



Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

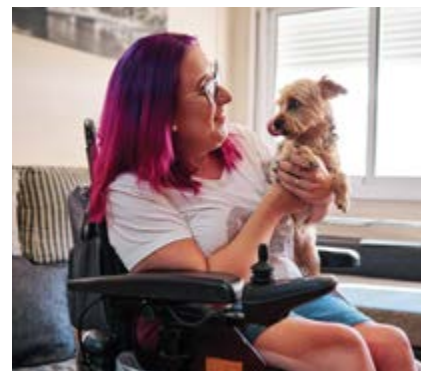


Effective July 1, 2023 – June 30, 2024



EMPLOYEE HEALTH BENEFITS REFERENCE GUIDE

(EUTF and HSTA VB)







April 2023

Aloha State and County Employees:

We are pleased to present the *EUTF Employee Health Benefits Reference Guide*. This guide provides you with important information on EUTF health benefit plans available to most active employees for plan year July 1, 2023, through June 30, 2024.

The open enrollment (OE) election period is April 3–28, 2023.

The OE election period is an opportunity to make changes to your enrollment in EUTF health benefit plans. You can also make changes to your enrollment if you have a qualifying event during the plan year. Please note that any changes you make during the April OE election period will take effect July 1, 2023. We encourage you to attend an information session in April to help you determine the health plan elections that will best meet the needs of you and your family.

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

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

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

Mahalo,

Roderick Becker, Chair
EUTF Board of Trustees

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Attention: Medicare-Eligible Members

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you additional choices for prescription drug coverage through Medicare Part D. However, the EUTF active employee prescription drug plans offer benefits that are as good, or better, than the standard Medicare Part D plan coverage; therefore, you do not have to enroll in a Medicare Part D plan until you retire. For more information, a Notice of Creditable Coverage appears on page 80. The Notice of Creditable Coverage is also available on the EUTF website at eutf.hawaii.gov.

Introduction

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

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

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

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

Disclaimer

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

Individuals With Special Needs

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

EUTF's Mission

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

Wellness Programs

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



HMSA Members

What You Can Do to Stay Healthy

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

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

Online Care

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

Health and Well-Being Support

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

Diabetes Prevention Program (DPP)

HMSA Diabetes Prevention Program helps eligible members who are at risk for prediabetes prevent the onset of type 2 diabetes through lifestyle and diet changes, exercise, and group support. This program includes lessons, handouts, and resources from the Centers for Disease Control and Prevention to help you live a healthier lifestyle. To learn more, call **1-808-948-6079** or **1-800-776-4672**, Monday through Friday, 8 a.m. to 5 p.m. or visit hmsa.com/well-being/diabetes-prevention.

Health Coaching

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

Tobacco Cessation Support

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

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

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

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

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

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

Mental Health Resources

Manage stress with access to behavioral health providers and services, programs to support mental health, and information on how to reduce anxiety. Visit hmsa.com/help-center/coronavirus-mental-health-resources for more information.

Pregnancy Support

The HMSA Pregnancy and Postpartum Support Program pairs pregnant women with their own maternity nurse for personalized education and counseling over the phone. Nurse support provides additional services that complement the prenatal care members receive from their doctors. To get an enrollment form, call **1-808-948-6079** on Oahu or **1-800-776-4672** toll-free on the Neighbor Islands, or visit hmsa.com/help-center/pregnancy-support.

Plan for the Future

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

My Account

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

- See a list of health care services you've received and your claims history.
- Access your well-being tools, such as ChooseHealthy® and Active&Fit Direct™.
- Access up-to-date information on your annual deductible and maximum out-of-pocket.
- Get a copy of your HMSA membership card, view your *Guide to Benefits*, and more.

HMSA365 Discounts

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

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

Learn more at hmsa.com/hmsa365.

HMSA's *Island Scene*

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

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

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

Kaiser Permanente Members

Preventive Services

Prevention makes good health possible!

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

Manage Your Care Online

Online tools to help you thrive.

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

Online Wellness Programs

Jump start your health online.

The program gives you and your covered spouse/domestic partner enrolled in EUTF a chance to earn up to \$100 each in gift card(s) annually for taking steps to improve health. Earn \$25 each for completing a total health assessment to get an overall snapshot of your health, plus a recommended plan based on your answers. You can also each earn an additional \$25 per online healthy lifestyle program, up to three programs per year. Choose from a variety of programs to help in reducing stress, quitting smoking, losing weight, and more. You can participate in a program when it's convenient for you at your own pace. Current rewards run from July 1, 2023, until June 30, 2024.* Visit **kp.org/eutf**, and click on **Reap the rewards**.

* You are responsible for any taxes that may be due on the amounts received. Please talk to your personal tax advisor for specific tax information about this reward. Participation in the program MAY be shared with employers for tax purposes. The online wellness rewards program runs from July 1, 2023, to June 30, 2024, and is open to all EUTF subscribers and their enrolled spouses, 18 years old and older, excluding retirees and those enrolled in the HSTA VB Plan. You can take the total health assessment as often as you like and use as many healthy lifestyle programs as you like, but you can only earn up to \$100 per contract period. You must complete the activities before June 30, 2024. Rewards will be issued four to six weeks after you complete your activity.

Kaiser Permanente Fit Rewards

Earn a free gym membership!

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

If you prefer working out at home, pay just \$10 per calendar year, and choose a home fitness kit, including the ability to choose a wearable fitness tracker at no additional cost. We're also offering new virtual offerings to help you move more and be healthier at home. Current Fit Rewards run from January 1 to December 31, 2023.** Visit kp.org/fitrewards.

Wellness Coaching

Get a personal coach in your corner.

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

Tobacco Cessation

Break the habit for good.

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

Health Classes

Take charge of your health and inspire others.

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

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

** Please consult with your own tax advisor about the taxability of the reimbursement. Participation in the program MAY be shared with employers for tax purposes. Kaiser Permanente Fit Rewards is available to all Kaiser Permanente Hawaii members, 16 years and older, excluding Medicare and Medicaid (QUEST Integration) members. Gym availability varies by island. Meet the 45-day, 30-minute-a-session activity requirement between January 1 and December 31, 2023, to qualify for reimbursement. Reimbursement is limited to your Active&Fit annual program fee each calendar year. Taxes and additional fees you pay your gym for classes, services, or amenities are not included in the Active&Fit program and are not eligible for reimbursement. Except for earning your annual program fee back by exercising 45 days a year, for at least 30 minutes a session, your Active&Fit annual program fee is not reimbursable and will not be prorated. The Active&Fit Home Fitness Program annual fee is nonrefundable and not eligible for reimbursement. Kaiser Permanente Fit Rewards is a value-added service and not part of your medical benefits. Your annual fee does not count toward your annual maximum out-of-pocket. Please see your Evidence of Coverage or kp.org/fitrewards for details, including conditions, limitations, and exclusions.

Member Discounts

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

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

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

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

CVS Caremark Members

Diabetes Products

Regular blood glucose testing is essential for people with diabetes. One of the best ways to manage diabetes is to check blood sugar every day with a blood glucose meter. The Diabetic Meter Program provides eligible members with a no-cost Accu-Chek or OneTouch blood glucose meter. To find out if you qualify for this benefit, call the CVS Caremark Member Services Diabetic Meter Team toll-free at **1-800-588-4456**, or request one at caremark.com/managingdiabetes.

Tobacco Cessation Products

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



Money Saving Tips

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

Choosing the Best Plan for Your Needs

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

Pick the Right Facility

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

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

Participating Providers

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

Preventive Care

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

Prescription Drug Benefits

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

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

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

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

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

What's New?

Effective July 1, 2023 (unless otherwise specified)

HMSA

1. Added an Artificial Insemination benefit at the same benefit level as non-cutting surgery to the EUTF and HSTA VB active PPO plans.

CVS Caremark

2. Added the Tier 1 Strategy to the EUTF active plans, which allows pharmacies to dispense the brand product when the cost for the brand is less than the generic. Member pays the generic copay or the cost of the drug, whichever is less.
3. Changed coverage for metformin (850mg) to a \$0 copay under the EUTF and HSTA VB active plans in accordance with federal law.
4. Changed coverage for male condoms, when prescribed, to a \$0 copay under the EUTF and HSTA VB active plans in accordance with federal law.
5. Excluded coverage of low-dose aspirin (81mg) for males ages 50 to 59 under the EUTF active plans.

Kaiser

6. Changed coverage for a Prostate Specific Antigen (PSA) screening to a \$0 copay under the EUTF and HSTA VB active plans.
7. Added the Kaiser Permanente Pregnancy Termination Travel Reimbursement Program to the EUTF and HSTA VB active plans, effective July 20, 2022.

VSP

8. Replaced the Diabetic Eye Care Plus Program with the Essential Medical Eye Care Program under the EUTF and HSTA VB active plans, effective January 1, 2023.

Securian

9. Changed the life insurance benefit amount from \$38,505 to \$33,770 for EUTF and HSTA VB actives.

Premium Rate Changes

For information about the 2023-24 monthly premium rates that take effect July 1, 2023, see the 2023 Health Plan Premiums section, starting on page 18.

Your EUTF Benefits Coverage

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

- **EUTF employees:** See page 25.
- **HSTA VB employees:** See page 35.

Open Enrollment for Active Employees

About Open Enrollment

Open enrollment (OE) is the time for you to review whether the health coverage you have for yourself and your family continues to best meet your needs.

The OE election period is April 3–28, 2023.

During the OE election period, you can:

- Add, change, or drop a plan
- Add or remove dependents
- Change coverage tiers, such as changing from Self to Family, or Family to Two-Party

**No Action Needed
If You Are Not Making
Any Changes**

If you decide to keep your current plans, you don't need to take action.

You are not required to complete any forms to continue your current coverage.

If you are making changes, complete and submit the EC-1 enrollment form at the back of this guide or on the website at eutf.hawaii.gov (or EC-1H for those enrolled in the HSTA VB benefit plans).

For open enrollment change requests, submit your completed EC-1/EC-1H enrollment form and required supporting documents to your employer's open enrollment designee by April 28, 2023, for changes to be effective July 1, 2023. **Required supporting documents must also be submitted by April 28, 2023. The EUTF will not contact you regarding outstanding supporting documents, and late submissions will not be accepted.**

Important Dates

Open Enrollment Dates	
Open Enrollment Election Period	April 3–28, 2023
Enrollment Change Requests and Supporting Documents Submission Deadline	April 28, 2023
New Coverage and Rate Changes	
Premium and Plan Changes Effective	July 1, 2023
For County Employees New Premium Deducted From Paychecks	July 15, 2023, through June 30, 2024
For State Employees New Premium Deducted From Paychecks	July 20, 2023, through July 5, 2024
Benefit Periods	
Plan Year Benefit Period	July 1, 2023, through June 30, 2024
Calendar Year Benefit Period	January 1, 2023, through December 31, 2023 and January 1, 2024, through December 31, 2024

Open Enrollment Informational Session Schedule

IN-PERSON INFORMATIONAL SESSIONS			
Dates	Island	Location	Session Times
Monday, April 10	Kauai	Kauai Community College OCET Room 106 C & D 3-1901 Kaumualii Highway, Lihue, HI 96766	9:30-10:30 a.m. 11:30 a.m-12:30 p.m. 3:00-4:00 p.m.
Wednesday, April 12	Oahu	Leeward Community College Education Building, Room 201 A & B 96-045 Ala Ike Street, Pearl City, HI 96782	9:30-10:30 a.m. 11:30 a.m-12:30 p.m. 3:00-4:00 p.m.
Thursday, April 13	Oahu	Mission Memorial Auditorium 550 South King Street, Honolulu, HI 96813	9:30-10:30 a.m. 11:30 a.m-12:30 p.m. 3:00-4:00 p.m.
Friday, April 14	Molokai	Kualapuu Park & Community Center 1 Uwao Street, Kualapuu, HI 96757	10:00-11:00 a.m. 11:30 a.m.-12:30 p.m.
Tuesday, April 18	Hawaii (Kona)	West Hawaii Civic Center Community Meeting Hale, Building G 74-5044 Ane Keohokalole Highway Kailua-Kona, HI 96740	10:00-11:00 a.m. 2:00-3:00 p.m.
Thursday, April 27	Hawaii (Hilo)	Edith Kanakaole Multi-Purpose Stadium 350 Kalanikoa Street Hilo, HI 96720	
Friday, April 28	Maui	UH Maui College Ka'a'ike Building, Room 105 C & D 310 W. Kaahumanu Avenue, Kahului, HI 96732	9:30-10:30 a.m. 11:30 a.m-12:30 p.m. 3:00-4:00 p.m.
WEBINAR INFORMATIONAL SESSIONS			
Dates			Session Times
April 3, 4, 5, 6, 11, 17, 19, 20, 21, 24, 25 & 26			9:00-9:30 a.m. 10:30-11:00 a.m. 3:45-4:15 p.m.

