coverage option available, the EUTF will inform the state agency of the coverage options from which you may elect coverage. In this event, the EUTF will also notify your employer, who will determine whether federal or state withholding rules permit withholding from your salary or wages the amount required to provide coverage to the child(ren) under the terms of the health insurance plan, and, if so, to withhold the required amounts from your pay for such coverage and remit these amounts withheld to the EUTF.

If the Notice is not qualified, then within 40 business days, the EUTF will notify the state agency and the parties involved, the specific reason(s) why the Notice failed to qualify. The EUTF may also provide additional notifications as provided for in the NMSN's instructions.

Michelle's Law

If a group health plan provides coverage for a dependent child on the basis of the child being a student at a post-secondary educational institution, a federal law popularly known as "Michelle's Law" limits the plan's ability to terminate coverage of such child when the child loses student status due to a medically necessary leave of absence. Under Michelle's Law, the group health plan may not terminate coverage of such a child before the earlier of: (a) one year after the first day of the medically necessary leave of absence; or (b) the date on which such coverage would otherwise terminate under the plan. In order to take advantage of this extended coverage, the dependent child's treating physician must provide a written certification to the plan which states that the child is suffering from a serious illness or injury and that a leave of absence or other change in enrollment is medically necessary.

If your child is covered as a full-time student under the EUTF plan and either takes a medically necessary leave of absence from school or ceases to qualify as a full-time student due to a serious illness or injury, your child may qualify for continued EUTF coverage under Michelle's Law. To claim coverage under Michelle's Law, you or your child must provide the EUTF with a written certification from the child's treating physician which certifies that your child is suffering from a serious illness or injury and that a leave of absence or other change in enrollment (e.g., reduction in class hours below full-time student status) is medically necessary. The written certification must state the date that the medically necessary leave of absence or change in enrollment will commence or has commenced.

Continuation of Group Health Coverage Under COBRA: Initial Notice

A federal law, commonly known as "COBRA," requires most employers to offer employees and their covered dependents the opportunity to elect a temporary continuation of health coverage, at group rates, when coverage would otherwise be terminated, because of a "qualifying event" (listed below).

The section serves as your initial notice of your rights and obligations under COBRA. It is subject to change without warning, as interpretations or changes in the law do occur. Please read this notice carefully, share it with your family, and keep it in your file.

Qualifying Events

Employees

If you are an employee covered under a group health plan, you (and your covered dependents) may elect COBRA coverage if you lose your group health coverage due to either of these "qualifying events":

- Termination of your employment (for reasons other than gross misconduct), or
- Reduction in your work hours causing you to be ineligible for health benefits insurance.

Covered Spouses

If you are the covered spouse of an employee enrolled in a group health plan, you may elect COBRA coverage if you lose group health coverage due to any of these "qualifying events":

- Termination of your spouse's employment (for reasons other than gross misconduct), or
- reduction in your spouse's work hours causing him or her to be ineligible for Plan benefits,
- Death of your spouse,
- Divorce or legal separation from your spouse, or
- Employee-beneficiary becomes entitled to Medicare benefits.

Covered Children

Dependent children who are covered under a group health plan have the right to elect COBRA coverage if they lose coverage under the Plan due to any of these "qualifying events":

- The employee-parent's employment stops (for reasons other than gross misconduct), or work hours are reduced resulting in ineligibility for Plan benefits,
- Death of the employee-parent,
- Parents' divorce or legal separation,
- Employee-parent becomes entitled to Medicare benefits, or
- Dependent child ceases to be a "dependent child" under the health insurance plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment or the death of the employee, your employer must notify the Plan Administrator of the Qualifying Event. The employee will not need to notify the EUTF of the occurrence of any of these three Qualifying Events.

You Must Give Notice of Some Qualifying Events

For the other initial Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must provide the Plan Administrator with notice of the Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date of the loss of coverage under the Plan.
You must provide this notice in writing by appropriately completing the attached "Notice of a COBRA-Related Event." For detailed instructions on completing this Notice, the documentation required to accompany the Notice and the procedures for submitting the Notice, see the EUTF's website or contact the Plan Administrator. If you do not follow these procedures or if you fail to provide written notice to the Plan Administrator within the 60-day notice period, YOU AND ANY OTHER FAMILY MEMBERS WHO WOULD OTHERWISE BE QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHTS UNDER COBRA, INCLUDING THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE..