How to Attend the Webinar

Go to eutf.hawaii.gov/learning-center, and click on **Active Employee Open Enrollment Fair**. You'll be able to view on-demand video presentations from the EUTF and each of the insurance carriers, and to attend an EUTF live webinar. For the best experience, use an up-to-date version of Google Chrome (preferred), Safari, or Firefox from a desktop/laptop.

DEADLINE TO SUBMIT ENROLLMENT FORMS AND REQUIRED SUPPORTING DOCUMENTS IS APRIL 28, 2023.

Do not submit forms to the EUTF. Submit forms to your:

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

Your Open Enrollment Checklist

- ☐ **Know your current coverage.** Visit the EUTF website, and use the plan finder tool to determine which EUTF plans you're enrolled in (eutf.hawaii.gov/eutf-plan-finder).
- ☐ **Learn more about the choices available to you.** You have a number of resources to help:
 - **Read this *Employee Health Benefits Reference Guide*** for the summaries of your plan options, including what's new or changing for 2023 (see page 13).
 - **Attend an Open Enrollment Informational Session or Webinar.** See page 15 for the schedule.
 - **Visit the EUTF website at eutf.hawaii.gov** for more details about the plans, including links to the insurance carriers' web pages and downloadable documents. Questions regarding specific plan provisions should be directed to the carriers (see pages 86–88).
- ☐ **Check your costs.** You can find the monthly premium rates (total employee portion and employer portion) starting on page 18 of this guide.
- ☐ **Enrolling dependents? Gather your supporting documents.** You may add or remove dependents from your plan, including a spouse/partner or eligible children. Please visit the EUTF Active – Eligibility webpage (eutf.hawaii.gov/active/eutf-hsta-active/eligibility) for eligibility definitions and information on required supporting documents.
- ☐ **Make a decision about which plans best suit your needs** and whether you want to keep or change your current coverage.
 - **If you decide to keep your current plans, you don't need to do anything.** You are not required to complete any forms to keep your current coverage.
 - **If you wish to make any changes,** complete the next step.

Dependents No Longer Eligible?

IMPORTANT: If any of your dependents are no longer eligible due to a divorce, legal separation, or a child no longer being a full-time student or who gets married (for dental and vision only), they cannot continue to be covered under EUTF or HSTA VB plans. You are required to notify the EUTF and make these terminations in coverage when these events occur. Do not wait for open enrollment to submit these terminations.

If your dependent child is reaching the maximum age covered (age 26 for medical and prescription drug; age 19 (24 for full-time students) for dental and vision), disenrollment will occur automatically, and an enrollment form is not necessary.

Your Open Enrollment Checklist *continued*

- ☐ **Complete and submit your signed enrollment form, along with any required supporting documents, on or before April 28, 2023.**
 - **Make your selections** on the EC-1 enrollment form (or EC-1H for those enrolled in the HSTA VB plans) and ***sign the form***.
 - **Submit your completed enrollment form and required supporting documents** to your employer's open enrollment designee by April 28, 2023:
 - Departmental Human Resources Office
 - County Personnel Office
 - DOE-EBU, P.O. Box 2360, Honolulu, HI 96804 (DOE employees)
 - Enrollment Designee

Do NOT submit forms to the EUTF.

NOTE: Forms received after April 28, 2023, will be rejected.

The EUTF will send you an enrollment confirmation notice after the processing of open enrollment forms is completed.

Your Open Enrollment Confirmation Notice

The EUTF will send you an enrollment Confirmation Notice after the processing of your EC-1/EC-1H enrollment form is completed.

Your Confirmation Notice details the OE changes that were made to your EUTF benefits. **Please carefully review the notice to make sure it does not contain any errors.** Please use the Corrective Action Request Form (attached to the Confirmation Notice) to inform EUTF of any data entry errors. Please be advised that **all plan selections are final if you are outside the OE election period.** Any additional changes to your plans will not be allowed until the next OE election period, unless you experience a qualifying event that permits changes under the EUTF Administrative Rules.

Open enrollment forms will be processed during the months of May and June. If you do not receive your Confirmation Notice by the end of June, please contact the EUTF at **1-808-586-7390** or toll-free at **1-800-295-0089**.

2023 Health Plan Premiums

Effective July 1, 2023

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

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

BENEFIT PLAN	Type of Enrollment	Semimonthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
Medical Plans						
PPO – 90/10 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	\$253.75	\$507.50	\$453.36	47.2%	\$960.86
	Two-Party	\$616.46	\$1,232.92	\$1,101.12	47.2%	\$2,334.04
	Family	\$786.10	\$1,572.20	\$1,403.80	47.2%	\$2,976.00
PPO – 80/20 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	\$151.12	\$302.24	\$453.36	60.0%	\$755.60
	Two-Party	\$367.05	\$734.10	\$1,101.12	60.0%	\$1,835.22
	Family	\$467.94	\$935.88	\$1,403.80	60.0%	\$2,339.68
PPO – 75/25 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	\$24.28	\$48.56	\$436.94	90.0%	\$485.50
	Two-Party	\$58.95	\$117.90	\$1,061.00	90.0%	\$1,178.90
	Family	\$75.14	\$150.28	\$1,352.38	90.0%	\$1,502.66
HMO – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug	Self	\$254.97	\$509.94	\$453.36	47.1%	\$963.30
	Two-Party	\$619.49	\$1,238.98	\$1,101.12	47.1%	\$2,340.10
	Family	\$790.00	\$1,580.00	\$1,403.80	47.0%	\$2,983.80
HMO – Kaiser Comprehensive Medical, Prescription Drug, and Chiropractic	Self	\$176.27	\$352.54	\$453.36	56.3%	\$805.90
	Two-Party	\$428.61	\$857.22	\$1,101.12	56.2%	\$1,958.34
	Family	\$547.24	\$1,094.48	\$1,403.80	56.2%	\$2,498.28
HMO – Kaiser Standard Medical, Prescription Drug, and Chiropractic	Self	\$25.00	\$50.00	\$449.98	90.0%	\$499.98
	Two-Party	\$60.75	\$121.50	\$1,093.48	90.0%	\$1,214.98
	Family	\$77.50	\$155.00	\$1,394.96	90.0%	\$1,549.96
Supplemental Medical and Prescription Drug – HMA	Self	\$6.78	\$13.56	\$20.32	60.0%	\$33.88
	Two-Party	\$12.13	\$24.26	\$36.40	60.0%	\$60.66
	Family	\$13.14	\$26.28	\$39.42	60.0%	\$65.70
Dental Plan						
HDS Dental	Self	\$7.16	\$14.32	\$21.48	60.0%	\$35.80
	Two-Party	\$14.32	\$28.64	\$42.96	60.0%	\$71.60
	Family	\$23.55	\$47.10	\$70.62	60.0%	\$117.72
Vision Plan						
VSP Vision	Self	\$0.84	\$1.68	\$2.52	60.0%	\$4.20
	Two-Party	\$1.57	\$3.14	\$4.68	59.8%	\$7.82
	Family	\$2.05	\$4.10	\$6.12	59.9%	\$10.22
Life Insurance						
Securian Life Insurance	Employee	\$0.00	\$0.00	\$4.12	100.0%	\$4.12

2023 Health Plan Premiums

Effective July 1, 2023

BU 05: ACTIVE EMPLOYEES FORMERLY UNDER THE HSTA VEBA

BENEFIT PLAN	Type of Enrollment	Semimonthly Employee Contribution	Monthly Employee Contribution	Monthly Employer Contribution	Percent Employer	Total
Medical Plans						
HSTA VB – PPO – 90/10 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug, VSP Vision	Self	\$196.48	\$392.96	\$416.52	51.5%	\$809.48
	Two-Party	\$476.23	\$952.46	\$1,009.26	51.4%	\$1,961.72
	Family	\$607.17	\$1,214.34	\$1,286.26	51.4%	\$2,500.60
HSTA VB – PPO – 80/20 Plan – HMSA Medical and Chiropractic, CVS Caremark Prescription Drug, VSP Vision	Self	\$138.85	\$277.70	\$416.52	60.0%	\$694.22
	Two-Party	\$336.42	\$672.84	\$1,009.26	60.0%	\$1,682.10
	Family	\$428.75	\$857.50	\$1,286.26	60.0%	\$2,143.76
HSTA VB – HMO – Kaiser Comprehensive Medical, Drug, Chiropractic, and VSP Vision	Self	\$142.10	\$284.20	\$416.52	59.4%	\$700.72
	Two-Party	\$345.56	\$691.12	\$1,009.26	59.4%	\$1,700.38
	Family	\$441.60	\$883.20	\$1,286.26	59.3%	\$2,169.46
Dental Plan						
HSTA VB – HDS Dental	Self	\$7.78	\$15.56	\$23.34	60.0%	\$38.90
	Two-Party	\$15.56	\$31.12	\$46.68	60.0%	\$77.80
	Family	\$25.61	\$51.22	\$76.80	60.0%	\$128.02
HSTA VB – HDS Supplemental Dental	Self	\$3.63	\$7.26	\$10.90	60.0%	\$18.16
	Two-Party	\$7.27	\$14.54	\$21.78	60.0%	\$36.32
	Family	\$10.90	\$21.80	\$32.68	60.0%	\$54.48
Vision Plan						
HSTA VB – VSP Vision	Self	\$0.84	\$1.68	\$2.52	60.0%	\$4.20
	Two-Party	\$1.57	\$3.14	\$4.68	59.8%	\$7.82
	Family	\$2.05	\$4.10	\$6.12	59.9%	\$10.22
Life Insurance						
HSTA VB – Securian Life Insurance	Employee	\$0.00	\$0.00	\$4.12	100.0%	\$4.12

General Health Plan Information

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

- **If you are eligible for and/or enrolled in an EUTF medical plan,**
see pages 25–34 for summaries of your 2023–24 benefits coverage.
- **If you are eligible for and/or enrolled in an HSTA VB medical plan,**
see pages 35–42 for a summary of your 2023–24 benefits coverage.

About the Medical Plans

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

Preferred Provider Organization (PPO) Plans

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

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

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

Health Maintenance Organization (HMO) Plans

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

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

Supplemental (Copayment/Coinsurance) Plan

- EUTF HMA Supplemental Medical and Prescription Drug

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

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

Please note:

- To ensure proper posting, please use a separate claim form for each covered member and for services incurred in different plan years.
- This supplemental plan does not cover chiropractic benefits.
- All reimbursement payments are made payable to the covered individual who receives the services. For all minors under the age of 18, reimbursement payments are made payable to the primary Subscriber of the plan.

Remember: Refer to Your Carrier Benefit Guides

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

Health Care Terms and Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Qualifying Event: An event such as eligibility for coverage, acquisition of coverage, marriage, divorce, or the birth or adoption of a child that allows enrollment changes to your health plans during the plan year.