Cost of Coverage

Insurance carriers providing coverage for the EUTF beneficiaries will administer the billing and collection of COBRA premiums.

You will be charged the full premium under the group health plan for COBRA coverage, plus a 2% administrative charge. If you are disabled and you extend your coverage for more than 18 months, you will have to pay the full cost of coverage plus another 50% of the premium for months 19 through 29.

You may pay for COBRA coverage on a monthly basis. Your first payment will cover the period from the date your former coverage terminated to the date you elect COBRA coverage — and is due within 45 days of your COBRA election date. The EUTF will give you specific cost information at that time. For subsequent premium payments, you have a grace period of 30 days for payment of the regularly

scheduled premium. If you fail to pay the full monthly premium amount when due, your COBRA coverage will be terminated for non-payment. If this happens, you will not be allowed to reinstate your COBRA coverage.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally may last for only up to a total of 18 months.

The COBRA continuation coverage periods described above are maximum coverage periods. COBRA coverage can end before the maximum coverage period described in this Notice for several reasons. For more information refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

There are three ways in which this 18-month period of COBRA continuation coverage resulting from a reduction in hours or employment or termination of employment can be extended.

Disability extension of 18-month period of continuation coverage

If a Qualified Beneficiary in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum COBRA coverage period of 29 months. For more information regarding this disability extension of the COBRA coverage period, the timeframe and procedures for providing the notice of disability and the cost of COBRA coverage during any disability extension period, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Second Qualifying Event extension of 18-month period of continuation coverage

If your family experiences another Qualifying Event while receiving 18 (or 29) months of COBRA continuation coverage resulting from the covered employee's termination of employment or reduction in hours of employment (or during the disability extension period following either of these Qualifying Events), the spouse and dependent children in your family who are receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for up to a maximum of 36 months of COBRA continuation coverage, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available only if the second Qualifying Event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (This extension in the COBRA coverage period is not available under the Plan when a covered employee becomes entitled to benefits under Medicare.) For more information regarding second Qualifying Events and the timeframe and procedures for providing the notice of a second Qualifying Event, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Medicare extension for a spouse and dependent children

If an employee loses coverage under the Plan due to a termination of employment or reduction of hours of employment that occurs within 18 months after the covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both), then the maximum coverage period for the spouse and dependent children (but not the employee) will be up to 36 months from the date the employee became entitled to Medicare benefits. However in this situation, the covered employee's maximum coverage period will be 18 months. For more information regarding this Medicare extension of the COBRA coverage period, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Children Born To or Placed for Adoption with the Covered Employee during a Period of COBRA Continuation Coverage

A child born to or adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a Qualified Beneficiary provided that, if the covered employee is a Qualified Beneficiary, the covered employee has elected COBRA continuation coverage for himself or herself. For more information regarding a newly acquired dependent child's COBRA, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Alternate Recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee's period of employment is entitled to the same rights under COBRA as a eligible dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent under the eligibility requirements of the Plan.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you must notify the Plan Administrator of any changes in the addresses of family members by submitting a fully completed Form EC-1 to the Plan Administrator. The Form EC-1 is available from the Plan Administrator. You should also keep a copy, for your records, of any notices or forms you send to the Plan Administrator.

Plan Contact Information

For more information about COBRA continuation coverage, you may contact the Plan Administrator at the following address. You may also view the EUTF's "COBRA Notice" on the website at: eutf.hawaii.gov.

Hawaii Employer-Union Health Benefits Trust Fund

P.O. Box 2121	Telephone:	(808) 586-7390
Honolulu, HI 96805-2121	Toll Free:	(800) 295-0089

Rights and Benefits

COBRA participants in a health insurance plan have the same rights and benefits as active participants in the plan. Any changes made to the plan for active participants will also apply to COBRA participants.

HIPAA Initial Notice: Notice of Privacy Rules

Effective date of this notice is October 1, 2009.

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.

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, and
- Follow the terms of the notice that is currently in effect.

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, all of the ways the EUTF is allowed to use and disclose your medical information will 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, improvement activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, 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 Plans, ChiroPlan Hawaii or Royal State Insurance in order to verify your eligibility for benefits or services.