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

Prescription Drug

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

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

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

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

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

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

EUTF Health Plan Options

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

For charts summarizing the HSTA VB medical and prescription drug plan options, see pages 41-42.

	Preferred Provider Organization (PPO) Plans
	<ul style="list-style-type: none"> • HMSA PPO 90/10 Plan • HMSA PPO 80/20 Plan • HMSA PPO 75/25 Plan
 	Health Maintenance Organization (HMO) Plans
	<ul style="list-style-type: none"> • Kaiser Permanente HMO Comprehensive • Kaiser Permanente HMO Standard • HMSA EUTF HMO
 	Prescription Drug Plans
	<ul style="list-style-type: none"> • CVS Caremark Prescription Drug Plan • Kaiser Permanente Prescription Drug Plan
	Supplemental Plan: Hawaii-Mainland Administrators (HMA)
 	Dental Plan: Hawaii Dental Service (HDS)
	Vision Plan: Vision Service Plan (VSP)
	Life Insurance: Securian Financial

About CVS Caremark Prescription Drug Coverage for EUTF Members

General Information

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

To comply with the Affordable Care Act, certain preventive care drugs (when prescribed) are covered with no copayment, including, but not limited to, generic statin drugs, tobacco cessation products, aspirin, and folic acid supplements. Please contact CVS Caremark for additional information on coverage for these preventive care drugs.

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

Web Service

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

Customer Care

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

Coordination of Benefits

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

Required Documentation for Paper Claims

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

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

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

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

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

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

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

Maintenance Medications

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

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

Specialty Medications

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

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

Specialty Benefit Under the CVS Caremark Prescription Drug Plan

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

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

Utilization Management Programs

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

1. **Quantity Limitations** – Ensures participants receive the medication in the quantity considered safe by the Food and Drug Administration (FDA), medical studies, and input, review, and approval from the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee.
2. **Generic Step Therapy Program (GSTP)** – The EUTF encourages the use of generic medications as an alternative to certain brand medications as an affordable and effective form of treatment for many health conditions. In an effort to promote use of generic medications, CVS Caremark has a generic step therapy program in place for all EUTF active employees. For certain brand drugs, GSTP may require that you try generic drug treatment(s) prior to the use of a brand drug. Please contact CVS Caremark Customer Care at **1-855-801-8263** for more information. Also see sections labeled Dispensed as Written (DAW 1&2) Program and Tier 1 Strategy on the next page.

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

Dispensed as Written (DAW 1&2) Program

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

Tier 1 Strategy

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

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

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

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

EUTF Medical Plan Summaries

EUTF Medical and Prescription Drug – PPO Plan Coverage

MEDICAL	HMSA 90/10 PPO Plan		HMSA 80/20 PPO Plan		HMSA 75/25 PPO Plan	
	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Calendar Year Deductible²	None	\$100/person \$300/family	None	\$250/person \$750/family	\$300/person \$900/family	
Calendar Year Maximum Out-of-Pocket Limit²	\$2,000/person \$4,000/family		\$2,500/person \$5,000/family		\$5,000/person \$10,000/family	
Lifetime Benefit Maximum	None		None		None	
Physician Office Visit	10%	30%	20%	40%	25% ³	40%
Online Care (through hmsaonlinecare.com)	No charge	Not covered	No charge	Not covered	No charge	Not covered
Urgent Care Visit	10%	30%	20%	40%	25% ³	40%
Emergency Room	10%	10% ³	20%	20% ³	25%	25%
Ambulance Air	10%	10% ³	20%	20% ³	25%	25%
Ambulance Ground	10%	30%	20%	40%	25%	40%
Inpatient Hospital Services	10%	30%	20%	40%	25%	40%
Outpatient Surgery	10%	30%	20%	40%	25%	40%
Outpatient Testing, Lab, and X-Ray Services	10%	30%	20%	40%	Lab: 25% ³ Diagnostic testing and X-ray: 25%	40%
Annual Preventive Health Evaluation	No charge	No charge ³	No charge	No charge ³	No charge ³	No charge ³
Well-Child Office Visit	No charge	30% ³	No charge	40% ³	No charge ³	40% ³
Preventive Screening	No charge	30%	No charge	40%	No charge ³	40%
Inpatient Mental Health	10%	30%	20%	40%	Facility: 25% Physician visit: 25% ³	40%
Outpatient Mental Health	10%	30%	20%	40%	Facility: 25% Physician visit: 25% ³	40%
Chiropractic Services (administered through American Specialty Health, Inc.)	\$15 for up to 20 visits per calendar year	Not covered	\$15 for up to 20 visits per calendar year	Not covered	\$15 for up to 20 visits per calendar year	Not covered

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

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

³ Deductible does not apply.

EUTF Medical and Prescription Drug – PPO Plan Coverage

PRESCRIPTION DRUG	CVS Caremark ⁴ EUTF HMSA PPO Plans		
	In-Network Pharmacy	Out-of-Network Pharmacy ⁵	Retail 90/Mail Order ⁶
Calendar Year Maximum Out-of-Pocket Limit⁷	90/10 and 80/20 PPO Plans: \$4,350/person, \$8,700/family 75/25 PPO Plan: \$3,150/person, \$6,300/family		
Day Supply	30/60/90	30/60/90	30/60/90
Generic	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	\$5/\$10/\$10
Preferred Brand	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	\$25/\$50/\$50
Non-Preferred Brand	\$50/\$100/\$150	\$50/\$100/\$150 + 20% of eligible charges	\$50/\$100/\$100
Preferred Insulin	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	\$5/\$10/\$10
Other Insulin	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	\$25/\$50/\$50
Preferred Diabetic Supplies	No charge	20% of eligible charges	No charge
Other Diabetic Supplies	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	\$25/\$50/\$50
Oral Contraceptives (up to a 12-month supply)	No charge	20% of eligible charges	No charge
Specialty Drugs/Injectables⁷	30-day supply only \$2,500/person calendar year maximum out-of-pocket limit Specialty generic: 10% of eligible charges, up to \$200/fill Specialty preferred brand: 20% of eligible charges, up to \$300/fill Specialty non-preferred brand: 30% of eligible charges, up to \$400/fill Oral oncology: \$30		Retail 90: 30-day supply only Mail: Not covered

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

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

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

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

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

EUTF Medical Plan Summaries

EUTF Medical and Prescription Drug – HMO Plan Coverage

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

1 Kaiser Permanente Members only:

- Except for certain situations described in your Group Medical and Hospital Service Agreement, all claims, disputes, or causes of action arising out of or related to your Group Medical and Hospital Service Agreement, its performance, or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your Group Medical and Hospital Service Agreement.
 - Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.
- 2 HMSA HMO Members:** Amounts paid toward the maximum out-of-pocket are measured on a calendar-year basis. However, if your new plan effective July 1, 2023, is with the same carrier, the amounts paid January 1, 2023 – June 30, 2023, will apply to your new plan maximum out-of-pocket. No refunds will be issued.

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

EUTF Medical and Prescription Drug – HMO Plan Coverage

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

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

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

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

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

EUTF Medical and Prescription Drug – Supplemental Plan Coverage

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

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

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

HSTA VB Health Plan Options

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

Disenrolling From HSTA VB Plans

HSTA VB members may disenroll from HSTA VB plans but will not be allowed to re-enroll in HSTA VB plans in the future. Members who wish to leave HSTA VB plans and switch to EUTF plans during open enrollment must complete an EC-1 enrollment form.

HSTA VB and EUTF Plan Enrollment

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

HSTA VB Health Plan Options

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

For charts summarizing the EUTF medical and prescription drug plan options, see pages 30–34.

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

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

About CVS Caremark Prescription Drug Coverage for HSTA VB Members

General Information

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

To comply with the Affordable Care Act, certain preventive care drugs (when prescribed) are covered with no copayment, including, but not limited to, generic statin drugs, tobacco cessation products, aspirin, and folic acid supplements. Please contact CVS Caremark for additional information on coverage for these preventive care drugs.

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

Web Service

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

Customer Care

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

Coordination of Benefits

Some participants may be enrolled in additional prescription drug coverage outside their EUTF or HSTA VB benefits. If this applies to you, please contact CVS Caremark Customer Care at [caremark.com/eutf](https://www.caremark.com/eutf) to advise if your HSTA VB plan is secondary. If your plan is secondary, be sure to let the pharmacy know, and they will be able to coordinate benefits for you at the point of sale. You also have the option to send in a paper claim form for reimbursement (see next page). Please note that Coordination of Benefits does not guarantee 100% coverage of your medication. All HSTA VB plan parameters and guidelines will still apply. Coverage under your non-HSTA VB drug plan does not imply coverage under the HSTA VB drug plan.

Required Documentation for Paper Claims

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

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

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

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

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

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

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

Maintenance Medications Through Mail Order

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

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

Specialty Medications

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

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

Utilization Management Programs

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

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

Dispensed as Written (DAW 2) Program

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

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

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

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

HSTA VB Medical Plan Summaries

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

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

¹ **Kaiser Permanente Members only:**

- Except for certain situations described in your Group Medical and Hospital Service Agreement, all claims, disputes, or causes of action arising out of or related to your Group Medical and Hospital Service Agreement, its performance, or alleged breach, or the relationship or conduct of the parties, must be resolved by binding arbitration. For claims, disputes, or cause of action subject to binding arbitration, all parties and family members give up the right to jury or court trial. For a complete description of arbitration information, please see your Group Medical and Hospital Service Agreement.
 - Members must reimburse Kaiser Permanente for care provided or paid for by Kaiser Permanente (from the proceeds of any settlement, judgment, or other payment the Member receives) if the care is for harm caused or alleged to be caused by a third party.
- ² **HMSA Members:** If you receive services from an out-of-network provider, you are responsible for the copayment or coinsurance plus any difference between the actual charge and the eligible charge, except for emergency services, air ambulance, and services from out-of-network providers received at an in-network facility.
- ³ Amounts paid toward the deductible and the maximum out-of-pocket are measured on a calendar-year basis. However, if your new plan effective July 1, 2023, is with the same carrier, the amounts paid January 1, 2023 – June 30, 2023, will apply to your new plan deductible and maximum out-of-pocket. No refunds will be issued.
- ⁴ Deductible does not apply.

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

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

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

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

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

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

Dental Benefits

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

For full plan details, including a plan brochure, visit the HDS website's dedicated EUTF page at hawaiidental-service.com/members/eutf.

In-Network and Out-of-Network Providers

To maximize your benefits and help keep your out-of-pocket costs down, it's best to visit dentists who participate in the HDS provider network. You can search online at HawaiiDentalService.com or contact HDS to find an in-network or participating dentist.

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

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

HDS Online

Visit the HDS website's dedicated EUTF page at hawaiidental-service.com/members/eutf. With an online account, you can check on your eligibility for services, view information on past services, find a participating dentist in Hawaii or on the Mainland, print an ID card, and receive paperless benefit statements from the convenience of your home computer or mobile device.

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

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

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

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

Dental Benefits Coverage Charts

EUTF, HSTA VB, and HSTA VB Supplemental Dental Plans

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

DENTAL BENEFIT	EUTF and HSTA VB	HSTA VB Supplemental	
Oral Surgeries	80%	50%	
	Plan Covers	Plan Covers	Frequency/Time Limitations
Major Care			
Crowns	60%*	45%	1 every 5 years per tooth when teeth cannot be restored with silver or white fillings Note: Composite (white) and porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent; the patient is responsible for the cost difference up to the amount charged by the dentist.
Fixed Bridges and Dentures	60%*	45%	1 every 5 years per tooth ages 16 and older
Implants	60%*	50%	EUTF: 1 every 5 years per tooth ages 19 and older HSTA VB and HSTA VB Supplemental: 1 every 5 years per tooth ages 16 and older. Implants are covered as an alternate benefit when one tooth is missing between two natural teeth.
Other Services			
Adjunctive General Services	80%	45%	
Athletic Mouth Guards	80%	45%	1 every 24 months through age 18
Emergency Treatment of Dental Pain (Palliative Treatment)	100%	50%	1 per visit per dental office for relief of pain
Orthodontics	50%	100%	EUTF and HSTA VB: Maximum amount payable by HDS for an eligible patient shall be \$1,000 lifetime per case, paid in eight quarterly payments of \$125. HSTA VB Supplemental: Maximum amount payable by HDS for an eligible patient shall be \$750 lifetime per case, paid in eight quarterly payments of \$93.75. Orthodontic services are not covered: <ul style="list-style-type: none"> • If services were started prior to the date the patient became eligible under this employer's plan. • If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. • If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.

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

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

Vision Benefits

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

In-Network and Out-of-Network Providers

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

No ID Cards

There are no ID cards issued for VSP members. Members simply notify their vision provider that they are VSP members, and VSP providers will file a claim to VSP. Members can download and print an ID card if desired, by setting up an online account at vsp.com.

VSP.com

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

To register, follow these simple steps:

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

Essential Medical Eye Care

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

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

VISION SERVICE PLAN (VSP)			
Vision Exam and Eyewear Benefits: Members can have an eye exam and choose between a pair of lenses or contact lenses every plan year. Frames are covered every other plan year. The plan year is July 1 – June 30.			
VISION BENEFIT	Frequency	In-Network	Out-of-Network Plan Pays
Exam	Every plan year	\$10 copay	Up to \$45
Prescription Glasses		\$25 copay	
Frame	Every other plan year	\$150 allowance plus 20% off out-of-pocket cost*	Up to \$47
Lenses	Every plan year		
Single-vision lenses		Included in \$25 copay	Up to \$45
Lined bifocal lenses		Included in \$25 copay	Up to \$65
Lined trifocal lenses		Included in \$25 copay	Up to \$85
Standard progressive lenses		Included in \$25 copay	Progressive lenses – up to \$85
Premium progressive lenses		\$80–\$90 copay	
Custom progressive lenses		\$120–\$160 copay	
Lenticular lenses		No charge	Up to \$125
Polycarbonate lenses for dependent children up to age 18		No charge	Not covered
UV protection		No charge	Not covered
Contact Lenses (instead of glasses)	Every plan year		
Contact lenses (elective)		\$130 allowance	Up to \$105
Contact lenses (medically necessary)		No charge	Up to \$210
Contact lenses fitting and evaluation		\$60 copay max	Not covered

Extra Discounts and Savings From VSP Providers

Glasses and Sunglasses

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

Contact Lenses

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

Laser Vision Correction

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

Retinal Screening

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

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

Chiropractic Plan Benefits

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

Chiropractic Plan Benefits

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

- **EUTF members:** The copayment is \$15 per visit for up to 20 visits per calendar year.
- **HSTA VB members:** The copayment is \$12 per visit for up to 20 visits per calendar year.

Chiropractic services must be received from a contracted and credentialed ASH Group network provider. You can request a complete list of ASH Group contracted providers and plan information from HMSA and Kaiser Permanente. Please refer to the plan certificate for complete information on benefits, limitations, and exclusions.



Life Insurance Benefits

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

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

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

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

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

— **Beneficiary financial counseling from PricewaterhouseCoopers LLP.**

Beneficiaries receiving \$25,000 or more will be invited to access professional guidance to help them make sound financial decisions regarding their policy proceeds. Resources include assessment, workbooks, newsletter, website access, and more. Information on how to access these services is provided with claims payment.

Beneficiary Changes

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

Premium Conversion Plan – State of Hawaii Employees Only

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

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



Enrolling in the PCP

Annual Open Enrollment Period (OEP) – Current Employees

During the annual open enrollment period (OEP), employees may enroll, make changes to, or cancel their existing PCP enrollment without experiencing an IRS-qualifying change-in-status event. Employees wishing to enroll, change, or cancel their PCP enrollment shall make their selection in the “Plan Selection” section of the EUTF’s EC-1/EC-1H enrollment form and submit it to their departmental Human Resources Office (HRO) designee prior to the end of the OEP. The PCP effective date for OEP enrollments/changes shall be July 1, the start of the new plan year.

New Hires/Newly Eligible Employees

New employees or newly eligible employees who enroll in a health benefits plan offered by the EUTF, and whose payroll deductions are processed through the State Department of Accounting and General Services (DAGS) are eligible to participate in the PCP. Employees shall make a PCP election in the “Plan Selection” section of the EUTF’s EC-1/EC-1H enrollment form and file it with their HRO designee. The PCP enrollment shall become effective as soon as administratively possible on a **prospective** basis from the date the form is received.

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

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

Making Changes

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

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

The PCP enrollment, change, or cancellation shall become effective as soon as administratively possible, on a **prospective** basis (except in the case of a new child, which may be retroactive to the date of birth, adoption, or placement for adoption) provided the forms are submitted within ninety (90) calendar days of the event.

Note: The PCP is not a health insurance coverage, rather it is a tax exemption type of benefit. Therefore, the PCP and EUTF have different administrative rules and are separately administered. Please refer to the Common Qualifying Events – Additions and Deletions on pages 63–67 for submission dates.



PCP Administrative Rules

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

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

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

For County Employees: Please contact your Departmental Human Resources Office for more information on available options.

Eligibility and Enrollment

Eligibility

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

Employee Eligibility

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

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

Dependent Eligibility

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

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

Annual Certification of Student Status

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

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

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

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

Dependent(s) under vision and dental who are no longer full-time students or who have married will be terminated at the end of the appropriate pay period.

Special Eligibility Requirements for Domestic and Civil Union Partners

Domestic Partner (DP): A person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

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

An employee may enroll a domestic partner's children as dependents so long as the children meet the EUTF eligibility requirements applicable to the enrollment of dependent children.

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

Civil Union Partner (CUP): A person who has entered into a civil union under the rules established by the State Department of Health. Employees may also enroll a civil union partner's children as dependents so long as the children meet the EUTF eligibility requirements applicable to the enrollment of dependent children.

Note: There may be federal and State income tax consequences with employer-paid coverage for domestic partners, and federal income tax consequences with employer-paid coverage for civil union partners. If your domestic partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic partner will be deemed taxable income and reported to you on the appropriate federal or State tax form. If your civil union partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your civil union partner will be deemed taxable income and reported to you on the appropriate federal tax form. Consult your tax advisor to determine your domestic or civil union partner's status. If you determine that your domestic or civil union partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available along with information/instructions on the EUTF website at eutf.hawaii.gov) to the EUTF.

Enrollment

Employee-Beneficiary Responsibility

Employee-beneficiaries are responsible for:

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

Employer Responsibility

Any public employer whose current or former employees participate in EUTF benefit plans is responsible for:

- Providing information as requested by the EUTF under section 87A-24(9) of the HRS;
- Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the Board;
- Assisting the EUTF in distributing information to and collecting information from the employee-beneficiaries;
- Complying with the EUTF's Administrative Rules; and
- Notifying EUTF immediately following termination, transfer, and bargaining unit changes or death.

How to Enroll

To enroll in EUTF health plans, you must submit an EC-1 enrollment form (or EC-1H if you are already enrolled in the HSTA VB plans). If you do not enroll eligible members of your family within 45 days (180 days for newborns) from the time you or they first become eligible, you must wait until you experience a qualifying event or wait until the next open enrollment period. The plan year for active employees begins July 1 and ends June 30 of the following year.

Confirmation Notice and ID Cards

Once your enrollment is processed by the EUTF, you will be sent a Confirmation Notice indicating your enrollment and dependents covered (if any). You will have 15 calendar days from the date indicated on the Confirmation Notice to notify the EUTF in writing if you need to correct EUTF data entry errors. More information can be found on the Confirmation Notice.

The EUTF will notify the health insurance carriers of your new enrollment, and you should receive identification cards from the insurance carriers shortly after. ID cards are not issued for HMA, American Specialty Health Group, Inc., Securian Financial, and VSP, as ID cards are not required to receive services.

Dual Enrollment Between Two EUTF Plans Is Not Allowed

No person may be enrolled in any EUTF benefit plan as both an employee-beneficiary and dependent-beneficiary, nor may children be enrolled by more than one employee-beneficiary (dual enrollment).

Employee and Spouse Both State and/or County Employees

In addition, if you and your spouse/DP/CUP are both employee-beneficiaries, the employer contribution cannot exceed a family plan contribution in accordance with Chapter 87A-32(3), HRS.

When Can You Enroll?

Eligible employees may enroll in EUTF plans by filing an EC-1/EC-1H form during regular or limited enrollment periods described in EUTF Administrative Rules. These enrollment periods include the following:

- **Within 45 days of initial hire date or newly eligible date.** A New Hire/Newly Eligible Enrollment Guide for EUTF benefits is available on our website at eutf.hawaii.gov.
- **During the open enrollment period.** Open enrollment information can be found starting on page 14.
- **If you experience a qualifying event.** Please refer to the Common Qualifying Events Additions and Deletions Charts on pages 63–67.

IMPORTANT: After the open enrollment period is completed (or, if you are a new hire, after your initial enrollment election period is over), generally you will not be allowed to change your benefit elections or add/delete dependents until next year's open enrollment, unless you have a Special Enrollment Event or a qualifying event. See Common Qualifying Events Additions and Deletions on pages 63–67.

End of Coverage

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

- Required premium payments are not made
- Death, subject to exceptions
- Noncompliance with the EUTF Administrative Rules
- Filing of fraudulent claims
- Dependent reaches the limiting age, or divorce; or losing full-time student status for dental/vision coverage
- Surviving spouse, DP, or CUP remarries or enters into another partnership

IMPORTANT: If any of your dependents are no longer eligible due to a divorce, legal separation, reaching the limiting age, or losing full-time student status (for dental and vision), they cannot continue coverage under EUTF plans (except under available COBRA continuation coverage). You are required to notify the EUTF and make these terminations when these events occur. Do not wait for open enrollment to submit terminations.

Effective Dates of Coverage for New Hires and Newly Eligible Employees

You have three choices of when you would like your coverage to begin:

1. Your date of hire or date you become newly eligible for EUTF benefits
2. First day of the first pay period from your date of hire or date you become newly eligible for EUTF benefits (the 1st or the 16th of the month)
3. First day of second pay period from your date of hire or date you become newly eligible for EUTF benefits (the 1st or the 16th of the month)

For example, if the date of hire or date you became newly eligible is January 3, 2023:

- Option 1 effective date of coverage: January 3, 2023
- Option 2 effective date of coverage: January 16, 2023
- Option 3 effective date of coverage: February 1, 2023

Although your coverage begins on the date you select, your enrollment may not be processed right away. Therefore, if you need to fill a prescription or go to the doctor prior to receiving your ID cards, you should email EUTF at eutf@hawaii.gov. In the email subject line type “URGENT – Confirmation of coverage needed.” EUTF checks this email daily and will contact the carrier to rush your enrollment after it receives the EC-1 or EC-1H.

If you are a **newly hired employee or enrolling in benefits for the first time**, your pay period deduction amounts may be **doubled** for at least one (1) to two (2) pay periods to accommodate processing time and the payroll lag.

Transfer of Employment

If you terminate employment and are rehired by the same public employer within the same pay period or the next consecutive pay period, you are considered as having transferred employment and shall be treated as if continuously enrolled in the EUTF benefit plans. If you terminate employment and are rehired by a different public employer (e.g., State to County) within the same pay period or the next consecutive pay period, you are allowed to change between plans, including adding or deleting dependents and changing coverage tiers.

For purposes of this section only, the different public employers are: (1) State, including executive, legislative, and judicial branches, Department of Education, University of Hawaii, Hawaii Health Systems Corporation, Office of Hawaiian Affairs, and all charter schools; (2) City and County of Honolulu; (3) County of Hawaii; (4) County of Kauai; and (5) County of Maui.