Disclosure to the Plan Sponsor and Its Representatives: the EUTF is sponsored by State, county and other public employers who are represented on the EUTF's Board of Trustees. The EUTF may disclose information to the EUTF's Board of Trustees, the sponsoring public employers, and the Employees Retirement System (ERS) for payment, health care operations, and EUTF operations. For example, the EUTF may disclose information to the sponsoring employers about whether you are participating in a group health plan that is offered by the EUTF, or whether you are enrolled or disenrolled in any such group health plan. Disclosure to the sponsoring employers may include disclosures to your departmental personnel officer (DPO) or any other person who functions as your employer's personnel officer. In the event you appeal a denied claim 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.

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.

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 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.

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 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 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.

To request confidential communications, you must submit a written request to the EUTF Privacy Officer whose address is provided at the end of this HIPAA notice. The EUTF will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how and/or where you wish to be contacted.

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.

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.

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.

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 with the Secretary of the Department of Health and Human Services at:

Secretary, DHHS
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

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.

Questions?

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

Governing Law

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

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

Mailing Address:	P.O. Box 2121, Honolulu, HI 96805
Location Address:	201 Merchant Street, Suite 1520, Honolulu, HI 96813
Local number:	808-586-7390, Toll-Free number: 800-295-0089

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

Submit the EC-1 form to your Personnel Office or Department Personnel Officer (DPO) for verification, signature, and routing.

SECTION A - EMPLOYEE DATA

1. If you are a new employee or are changing your employment status from part time to full time employment, please mark the New Hire block and enter the effective date of hire.
2. Mark the Open Enrollment block only during the annual Open Enrollment period.
3. If you have any changes to be made during the year, check the Mid-Year Event Changes block and enter the date of the event. The following are some of the most common events: Address Change, Birth, Divorce, Loss of Coverage, Acquisition of Coverage, Marriage, New Hire, Retirement, Death, Termination, Transfer In, Transfer Out, etc. If there are simultaneous events, please describe the most prevalent event. For example, if the event is a birth and an address change, enter Birth in the event section.
4. Enter your full legal name as recorded on your Social Security card.
5. Enter your address information. If your mailing address differs from your residential address, you need to enter both addresses to ensure that correspondence timely reaches you.
6. If you are enrolling with the EUTF for the first time, you are required to provide your Social Security number.

*** Section 7(b), of the Privacy Act of 1974 (Public Law 93—579) requires that any federal, state, or local governmental agency which requests an individual to disclose their Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) requests each employee-beneficiary's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other entities for identification purposes, the EUTF may be unable to verify eligibility for benefits without the Social Security account number. The EUTF uses Social Security account numbers for the following purposes: 1. Employee-beneficiary identification for eligibility processing and eligibility verification; 2. Payroll premium deduction from paychecks for state/county employees; 3. Eligibility file to carriers; 4. Completion of 1099's for employee-beneficiaries with domestic partners. ***

SECTION B – COVERAGE SELECTIONS

1. Carefully review each selection that you make. You can choose ONE Medical, ONE dental, and ONE vision plan. Your choice of the prescription drug plan will depend on the MEDICAL plan that you select. If you select an HMO, HDHP, or a Supplemental plan, your medical selection also will include a prescription drug plan. If you select a PPO plan, you must select the prescription drug plan if you want drug coverage. If you don't make a selection, you will not have any prescription drug coverage.
2. You may now choose to elect only the Medical PPO plan without the Prescription Drug plan or vice versa. If you want both the medical and drug plans, please mark the appropriate blocks. Select one plan from the Medical plans and the appropriate coverage for you. If you do not want any plan coverage, mark the "Cancel/Waive" box. To be eligible for Supplemental Medical plan coverage, you must have other medical coverage from another source, not sponsored by your employer.
3. The RSN ChiroPlan is included with all medical plans except for the EUTF High Deductible Health Plan (HDHP).
4. If you have other health plan coverage and do not want to participate in the EUTF plans, select Cancel/Waive for each plan that you choose not to select.
5. Life insurance is provided for the employee only.
6. FOR STATE EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pre-tax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. For more information, go to the DHRD website at http://hawaii.gov/hrd/. The PCP-2 form is not required for Open Enrollment. For all other qualifying events, please inquire with your DPO or DHRD on completing a PCP-2 form.
   -Select Enroll, Do Not Enroll, Change Amount, or Cancel PCP.