Effective Date of Termination

In general, when an event causes you or your dependent's coverage to terminate, such termination will be effective on the first day of the first pay period following the occurrence of the event, e.g., divorce, end of domestic or civil union partnership, death, surviving spouse/partner remarries, or child ceases to be eligible for coverage. There may be certain instances in which the effective date of termination is different, e.g., on the last day of the month in which a dependent reaches the limiting age. You may obtain additional information by referring to the EUTF Administrative Rules on the EUTF website at eutf.hawaii.gov.

Rejection of Enrollment

Enrollment in EUTF benefit plans is contingent on meeting eligibility criteria detailed in the EUTF Administrative Rules. Enrollment applications may be rejected if incomplete. An enrollment application shall be rejected if:

- The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
- The application is not filed within the time limitations prescribed by the EUTF Administrative Rules (see Common Qualifying Events Additions/Deletions on pages 63–67);
- The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
- The employee-beneficiary owes past-due contributions or other amounts to the EUTF; or
- Acceptance of the application would violate applicable federal or State law or any other provision of the rules.

Employee-beneficiaries will be notified by mail of the rejection of their enrollment application.

Authorized Leave of Absence Without Pay (LWOP) and Other Contribution Shortages

If you are going on an authorized leave without pay (LWOP) lasting more than 30 days, an L-1 Authorized Leave of Absence Without Pay form must be completed by your personnel office. Employee health plan options include:

- **Cancelling EUTF Coverage.** You may cancel your EUTF coverage by submitting an EC-1/EC-1H form within 45 days of the beginning of an LWOP. Employees may re-enroll in the same benefit plans upon return from an LWOP by submitting an EC-1/EC-1H form within 45 days of your return from an LWOP.
- **Continuing EUTF Coverage.** You may continue coverage while on an LWOP by submitting premium payments directly to the EUTF. Employees may submit payment to the EUTF using personal check, cashier's check, or money order. Premiums can also be paid electronically through automatic deductions from the employee's checking account, savings account, credit card, or with an electronic check. Information on electronic premium payment options can be found on the EUTF website at eutf.hawaii.gov.
- If any employee on an LWOP fails to cancel EUTF plans by submitting an EC-1/EC-1H form or fails to continue coverage by making payments to the EUTF, he or she will be cancelled for nonpayment from all plans (except for the EUTF life insurance plan) and will not be able to re-enroll until the next open enrollment period (except for certain qualified leave under FMLA or USERRA, where coverage can be reinstated upon return from leave).

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

If the employee-beneficiary fails to pay the premium shortage by the date specified in the Contribution Shortage Reminder Notice, his/her plans will be cancelled retroactive to the date of the last paid premium. Reinstatement of the terminated employee-beneficiary and their dependent's health benefit coverage which was cancelled for nonpayment, will be allowed if, within 60 days from the date of the notice of cancellation, payment is made in full of past and currently due premiums. To be eligible for reinstatement, the terminated member must not have been terminated for nonpayment of premiums within 12 months from the date of the notice of cancellation. Otherwise, employees may only re-enroll during the next open enrollment or qualifying event occurring within the next plan year, except in instances of return from FMLA or USERRA leave.

Address Changes

Employees are responsible for reporting address changes to their employer as soon as possible. Address changes for employees in departments under the State of Hawaii Executive Branch and University of Hawaii must be submitted through HiPAY. All other employees must notify their employer of any address changes. The Counties of Hawaii and Kauai may complete the Employee Address Change form available on the website at eutf.hawaii.gov. Once the address change is processed, the EUTF will notify the health carriers of your new address. Be advised that all address changes must go through your employer, as health plan carriers are not able to make changes.

Special Enrollment Notice

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 45 days or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

You and/or your Dependents may also enroll in this Plan if you or your Dependents have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your Dependents lose eligibility for that coverage or become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends or is determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the EUTF Member Services Branch at **1-808-586-7390** or toll free at **1-800-295-0089**.

Common Qualifying Events – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Adoption	EC-1/EC-1H form within 45 days of adoption or placement for adoption date. Adoption decree or placement for adoption documents, Social Security number, and birth certificate submitted within 45 days from the adoption date.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Birth	EC-1/EC-1H form within 180 days of birth date. Birth certificate and Social Security number must be submitted with enrollment. Hospital certificate is acceptable as temporary supporting document while awaiting birth certificate .	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Civil Union	EC-1/EC-1H form within 45 days of civil union. Civil Union Certificate, Affidavit of Dependency, and Social Security number submitted within 45 days from the civil union date. Birth certificate, student certification (a letter from the school registrar's office or certificate from the National Student Clearinghouse, if applicable) and Social Security number if adding any dependent children within 45 days from the civil union marriage date.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Court Order (aka Qualified Medical Child Support Order-QMCSO) (to cover eligible dependent)	EUTF receives the order directly from the Child Support Enforcement Agency (CSEA). No EC-1/EC-1H is required if employee is already enrolled in plans. If not enrolled, employee has 45 days from the Event Date to submit EC-1/EC-1H form. If enrollment is not completed within 45 days, employee and child(ren) will be added to the lowest-cost PPO plan.	Event Date	Plan changes allowed if required by court order. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Domestic Partnership	EC-1/EC-1H form within 45 days of notarized signature. Notarized Declaration of Domestic Partnership, Affidavit of Dependency & Acknowledgement , and two sets of documents showing proof of shared residency submitted within 45 days from the domestic partnership notary date. Documents available at eutf.hawaii.gov . Applicable supporting document and Social Security number if adding any dependent children within 45 days from the domestic partnership date.	Employee can choose: The Event Date (notary date), first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.

Common Qualifying Events – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Guardianship (Employee wishes to add child to EUTF plans)	EC-1/EC-1H form within 45 days of guardianship date. Guardianship decree, Social Security number, and birth certificate submitted within 45 days from the guardianship date.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Loss of Coverage (Employee and/or dependent loses health coverage and wishes to enroll in EUTF or HSTA VB plans)	EC-1/EC-1H form within 45 days of loss of coverage. Letter from previous employer or carrier detailing type of coverages lost (i.e., medical, drug, dental, vision), date of loss of coverage, and names of any covered dependents. Applicable supporting document and Social Security number if adding dependent(s) for the first time within 45 days of loss of coverage. If proof document notification date is outside of the initial 45-day enrollment period, the employee will be given 45 days from the notification date to submit EC-1/EC-1H form and required documents. Those losing coverage from a Medicaid plan have 60 days from the Event Date to submit EC-1/EC-1H form and required documents. The effective date of coverage will be the day following the day non-EUTF coverage was lost.	The first day following the day non-EUTF coverage was lost.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Marriage	EC-1/EC-1H form within 45 days of marriage, along with marriage certificate and Social Security number . Applicable supporting document and Social Security number if adding any dependent children within 45 days from the marriage date.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in plans if not already enrolled or may add dependents to current plans if already enrolled.
Newly Eligible Student (Unmarried dependent age 19 through 23 becomes a full-time student)	EC-1/EC-1H form, and a letter from the school's registrar's office or certificate from the National Student Clearinghouse within 45 days from school start date.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	No plan changes allowed if already enrolled. May enroll in dental and/or vision plans if not already enrolled.
Eligible Student – yearly certification on child's birthdate (already enrolled in EUTF plans) (Unmarried dependent age 19 through 23 is a full-time student)	Student certification: A letter from an accredited school on school letterhead with registrar's signature confirming full-time status or certificate from the National Student Clearinghouse within 45* days of student's birthdate. Transcripts are not accepted. No enrollment change request is required.	N/A	No plan changes allowed.

* If proof of full-time student's status is not received within 15 days of the student's birthdate, his/her coverage (dental and vision for Active Employee dependents) will be terminated effective the end of the pay period during which the birthdate occurs. If EUTF receives proof of full-time student status within 45 days from the student's birthdate, his/her coverage will be reinstated without a break in coverage.

Common Qualifying Events – Additions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
New Hire/Newly Eligible Employee (New employee wishes to enroll in EUTF plans)	EC-1 form within 45 days from new hire/newly eligible start date. (1) Marriage certificate, Civil Union certificate, or Domestic Partnership forms (see above) if enrolling a spouse/DP; (2) Social Security number ; (3) Birth certificate for dependent children; (4) Student certification from an accredited school on school letterhead with registrar's signature confirming full-time status or certificate from the National Student Clearinghouse, within 45 days from date of hire if enrolling a dependent age 19 through 23, in dental and/or vision.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	N/A
Retirement	EC-2 form and ERS Retirement Estimate Letter must be submitted within 60 days of retirement date. If Medicare-eligible, a copy of Medicare Part B ID card, Direct Deposit Agreement form , and letter from Social Security indicating Medicare Part B premium paid. If paying all or a portion of your health benefit premium, ERS Pension Deduction Form or ACH Deduction Form . All documents must be submitted within 60 days of retirement date.	Retirement Date	N/A
Return From Leave of Absence Without Pay (LWOP) (Applies only to employees who waived their plans while on LWOP or for USERRA or FMLA)	EC-1/EC-1H form within 45 days after returning from an LWOP.	Employee can choose: The Event Date, first day of the pay period following the Event Date, or first day of the 2nd pay period following the Event Date.	Employee must enroll in the same plans (and with the same dependents, if eligible).

Common Qualifying Events – Deletions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Acquisition of Coverage (Employee or dependent gets coverage from another plan and wishes to cancel EUTF or HSTA VB plans)	EC-1/EC-1H form within 45 days of acquisition of coverage. Letter from carrier or employer detailing type of coverage enrolled in (i.e., medical, drug, dental, vision), effective date of coverage, and names of covered dependents within 45 days from the date of acquisition.	If coverage is gained on the 1st of the month, EUTF coverage ends on the last day of the month preceding. If coverage is gained on the 16th of the month, EUTF coverage ends on the 15th of the month. Otherwise, coverage ends on the first day of the pay period following the acquisition of non-EUTF coverage.	Employee may enroll in the supplemental health benefit plan effective the first day of the pay period following the cancellation of their EUTF coverage.
Child is No Longer a Full-time Student* (Employee must terminate dental and vision coverage for a child from age 19 through 23)	EC-1/EC-1H form as soon as the dependent child is no longer a full-time student.	Coverage ends on the first day of the pay period following the school's end date.	No
Death of Dependent	EC-1/EC-1H form as soon as reasonably practical. Death certificate or copy of obituary as soon as available.	Coverage ends on the date of the dependent's death or on the first day of the pay period following the dependent's death.	N/A
Divorce* (Employee must terminate coverage for former spouse and stepchildren or civil union partner)	EC-1/EC-1H form within 45 days of divorce; however, it will be accepted and processed regardless of when form is received. Submit pages 1 and 2 of divorce decree along with the signature page within 45 days from the date of the divorce.	If submitted within 60 days of the divorce, coverage ends on the first day of the first pay period following the divorce. If submitted 60+ days following the divorce, coverage ends prospectively on the first day of the first pay period following EUTF's receipt of the enrollment change request.	No
Legal Separation* (Employee may terminate coverage for spouse and stepchildren)	EC-1/EC-1H form within 45 days of date of legal separation. Court documents establishing legal separation along with the signature page within 45 days from separation date.	If submitted within 60 days, coverage ends on the first day of the first pay period following the legal separation. If submitted 60+ days, coverage ends prospectively on the first day of the first pay period following EUTF's receipt of the enrollment change request.	No
Leave of Absence Without Pay Lasting More Than 30 Days (Employee may waive all plans excluding life insurance or continue coverage by paying his/her share of premium)	EC-1/EC-1H form within 45 days from beginning of an LWOP to waive plans. Employer is required to submit L-1. To re-enroll after LWOP, EC-1/EC-1H form must be submitted within 45 days of return from LWOP.	If employee cancels plans, the cancellation is effective the first day of the pay period following the LWOP.	No

Note: Employers must notify EUTF of an employee's Demographic Change, Bargaining Unit change, or Death.

*If the EUTF is not notified of ineligible dependent(s) within 60 days of their becoming ineligible, the affected dependent(s) coverage will be terminated prospectively, and the employee will be responsible for the employee and employer contributions of premiums for the ineligible dependent(s).

Common Qualifying Events – Deletions

Qualifying Event	Required Documents and Submission Deadline	Effective Date	Changes Allowed?
Nonpayment Termination	N/A	Coverage is cancelled as of the first day following the last period for which full payment was made. Employee can make a full payment of all contributions due within 60 days of the cancellation and have previous coverage reinstated, if coverage has not been cancelled due to nonpayment within 12 months of the date of the notice of cancellation.	N/A
Termination of Domestic Partnership* (Employee must terminate coverage for domestic partner and domestic partner's dependents)	N/A	Coverage ends on the first day of the first pay period following the date of termination of the domestic partnership.	No
Termination of Employment	Termination Close of Business (COB) must be submitted by the Employer within 30 days of the termination. However, it will be accepted and processed regardless of when the form is received.	Coverage ends the first day of the pay period following the last day of employment.	N/A

Note: Employers must notify EUTF of an employee's Demographic Change, Bargaining Unit change, or Death.

* If the EUTF is not notified of ineligible dependent(s) within 60 days of their becoming ineligible, the affected dependent(s) coverage will be terminated prospectively, and the employee will be responsible for the employee and employer contributions of premiums for the ineligible dependent(s).

Future Retirees

Applying for Your Retirement Benefits

Employees who wish to file for retirement must do so with the Employees' Retirement System (ERS). After filing for retirement with ERS, employees need to submit an EC-2 form and the following documents to the EUTF in order to obtain retiree health and life insurance benefits:

- ERS Retirement Estimate Letter
- If you must pay a portion of your retiree health premiums, a completed ERS Pension Deduction Authorization Agreement or ACH Authorization Deduction Agreement

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

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

Additional resources, including a Pre-Retirement Checklist, Medicare Checklist, and required EUTF forms are available on the EUTF website at eutf.hawaii.gov. The EUTF also conducts Pre-Retirement workshops and webinars. Please visit our website for more information on upcoming workshops and how to attend.

Enrollment or Changes in Enrollment Upon Retirement

An employee-beneficiary may enroll or change coverages in the health benefit plans offered or sponsored by the EUTF and obtain coverage for eligible dependent-beneficiaries when they become a retired member of the ERS as defined in 87A-1HRS. The effective date of the coverage shall be the first of the month on or after the employee-beneficiary's date of retirement, provided a completed enrollment application is received by the EUTF within sixty (60) days of retirement or within sixty (60) days of certification from the ERS of a disability retirement. Retired employee-beneficiaries are eligible to enroll in EUTF benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the date of retirement.

Portability of Annual Maximums and Annual Limits Between Active and Retiree Plans

If you are thinking about retirement during the upcoming plan year, you should consider plan annual maximums and annual limits for medical, dental, vision, and prescription drug benefits. Retiree prescription drug plans have an annual maximum for specialty drugs only. **Benefits that are paid under the active employee plans are counted against the maximums and limitations of the retiree plans of the same carrier if they occur within the same calendar year.**

Medical Maximum Out-of-Pocket Example

Jane is an active employee in the EUTF HMSA 90/10 PPO Plan. On July 1, 2023, Jane meets her \$2,000 calendar-year maximum out-of-pocket under the plan. She incurs additional medical expenses of \$100 in August 2023, which are paid at 100% since her maximum out-of-pocket was satisfied. Jane retires on September 1, 2023, and enrolls in the EUTF HMSA Non-Medicare Retiree PPO plan. She proceeds to have additional medical services totaling \$1,000 before the end of 2023. As an active employee, Jane's maximum out-of-pocket was \$2,000 per calendar year, but as a retiree, her maximum out-of-pocket is \$2,500 per calendar year. Therefore, instead of 100% coverage for the additional \$1,000 of medical expenses, Jane is responsible for 10% on \$500 of the additional expenses, to meet the \$2,500 maximum out-of-pocket under her retiree plan.

Medical Deductible Example

On January 1, 2023, Jill was an active employee enrolled in the EUTF HMSA 90/10 PPO Plan. She met her individual out-of-network deductible of \$100 in May 2023. Jill retires on June 1, 2023, and enrolls in the EUTF HMSA Retiree PPO plan. The \$100 deductible she met under the active employee plan will apply to the retiree plan since it falls within the same calendar year. Jill will not be subject to an additional deductible under the retiree plan in 2023.

Medicare

Medicare is the federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with end stage renal disease (permanent kidney failure requiring dialysis or kidney transplant) or Amyotrophic Lateral Sclerosis (ALS).

Medicare has four parts:

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

Medicare Part B Enrollment for Medicare-Eligible Employees Considering Retirement

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

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

Medicare Part B Premium Reimbursement

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

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

How to Enroll in Medicare

Enrollment in Medicare is done through the Social Security Administration:

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

Medicare Enrollment Periods

- **Initial Enrollment Period.** Individuals eligible for Medicare due to age may enroll as early as three months prior to their 65th birthday, the month they turn 65, or three months after their 65th birthday (seven-month period). This seven-month period is called the Initial Enrollment Period (IEP). Individuals who are collecting Social Security at the time they reach age 65 will usually be enrolled into Medicare Part A and B automatically.
- **Special Enrollment Period.** Individuals covered under an active employer group plan may enroll in Medicare after the Initial Enrollment Period under a Special Enrollment Period (SEP) at any time while covered by the employer group plan. They may also enroll in the eight-month period beginning the month after employment ends or the employer group coverage ends.
- **General Enrollment Period.** This enrollment period occurs annually from January 1 to March 31 with Medicare coverage effective July 1. Individuals who miss their Initial Enrollment Period or Special Enrollment Period may enroll during the General Enrollment Period (GEP).

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

Important Notices

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

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

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

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

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

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

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

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

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

These benefits will be provided subject to the same plan limits, deductibles, copayments, and coinsurance applicable to other medical and surgical benefits provided under the plan. For more information on WHCRA benefits, contact HMSA or Kaiser Permanente.

PRIVACY NOTICE REMINDER

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

This plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this notice when you enroll in the plan. You can get another copy of this notice from our Member Services Branch at **1-808-586-7390** or toll-free at **1-800-295-0089**. The Privacy Notice is also available on the EUTF website at eutf.hawaii.gov.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP)

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

Direct Access to OB/GYN Providers

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

SPECIAL EXTENSION OF COVERAGE FOR A STUDENT ON A MEDICALLY NECESSARY LEAVE OF ABSENCE

If the plan receives a written certification from a covered child's treating physician that:

1. The child is suffering from a serious illness or injury, and
2. A leave of absence (or other change in enrollment) from a postsecondary institution is medically necessary, and the loss of postsecondary student status would result in a loss of health coverage under the plan, then

the plan will extend the child's dental and/or vision coverage for up to one year.

This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (1) one year later or (2) the date on which coverage would otherwise terminate under the terms of the plan. Contact the EUTF Office at **1-808-586-7390** or toll-free at **1-800-295-0089** for more information.

NOTICE REGARDING THE WELLNESS PROGRAM

The wellness programs are voluntary wellness programs available to participants enrolled in the group health plan and are designed to promote health or prevent disease. The programs are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment (HRA) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA questionnaire, participate in medical examinations, or to work with a health coach.

The information from your HRA questionnaire will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections From Disclosure of Medical Information

Our group health plan is required by law to maintain the privacy and security of your personally identifiable health information.

Information collected from wellness program participants will only be received by EUTF in aggregate form. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, our group health plan will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separately from your personnel records, and no information you provide as part of the wellness program will be used in making any employment decision.

Appropriate precautions will be taken by the group health plan to avoid any data breach, and in the event a HIPAA data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the EUTF Office at **1-808-586-7390** or toll-free at **1-800-295-0089**.

AVAILABILITY OF SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. In accordance with law, our plan provides you with a Summary of Benefits and Coverage (SBC) as a way to help you understand and compare medical plan benefits. The SBC summarizes and compares important information, including what is covered, what you need to pay for various benefits, what is not covered, and where to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC. To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, and the Uniform Glossary that defines many terms in the SBC, go to eutf.hawaii.gov, or for a paper copy, contact **1-808-586-7390** or toll-free at **1-800-295-0089**.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	CALIFORNIA Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	INDIANA Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	KANSAS Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	LOUISIANA Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	MASSACHUSETTS Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	MISSOURI Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	NEBRASKA Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	NEW YORK Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	NORTH DAKOTA Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	OREGON Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	RHODE ISLAND Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA Medicaid	SOUTH DAKOTA Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	UTAH Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	VIRGINIA Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	WEST VIRGINIA Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	WYOMING Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Important Notice From the Hawaii Employer-Union Health Benefits Trust Fund (EUTF) About Prescription Drug Coverage for People With Medicare

This notice is for people who may become eligible for Medicare during the next 12 months.

Please read this notice carefully, and keep it where you can find it.

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

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

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

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

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

- HMSA 75/25 PPO Plan (as administered by CVS Caremark)
- HMSA 80/20 PPO Plan (as administered by CVS Caremark)
- HMSA 90/10 PPO Plan (as administered by CVS Caremark)
- HMSA HMO Plan (as administered by CVS Caremark)
- HSTA VB HMSA 90/10 PPO Plan (as administered by CVS Caremark)
- HSTA VB HMSA 80/20 PPO Plan (as administered by CVS Caremark)
- Kaiser Permanente HMO plans (as administered by Kaiser)

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

Because the plan options noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the CVS Caremark-administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser).** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

YOUR RIGHT TO RECEIVE A NOTICE

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

WHY CREDITABLE COVERAGE IS IMPORTANT (WHEN YOU WILL PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN)

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug

coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

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

WHAT ARE MY CHOICES?

You can choose any one of the following options:

Your Choices	What You Can Do	What This Option Means to You
Option 1	You can select or keep your current medical and prescription drug coverage under the CVS Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser Permanente), and you do not have to enroll in a Medicare prescription drug plan.	<p>You will continue to be able to use your prescription drug benefits through the CVS Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser).</p> <ul style="list-style-type: none"> • You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (October 15 through December 7 of each year). • As long as you are enrolled in creditable drug coverage, you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	<p>You can select or keep your current medical and prescription drug coverage with the CVS Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser Permanente) and also enroll in a Medicare prescription drug plan.</p> <p>If you enroll in a Medicare prescription drug plan, you will need to pay the Medicare Part D premium, if applicable, out of your own pocket.</p>	<p>Your current coverage pays for other health expenses in addition to prescription drugs.</p> <p>If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all your current health and prescription drug benefits. Having dual prescription drug coverage under this plan and Medicare means that this plan will coordinate its drug payments with Medicare, as follows:</p> <ul style="list-style-type: none"> • For Medicare-eligible retirees and their Medicare-eligible dependents, Medicare Part D coverage pays primary, and the group health plan pays secondary. • For Medicare-eligible active employees and their Medicare-eligible dependents, the group health plan pays primary, and Medicare Part D coverage pays secondary. <p>Note that you may not drop just the prescription drug coverage under the CVS Caremark administered drug plans: HMSA 75/25 PPO Plan, HMSA 80/20 PPO Plan, HMSA 90/10 PPO Plan, HMSA HMO Plan, HSTA VB HMSA 90/10 PPO Plan, and HSTA VB HMSA 80/20 PPO Plan, as well as the Kaiser Permanente HMO plans (as administered by Kaiser Permanente). That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this plan's next open enrollment period.</p> <p>Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:</p> <ul style="list-style-type: none"> • PDPs may have different premium amounts; • PDPs cover different brand-name drugs at different costs to you; • PDPs may have different prescription drug deductibles and different drug copayments; • PDPs may have different networks for retail pharmacies and mail-order services.