   FOR COUNTY EMPLOYEES ONLY: Premium Conversion Plan (PCP) - PCP is administered by the Budget and Fiscal Services Department. Please contact your Department Personnel Office for more information.

SECTION C - DEPENDENT INFORMATION AND COVERAGE SELECTIONS

1. Enter your Dependent(s) data. If enrolling your dependent for the first time, enter their birth date and social security number. Otherwise, you may leave the birth date blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 7 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of letter size paper to list additional dependent(s) information.
2. Use the following Relationship codes:

SP = Spouse	CH = Child	DC = Disabled Child√√
DP = Domestic Partner√	DPC = Domestic Partner Child√	GC = Guardianship or Foster Child

3. For Relationship codes with √ or √ √, please see item #9 below for other required forms.
4. Gender - Mark either M or F.
5. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Cancel/Waive" box.
6. Dependent certification. Your initials confirm that you are certifying that all of your dependent children are eligible to be enrolled under your enrollment. You confirm that you will provide a copy of your child(ren)'s birth certificate and/or social security card if/when requested by the EUTF.
7. Student certification. Your initials confirm that you are certifying that all of your dependent children ages 19 through 23, are eligible to be enrolled under your enrollment as students. You further confirm that you will provide proof of student status if/when requested by the EUTF.
8. If you are enrolling a domestic partner (and children), you are required to complete all required forms in accordance with the instructions for Domestic Partners. You are responsible to obtain, complete and submit all necessary documentation to the EUTF. Failure to do so will result in denying your domestic partner coverage. You may add your Domestic Partner at anytime outside of Open Enrollment provided all required documents have been received. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding domestic partnership.
9. Other EUTF and/or DRHD forms to include with EC-1 (if applicable):

   √ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership
   √ Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
   √ DHRD Domestic Partnership Acknowledgement Form (State Employees with PCP enrolling Domestic Partners)
   √ DHRD PCP 2 form (For State Employees Only)
   √ √ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child

   √√ √ Legal documents for guardianship or foster child

SECTION D – OTHER INSURANCE INFORMATION

1. If any of your dependents have health benefit coverage through another employer's health plan(s), you are required to complete this section. If you selected a supplemental medical plan, you are required to complete this portion.
2. The information that you provide does not determine how your benefits are coordinated. COB rules are determined by the health benefit plans and follow the guidelines of the National Association of Insurance Commissioners (www.naic.org).

SECTION E - EMPLOYEE SIGNATURE AND AUTHORIZATION

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

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

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

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

EC-1

rev Oct 2009

Hawaii Employer-Union Health Benefits Trust Fund
ENROLLMENT FORM FOR ACTIVE EMPLOYEES

PLEASE SUBMIT THIS FORM EC-1 TO YOUR PERSONNEL OFFICE

SECTION A - EMPLOYEE DATA

Please complete all applicable fields below. Social Security Numbers are required to process new employee and dependent enrollments.

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

☐ New Hire
Date of Hire / /
☐ Open Enrollment

☐ Mid-Year Event Changes
Event
Event Date / /

Employee's Last Name, First Name, Middle Initial
(enter your full legal name as recorded on your Social Security card)

Residence Address (☐ Check this box it your address has changed)

Employee's Social Security Number or EUTF ID Number

If you are a new employee, you are required to provide your social security number. Otherwise, enter your EUTF ID number above.

City	State	Zip Code

Mailing Address (if different from above)

City	State	Zip code

Special Note: If your Spouse or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide their SSN below.

Social Security Number:

Marital Status	Marriage Date (MM/DD/YY)	Domestic Partnership (DP) Status	DP Date (MM/DD/YY)	Phone Number – Work / Home
☐ Married ☐ Single	/ /	☐ IRS Qualified ☐ Not Qualified	/ /	(W) (H)

SECTION B – COVERAGE SELECTIONS

Make your selection by checking the box for the appropriate benefit plans below.
Select Self, 2-Party, Family or Cancel/Waive coverage. Choose only one box in each plan section.