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

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

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

PARA MÁS INFORMACIÓN SOBRE SUS OPCIONES BAJO LA COBERTURA DE MEDICARE PARA RECETAS MÉDICAS.

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

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

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

Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

201 Merchant Street, Suite 1700

Honolulu, HI 96813

Phone number: **1-808-586-7390** or toll-free at **1-800-295-0089**

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

Administrative Appeals

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

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary, or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;
2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long-term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long-term care, offered or sponsored by the EUTF.
5. In addition to the appeal rights outlined in this section, an aggrieved person may have a right to file an external appeal if denial is due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time. Contact EUTF for a full description of any external review rights.

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

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

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

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

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

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

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

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

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

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

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

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

Who to Contact

For Questions About...	Please Contact...
Eligibility and EUTF Information	<p>eutf.hawaii.gov EUTF Member Services Branch 1-808-586-7390 (Oahu) or toll-free: 1-800-295-0089 Monday through Friday, 7:45 a.m.–4:30 p.m. HST, excluding State holidays</p>
Hawaii Medical Service Association (HMSA)	<p>hmsa.com/eutf 1-808-948-6499 (Oahu) or toll-free: 1-800-776-4672 (Neighbor Islands) Monday through Friday, 7 a.m.–7 p.m. HST Saturday, 9 a.m.–1 p.m. HST</p> <p>In person:</p> <p>HMSA Center @ Honolulu HMSA Building 818 Keeaumoku St. Honolulu, HI 96814 Monday through Friday, 8 a.m.–5 p.m. HST Saturday, 9 a.m.–2 p.m. HST</p> <p>HMSA Center @ Pearl City Pearl City Gateway 1132 Kuala St., Suite 400 Pearl City, HI 96782 Monday through Friday, 9 a.m.–6 p.m. HST Saturday, 9 a.m.–2 p.m. HST</p> <p>HMSA Center @ Kahului Puunene Shopping Center 70 Hookele St., Suite 1220 Kahului, HI 96732 Monday through Friday, 9 a.m.–6 p.m. HST Saturday, 9 a.m.–2 p.m. HST</p> <p>HMSA Center @ Hilo Waiakea Center 303A E. Makaala St. Hilo, HI 96720 Monday through Friday, 9 a.m.–6 p.m. HST Saturday, 9 a.m.–2 p.m. HST</p> <p>Kauai Office 4366 Kukui Grove St., Suite 103 Lihue, HI 96766 Monday through Friday, 8 a.m.–4 p.m. HST</p>

Kaiser Permanente (Kaiser)	<p>kp.org/eutf 1-808-432-5250 (Oahu) or toll-free: 1-844-276-6628 (Neighbor Islands) Monday through Friday, 7 a.m.–7 p.m. HST Saturday, 9 a.m.–1 p.m. HST</p> <p>Walk-In Service: 711 Kapiolani Blvd. Honolulu, HI 96813 Monday through Friday, 8 a.m.–4:30 p.m., excluding State observed holidays</p>
CVS Caremark (CVS) For HMSA members	<p>caremark.com 1-855-801-8263 TTY: 711 (24 hours a day, 7 days a week)</p> <p>Walk-In Service: Pauahi Tower 1003 Bishop Street, Suite 704 Monday through Friday, 7:45 a.m.–4:30 p.m. HST</p>
Hawaii-Mainland Administrators (HMA)	<p>hma-hi.com/eutf Oahu: 1-808-951-4643 or toll-free: 1-866-437-1992 For phone calls, the hours are: Monday through Friday, 7:30 a.m.–7 p.m. HST, Saturday, 9 a.m.–1 p.m. HST For walk-ins, the hours are: Monday through Friday, 7:30 a.m.–5 p.m. HST Office located: 1440 Kapiolani Blvd., Suite 1000</p>
Hawaii Dental Service (HDS)	<p>hawaiidentalsservice.com/members/eutf 1-808-529-9310 or toll-free 1-866-702-3883 Over the phone: Monday through Friday, 7:30 a.m.–6 p.m. HST, except State observed holidays Walk-In Hours: Monday through Friday, 8 a.m.–4:30 p.m., except State observed holidays Office located: Pioneer Plaza, 900 Fort Street Mall, Suite 1900</p>
Vision Service Plan (VSP)	<p>vsp.com Oahu: 1-808-532-1600 or toll-free 1-800-522-5162 Monday through Friday, 7:30 a.m.–6 p.m. HST</p> <p>Toll-free: 1-866-240-8420 Through March 11, 2023: Monday through Saturday, 4 a.m.–3 p.m. HST From March 12, 2023: Monday through Saturday, 3 a.m.–2 p.m. HST</p>

American Specialty Health (ASH)	ashlink.com/ash/hmsa for HMSA members ashlink.com/ash/kaiserhic for Kaiser Permanente members Toll-free: 1-800-678-9133 10/1/22–3/31/23: Sunday through Saturday, 8:00 a.m.–8:00 p.m. HST, excluding Thanksgiving Day and Christmas Day 4/1/23–9/30/23: Monday through Friday, 2:00 a.m.–5:00 p.m. HST, excluding ASH-observed holidays
Securian Financial	LifeBenefits.com/EUTF Local office: 1-808-536-9890 or toll-free: 1-877-291-8466 Monday through Friday, 7:30 a.m.–6 p.m. HST, except State observed holidays Email: lifebenefits@securian.com
Social Security Administration (SSA)	ssa.gov 1-800-772-1213
Centers for Medicare & Medicaid Services	cms.gov 1-800-MEDICARE

EC-1 Enrollment Form Instructions

I. Employee Data

Select the Enrollment Type for which you are submitting the Enrollment form. Mark the New Hire box if you're newly hired, the Qualifying Event box if you are making changes outside of the Open Enrollment period, or the Open Enrollment box during the annual or limited Open Enrollment period. If submitting the enrollment form for a qualifying event, give a brief description of the event and input the date the qualifying event occurred. Common qualifying events include: **Acquisition of Coverage, Adoption, Birth, Civil Union Partner, Court Order, Death, Divorce, Domestic Partnership, Foster Child, Guardianship, Ineligible Student, Approved Leave of Absence Without Pay/Waive (LWOP/Waive), Approved Leave of Absence Without Pay/Re-enroll (LWOP/Re-enroll), Legal Separation, Loss of Coverage, Marriage, Moving Out of the Coverage Area, New Hire, Newly Eligible Employee, Newly Eligible Student, Reinstatement of Employment, or Termination of Domestic Partnership.** Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

Carefully consider when you would like your health plans and premium deductions to begin and check the appropriate box. You can select one of the following:

- (Option #1) Coverage starts on the date of hire or event date. Premium contributions start 1st day of the pay period in which the date of hire or event date occurs.
- (Option #2) Coverage and contributions start 1st day of the first pay period following the date of hire or event date.
- (Option #3) Coverage and contributions start 1st day of the second pay period following the date of hire or event date.

If no selection is made, Option #1 will be used, and you will be responsible for the full premium in said pay period. Loss of Coverage and Acquisition of Coverage must start on event date (Option #1).

III. Plan Selection

Mark all plans you wish to be enrolled in. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan you select. If you do not want any plan coverage, mark the "Cancel/Waive" box. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.

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

For State and Maui County Employees Only: The Premium Conversion Plan (PCP) is a voluntary benefit plan, that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. For State employees, PCP is administered by the Department of Human Resources Development (DHRD). For County of Maui employees, PCP is administered by the County of Maui. By enrolling in the PCP, you are allowing deductions for your health plan premium contributions from your gross pay before federal, State and social security taxes are withheld. Since there may be tax implications, please visit the DHRD website at dhrd.hawaii.gov or County of Maui intranet for more information. State employees making mid-plan year elections, should inquire with their Human Resources Office or DHRD on completing a PCP-2 form (the PCP-2 form is not required of County of Maui employees). Enrollment in the PCP is not automatic. Mark the "Enroll" or "Cancel/Waive" box. If no election is made (i.e., left blank), new enrollments shall default to "Not Enrolled" and existing PCP enrollments shall continue. **For All Other County Employees:** Premium Conversion Plan (PCP) is administered by the Budget and Fiscal Services Department. Please contact your Department Personnel Office for more information on available options.

IV. Dependent Information

Complete dependent information and indicate plan selection if adding, removing or continuing coverage for dependents. If you are adding/removing more than five dependents and additional rows are needed, please attach another sheet to your enrollment form. If this is your first time enrolling dependents in EUTF plans, please submit required proof documents including a marriage certificate if adding your spouse or partner and a birth certificate and guardianship or adoption decree (if applicable), if adding a child(ren). If a dependent child is age 19 to 24, unmarried and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Required proof documents must be submitted to the EUTF within 45 days of the event date. Social security numbers are required for all newly added dependents. Detailed eligibility information including required proof documents for other life events are available online at eutf.hawaii.gov. **Use the following Relationship codes:**

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

V. Other Insurance Information

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

VI. Employee Signature

Read, sign and date the form. Submit your EC-1 form to your department human resource office or enrollment designee for verification, signature and routing to EUTF within 45 days (180 days for newborns) of the event date. DOE employees please submit your EC-1 form to the address printed on the top right-hand corner of the enrollment form. To ensure proper processing, all required fields must be completed, and proper documentation submitted timely.

EC-1H Enrollment Form Instructions

Use of this form is for members currently enrolled in the HSTA VB plans. If you are not currently enrolled in the HSTA VB plans, please use the EC-1 form.

I. Employee Data

Select the Enrollment Type for which you are submitting the Enrollment form. Mark the New Hire box if you're newly hired, the Qualifying Event box if you are making changes outside of the Open Enrollment period, or the Open Enrollment box during the annual or limited Open Enrollment period. If submitting the enrollment form for a qualifying event, give a brief description of the event and input the date the qualifying event occurred. Common qualifying events include: **Acquisition of Coverage, Adoption, Birth, Civil Union Partner, Court Order, Death, Divorce, Domestic Partnership, Foster Child, Guardianship, Ineligible Student, Approved Leave of Absence Without Pay/Waive (LWOP/Waive), Approved Leave of Absence Without Pay/Re-enroll (LWOP/Re-enroll), Legal Separation, Loss of Coverage, Marriage, Moving Out of the Coverage Area, New Hire, Newly Eligible Employee, Newly Eligible Student, Reinstatement of Employment, or Termination of Domestic Partnership.** Complete all information about yourself and your spouse/partner.

II. Coverage Start Date

Carefully consider when you would like your health plans and premium deductions to begin and check the appropriate box. You can select one of the following:

- (Option #1) Coverage starts on the date of hire or event date. Premium contributions start 1st day of the pay period in which the date of hire or event date occurs.
- (Option #2) Coverage and contributions start 1st day of the first pay period following the date of hire or event date.
- (Option #3) Coverage and contributions start 1st day of the second pay period following the date of hire or event date.

If no selection is made, Option #1 will be used, and you will be responsible for the full premium in said pay period. Loss of Coverage and Acquisition of Coverage must start on event date (Option #1).

III. Plan Selection

Mark all plans you wish to be enrolled in. You can choose one medical/prescription drug plan, one dental plan, and one vision plan. The prescription drug plan is bundled with the medical plan and will depend on the medical plan you select. If you do not want any plan coverage, mark the "Cancel/Waive" box. If no selection is made and you currently have coverage, EUTF will assume no changes are being made.

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

For State Employees Only: The Premium Conversion Plan (PCP) is a voluntary benefit plan, that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. For State employees, PCP is administered by the Department of Human Resources Development (DHRD). By enrolling in the PCP, you are allowing deductions for your health plan premium contributions from your gross pay before federal, State and social security taxes are withheld. Since there may be tax implications, please visit the DHRD website at dhrd.hawaii.gov for more information. State employees making mid-plan year elections, should inquire with their Human Resources Office or DHRD on completing a PCP-2 form. Enrollment in the PCP is not automatic. Mark the "Enroll" or "Cancel/Waive" box. If no election is made (i.e., left blank), new enrollments shall default to "Not Enrolled" and existing PCP enrollments shall continue.

IV. Dependent Information

Complete dependent information and indicate plan selection if adding, removing or continuing coverage for dependents. If you are adding/removing more than five dependents and additional rows are needed, please attach another sheet to your enrollment form. If this is your first time enrolling dependents in EUTF plans, please submit required proof documents including a marriage certificate if adding your spouse or partner and a birth certificate and guardianship or adoption decree (if applicable), if adding a child(ren). If a dependent child is age 19 to 24, unmarried and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Required proof documents must be submitted to the EUTF within 45 days of the event date. Social security numbers are required for all newly added dependents. Detailed eligibility information including required proof documents for other life events are available online at eutf.hawaii.gov. **Use the following Relationship codes:**

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

V. Other Insurance Information

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

VI. Employee Signature

Read, sign and date the form. Please submit your completed EC-1H form to DOE-EBU, PO Box 2360, Honolulu, HI 96804. To ensure proper processing, all required fields must be completed, and proper documentation submitted timely.

**EUTF ACTIVE EMPLOYEE
EC-1 HEALTH BENEFITS ENROLLMENT FORM****All BUs and Employees Excluded from all Bargaining Units**

Complete each section thoroughly, please print clearly

Enrollment Type (you must check one box):	New Hire <input type="checkbox"/>	Qualifying Event <input type="checkbox"/>	Open Enrollment <input type="checkbox"/>
New Hire or Qualifying Event Date: _____	Qualifying Event Description: _____		

Full Legal Name: _____	Social Security No. or HB#: _____
Last, First M.I.	

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

City _____ State _____ Zip Code _____

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: _____
Marriage Date: _____		

Home Phone: _____ Cell Phone: _____ Email: _____

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

Note: If you will be adding your spouse or partner to your health plans, you must also indicate this information under the "Dependent Information" section.

COVERAGE START DATE**DO NOT SKIP THIS SECTION. Read the "EC-1 Enrollment Form Instructions" and complete this section before moving on. Mark one option.**Option #1 ☐ Coverage starts day of the event. Premium contributions start 1st day of the pay period in which the effective date of coverage occurs. **(IF NO OPTION IS SELECTED, OPTION #1 WILL BE USED.)**Option #2 ☐ Coverage and premium contributions start 1st day of the first pay period following event date (1st or the 16th of the month).Option #3 ☐ Coverage and premium contributions start 1st day of the second pay period following event date (1st or the 16th of the month).**PLAN SELECTION EFFECTIVE 7/1/23 THROUGH 6/30/24****Medical, Chiro and Prescription Drug (select one)**

HMSA PPO 90/10 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$507.50	<input type="checkbox"/> Two-Party \$1,232.92	<input type="checkbox"/> Family \$1,572.20
HMSA PPO 80/20 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$302.24	<input type="checkbox"/> Two-Party \$734.10	<input type="checkbox"/> Family \$935.88
HMSA PPO 75/25 Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$48.56	<input type="checkbox"/> Two-Party \$117.90	<input type="checkbox"/> Family \$150.28
HMSA HMO Medical, Chiro and CVS Prescription Drug Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$509.94	<input type="checkbox"/> Two-Party \$1,238.98	<input type="checkbox"/> Family \$1,580.00
Kaiser HMO Comprehensive Medical, Chiro and Prescription Drug Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$352.54	<input type="checkbox"/> Two-Party \$857.22	<input type="checkbox"/> Family \$1,094.48
Kaiser HMO Standard Medical, Chiro and Prescription Drug Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$50.00	<input type="checkbox"/> Two-Party \$121.50	<input type="checkbox"/> Family \$155.00
HMA Supplemental Medical and Prescription Drug (Must have coverage under a non-EUTF health plan to be eligible for Supplemental)	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$13.56	<input type="checkbox"/> Two-Party \$24.26	<input type="checkbox"/> Family \$26.28

Dental (select one)

Hawaii Dental Service Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$14.32	<input type="checkbox"/> Two-Party \$28.64	<input type="checkbox"/> Family \$47.10
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Vision (select one)

Vision Service Plan Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$1.68	<input type="checkbox"/> Two-Party \$3.14	<input type="checkbox"/> Family \$4.10
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Life (select one)

Securian	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self	No cost to employee	
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Premium Conversion Plan* (State and Maui County Employees only) (if no election is made (i.e., left blank), the PCP election shall default to "Not Enrolled")	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Enroll		
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* **State and Maui County Employees Only:** The Premium Conversion Plan (PCP) is a voluntary benefit plan that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. Refer to the EC-1 instructional page for more information. Enrollment in the PCP is not automatic. Mark the "Enroll" or "Cancel/Waive" box. If no election is made (i.e., left blank), new enrollments shall default to "Not Enrolled" and existing PCP enrollments shall continue.

Employee's Name: _____

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

Complete dependent (including spouse and children) information and indicate plan selection if adding/removing dependents.										
Continue	Add	Delete	Last Name, First Name, Middle Initial	Birthdate	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If dependents are age 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov.

OTHER INSURANCE INFORMATION		
If you or any of your dependents are covered under another non-EUTF health plan(s), provide data below.		
Type of Plan: (eg. Medical, Dental)	Name of Plan: (eg. HMSA, Quest)	Subscriber's Name(s):

EMPLOYEE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I understand that if I waive coverage for myself or my dependents that I/they cannot enroll for benefits in EUTF's Plan unless eligible at the next Open Enrollment period or earlier, if there is a mid-year Special Enrollment event such as loss of other coverage, marriage, birth or adoption. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans elected. I authorize my employer or finance officer to make the pre-tax or after-tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. I agree to immediately notify the Fund in writing of any changes that would result in the loss or change of eligibility of my or any of my dependent- beneficiary's benefits. I understand that the Fund reserves the right to terminate benefits and to seek recovery of any overpayment of benefits resulting from my failure to provide written notice within forty-five (45) days of the event that caused the change or ineligibility. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalties for perjury.

Employee Signature

Date

Official Use Only

Department ID#	Department	Division/School	Bargaining Unit
Date Received in Office	DPO Phone Number	DPO Fax Number	
DPO (or employer designee) Printed Name		Date of DPO (or employer designee) Signature	
DPO (or employer designee) Signature			
By signing this EC-1 form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.			
Comments:			



Hawaii Employer-Union Health Benefits Trust Fund

Submit completed form to:
DOE-EBU
PO Box 2360
Honolulu HI, 96804

HSTA VB ACTIVE EMPLOYEE EC-1H HEALTH BENEFITS ENROLLMENT FORM

Bargaining Unit 05 (Formerly Under HSTA VEBA)*Complete each section thoroughly, please print clearly*

	Qualifying Event	Open Enrollment
Enrollment Type (you must check one box):	<input type="checkbox"/>	<input type="checkbox"/>
Qualifying Event Date: _____	Qualifying Event Description: _____	

Full Legal Name: _____ Social Security No. or HB#: _____
Last, First M.I.

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

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner Gender: ☐ Male ☐ Female Birthdate: _____
Marriage Date: _____

Home Phone: _____ Cell Phone: _____ Email: _____

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

Note: If you will be adding your spouse or partner to your health plans, you must also indicate this information under the "Dependent Information" section.

COVERAGE START DATE

DO NOT SKIP THIS SECTION. Read the "EC-1 Enrollment Form Instructions" and complete this section before moving on. Mark one option.

Option #1 Coverage starts day of the event. Premium contributions start 1st day of the pay period in which the effective date of coverage occurs. **(IF NO OPTION IS SELECTED, OPTION #1 WILL BE USED.)**

Option #2 Coverage and premium contributions start 1st day of the first pay period following event date (1st or the 16th of the month).

Option #3 Coverage and premium contributions start 1st day of the second pay period following event date (1st or the 16th of the month).

PLAN SELECTION EFFECTIVE 7/1/23 THROUGH 6/30/24**Medical, Chiro and Prescription Drug and Vision (select one)**

HSTA VB HMSA PPO 90/10 Medical, Chiro, CVS Prescription Drug and VSP Vision Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$392.96	<input type="checkbox"/> Two-Party \$952.46	<input type="checkbox"/> Family \$1,214.34
HSTA VB HMSA PPO 80/20 Medical, Chiro, CVS Prescription Drug and VSP Vision Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$277.70	<input type="checkbox"/> Two-Party \$672.84	<input type="checkbox"/> Family \$857.50
HSTA VB Kaiser HMO Comprehensive Medical, Chiro, Prescription Drug and VSP Vision Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$284.20	<input type="checkbox"/> Two-Party \$691.12	<input type="checkbox"/> Family \$883.20
Other Plans				
Dental - Hawaii Dental Service Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$15.56	<input type="checkbox"/> Two-Party \$31.12	<input type="checkbox"/> Family \$51.22
Supplemental Dental - Hawaii Dental Service Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$7.26	<input type="checkbox"/> Two-Party \$14.54	<input type="checkbox"/> Family \$21.80
Vision - Vision Service Plan Monthly Employee Premium	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self \$1.68	<input type="checkbox"/> Two-Party \$3.14	<input type="checkbox"/> Family \$4.10
Life - Securian	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Self	No cost to employee	
Premium Conversion Plan* (State Employees only) (if no election is made (i.e., left blank), the PCP election shall default to "Not Enrolled")	<input type="checkbox"/> Cancel/Waive	<input type="checkbox"/> Enroll		

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

* **State Employees Only:** The Premium Conversion Plan (PCP) is a voluntary benefit plan that allows you to purchase your health benefit plans on a pre-tax basis and is offered pursuant to Section 125 of the Internal Revenue Code. Refer to the EC-1 instructional page for more information. Enrollment in the PCP is not automatic. Mark the "Enroll" or "Cancel/Waive" box. If no election is made (i.e., left blank), new enrollments shall default to "Not Enrolled," and existing PCP enrollments shall continue.

Employee's Name: _____

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

DEPENDENT INFORMATION

Complete dependent (including spouse and children) information and indicate plan selection if adding/removing dependents.

Continue	Add	Delete	Last Name, First Name, Middle Initial	Birthdate	SSN	Relationship	Gender	Medical/Rx	Dental	Vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If dependents are age 19 to 23 and covered under your dental and/or vision plans, please submit certification from the school registrar or national clearinghouse indicating they are a full-time student. Detailed eligibility information is available online at eutf.hawaii.gov.

OTHER INSURANCE INFORMATION

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

Type of Plan: (eg. Medical, Dental)	Name of Plan: (eg. HMSA, Quest)	Subscriber's Name(s):

EMPLOYEE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I understand that if I waive coverage for myself or my dependents that I/they cannot enroll for benefits in EUTF's Plan unless eligible at the next Open Enrollment period or earlier, if there is a mid-year Special Enrollment event such as loss of other coverage, marriage, birth or adoption. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans elected. I authorize my employer or finance officer to make the pre-tax or after-tax deductions, adjustments or cancellations from my salary, wages, or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. I agree to immediately notify the Fund in writing of any changes that would result in the loss or change of eligibility of my or any of my dependent- beneficiary's benefits. I understand that the Fund reserves the right to terminate benefits and to seek recovery of any overpayment of benefits resulting from my failure to provide written notice within forty-five (45) days of the event that caused the change or ineligibility. EUTF retains the right to terminate coverage in the event of non-payment, if payment is applicable. This form supersedes all forms and submissions previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalties for perjury.

Employee Signature

Date

Official Use Only

Department ID#	Department	Division/School	Bargaining Unit
Date Received in Office	DPO Phone Number	DPO Fax Number	
DPO (or employer designee) Printed Name		Date of DPO (or employer designee) Signature	
DPO (or employer designee) Signature			
By signing this EC-1 form, I am attesting that this employee is eligible for EUTF benefits as per Chapter 87A, Hawaii Revised Statutes.			
Comments:			

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State of Hawaii

Department of Budget and Finance
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813