Plan	Type	Carrier Selection	Self	2-Party	Family	Cancel/ Waive
Medical Plan Select one plan from this list. Except for the HDHP plan as noted, the RSN chiropractic plan is included with the medical plan.	PPO	90/10 PPO-Health Management Associates **(HMA)** w/ RSN ChiroPlan	☐	☐	☐	☐
		80/20 PPO-Hawaii Medical Service Association **(HMSA)** w/ RSN ChiroPlan	☐	☐	☐	
			☐	☐	☐	
	HMO	HMO-Hawaii Medical Service Association **(HMSA)** and Drug w/ RSN ChiroPlan	☐	☐	☐	
		HMO-Kaiser Basic <Medical and Drug> w/ RSN ChiroPlan	☐	☐	☐	
		HMO-Kaiser Comprehensive <Medical and Drug> w/ RSN ChiroPlan	☐	☐	☐	
			☐	☐	☐	
	HDHP	HDHP-High Deductible Health Plan **(HMSA)** <Medical and Drug>	☐	☐	☐	
			☐	☐	☐	
	Supplemental	Supplemental-Hawaii Medical Service Association **(HMSA)**, InformedRx Supplemental Drug <Medical and Drug> w/ RSN ChiroPlan	☐	☐	☐	
		Supplemental-Royal State National Insurance Company **(RSN)**, RSN Drug <Medical and Drug> w/ RSN ChiroPlan	☐	☐	☐	
Prescription Drug Plan If you want drug coverage with a PPO plan, select this option.		InformedRx Prescription Drug (not a valid selection w/ the HMO, HDHP, or supplemental medical plans)	☐	☐	☐	☐
Dental Plan		Hawaii Dental Service (HDS) - Dental	☐	☐	☐	☐
Vision Plan		Vision Service Plan (VSP) - Vision	☐	☐	☐	☐
Life Insurance Plan		Standard Insurance Company - Life Insurance	☐			☐

For STATE Employees ONLY: Premium Conversion Plan ☐ Enroll ☐ Do NOT Enroll ☐ Change Amount ☐ Cancel PCP

For COUNTY Employees ONLY: Premium Conversion Plan - Please contact your DPO for more information on available options.

SECTION C – DEPENDENT INFORMATION AND COVERAGE SELECTIONS

List all eligible dependents you wish to cover and check the plan selections desired. Relationship Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship or Foster child, and DC=Disabled Child if your child is age 19 or over and is also disabled. Please see specific instructions in Section C for additional details.

Add	Delete	Dependent: Last Name (if different), First Name, Middle Initial	Birth Date (MM/DD/YY)	Social Security Number or EUTF ID Number	Relationship	Gender	Medical	Drug	Dental	Vision
☐	☐		/ /			☐ M ☐ F	☐	☐	☐	☐
☐	☐		/ /			☐ M ☐ F	☐	☐	☐	☐
☐	☐		/ /			☐ M ☐ F	☐	☐	☐	☐
☐	☐		/ /			☐ M ☐ F	☐	☐	☐	☐
☐	☐		/ /			☐ M ☐ F	☐	☐	☐	☐
☐	☐		/ /			☐ M ☐ F	☐	☐	☐	☐
☐	☐		/ /			☐ M ☐ F	☐	☐	☐	☐

Dependent Certification and Student Certification– See Section C.6 and C.7 for more information. Detailed eligibility information is available at eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes.

I certify that all of my dependent children meet eligibility requirements for enrollment in the EUTF plans. _________ (initials)

I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution. _________ (initials)

Domestic Partner Certification – See Section C.8 and C.9. for specific instructions. Detailed eligibility information is available at eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawaii Revised Statutes and Domestic Partner Enrollment Instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _________ (initials)

SECTION D - OTHER INSURANCE INFORMATION

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family, etc).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage		
			/ /	Self ☐	2-Party ☐	Family ☐
			/ /	Self ☐	2-Party ☐	Family ☐

SECTION E - EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on the enrollment form are also eligible. I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Employee Signature: ____ Date Signed: ________________

Department ID#	Department	Division/School	Bargaining Unit
Date EC-1 Received in Employing Office / /		DPO Phone Number	DPO Fax Number
DPO (or employer designee's) Printed Name DPO (or employer designee's) Signature:			Date of DPO (or employer designee's) Signature / /

Remarks: