



Reference Guide For Active Employees

*Hawaii Employer-Union
Health Benefits Trust Fund*

Effective July 1, 2005

Reference Guide for Active Employees

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INTRODUCTION

This benefits booklet is designed to help public employees understand the benefit options available to them and assist public employees in enrolling or changing their enrollment in the benefit plans offered by the Hawaii Employer-Union Health Benefits Trust Fund (EUTF). This booklet will also be available at the EUTF's website, www.eutf.hawaii.gov, where you can easily access it when you have questions about your benefits.

2005 OPEN ENROLLMENT IS EASY!

The open enrollment period is April 18 through May 20, 2005. Each active employee should have received a pre-completed Open Enrollment Form for Active Employees (OE-1) that contains the information that EUTF had available as of the beginning of March 2005. Each employee is asked to review the information for accuracy of information and make any changes that are needed. You may cross out any information that should be deleted and print legibly any new information.

If you have no changes, you are done with open enrollment. You will be re-enrolled in the same plans and coverage that you currently have. Otherwise, return the changed and signed OE-1 by May 20, 2005 to your personnel office.

Rates

At the time this reference guide went to press, collective bargaining was not complete. When collective bargaining is complete you will be informed of the employee contribution required for each plan.

Plan Benefit Changes

HDS dental coverage will now include pulp vitality testing for emergency situations, as well as guided tissue regeneration, bone replacement grafts and soft tissue allografts for advanced periodontal disease. Titanium crowns, pontics, inlays and onlays, prefabricated steel crowns and procedures to construct new crowns under existing partial dentures are also now included. Age limits have also increased for some services, as shown in the benefit summary in this booklet.

Kaiser Permanente coverage is available to all Hawaii residents except for a few living on the southern tip of the island of Hawaii in zip codes 96718, 96772 and 96777. .

The plan now has an increased copayment of \$12 rather than \$10, is now offering some preventive screening services without a lab/x-ray copayment, and has changed the copayment structure for contraceptive drugs and devices to 50% of costs, rather than \$10 per 30-day supply.

In addition, billing charges for Kaiser services not paid on the date of service will increase to \$20 from \$15, and any outstanding balances over 60 days will be subject to a 12% simple interest charge.

Inpatient and outpatient chemical dependency benefits will be provided in accordance with state law, in which copayments and limits are the same as for any other physical disease or illness.

Long Term Care Insurance. The Long-Term Care plan, currently offered by Hartford Life Insurance, will no longer be offered to new applicants. Those individuals that are currently covered under the plan will continue to be covered and will continue to be billed for the premium. Your coverage is not being cancelled. The insurance company has the right to increase your premiums after January 1, 2006. They can only increase premiums if they are increased for all people covered by the plan.

OPEN ENROLLMENT ASSISTANCE

The EUTF will be contacting you to invite you to attend Open Enrollment informational sessions. **Please check our website, www.eutf.hawaii.gov, for the most current schedule.**

These meetings are offered so that you can meet with your insurance carriers to learn more about your EUTF benefit plans. The meetings will begin with a half-hour overview of the benefits. The remaining hour and a half is for you to meet with the insurance carriers and the EUTF staff. If you have questions regarding your pre-completed open enrollment form, please bring it with you.

Please note: Because there are minimal changes to the plans in 2005, the EUTF has not requested paid time off for employees to attend these meetings.

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for:

- ▶ Providing current and accurate personal information as prescribed in this booklet
- ▶ Paying the employee's premium contributions in the amount or amounts provided by statute, an

- ▶ applicable bargaining unit agreement, or by the applicable EUTF benefit plan;
- ▶ Paying the employee's premium contributions at the times and in the manner designated by the board; and
- ▶ Complying with the EUTF's rules.

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

- ▶ Providing information as requested by the EUTF under section 87A-24(9) of the Hawaii Revised Statutes;
- ▶ Paying the employer's premium contributions in the amount or amounts provided by statute or an applicable bargaining unit agreement and at the times and in the manner designated by the board;
- ▶ Assisting the EUTF in distributing information to and collecting information from the employee-beneficiaries; and
- ▶ Complying with the EUTF's rules.

Enforcement Actions of the EUTF

Verifications

The EUTF may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the dependent-beneficiary's enrollment shall be cancelled as set forth in the EUTF's Administrative Rules. The Administrative Rules are available at the EUTF website, www.eutf.hawaii.gov.

Contribution Shortages

A notice of contribution shortage shall be sent to an employee-beneficiary at his or her last known address if any portion of the employee-beneficiary's required semi-monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the EUTF. The notice shall be sent within fifteen days of the date on which the required semi-monthly contribution payment was due. The notice shall require the employee-beneficiary to make full payment of the contribution shortage prior to the last day of the second pay period immediately following the date that the required semi-monthly contribution payment was due.

Regardless of whether or not the notice of contribution shortage is received by the employee-beneficiary, if the employee-beneficiary fails to make full payment by the last day of the second pay period immediately following the date that the required semi-monthly contribution

payment was due, the employee-beneficiary's enrollment in the benefit plans offered or sponsored by the EUTF and all coverages for dependent-beneficiaries under such enrollment shall be canceled as set forth in Rule 4.12(c).

Cancellation of an employee-beneficiary's coverage pursuant to this rule shall not affect the EUTF's right to collect any and all contribution shortages from the employee-beneficiary.

Other Actions

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

Active Employee Eligibility

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

Health Plans

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

- ▶ An employee, including an elective officer of the State, county or legislature
- ▶ A retired employee
- ▶ Surviving spouse of an employee killed in performance of duty, spouse does not remarry
- ▶ Surviving spouse of a retired employee, spouse does not remarry
- ▶ Unmarried child of an employee killed in performance of duty providing child is under age 19 and has no surviving parent
- ▶ Unmarried child of retiree and under age 19 with no surviving parent

Please note: Surviving spouse coverage does not extend to domestic partners.

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

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

Group Life Insurance

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

Special Eligibility Requirements

Student

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

Domestic Partner

Person in a spouse-like relationship with an employee-beneficiary who meets the following requirements:

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

8. Both sign and file a declaration of domestic partnership (affidavit) to the EUTF

If your domestic partner does not qualify as your dependent for tax purposes, a portion of the premium paid for your domestic partner will be deemed taxable income and reported to you on your W-2. This income is subject to normal payroll taxes. Consult your tax advisor to determine your domestic partner's status. If you determine that your domestic partner is a dependent, submit a completed Affidavit of "Dependency" for Tax Purposes (available on the EUTF website, www.eutf.hawaii.gov) to the EUTF. Please refer to the website for detailed information and instructions.

Enrollment

During Open Enrollment 2005, **you need only return your pre-completed OE-1 form if you are making changes.** Subsequently, those who become eligible must complete an EUTF Enrollment Form for Active Employees (EC-1).

If you do not enroll all eligible members of your family within 30 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods generally occur once a year, usually two to three months prior to July 1. Coverage dates for all plans begin July 1 and end June 30 of the following year.

ID Cards

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

- ▶ HMSA and HDS will issue two identical ID cards showing the name of the subscriber.
- ▶ Kaiser issues an ID card for each enrolled member of a family upon initial enrollment.
- ▶ VSP, Mutual Benefit Association of Hawaii (provider of ChiroPlan) and Royal State do not issue ID cards.

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

Dual Enrollment Is Not Allowed

Dual enrollment is not allowed under the EUTF rules. If both you and your spouse are employees of the State or a county, one of you may only enroll in a Family plan, or if no other dependents are involved, both enroll in a Self plan. If your spouse has coverage outside of the EUTF that provides a family coverage, this rule does not preclude you from also enrolling in a

family coverage plan to cover your spouse. The dual enrollment rule does not apply if your other coverage is not provided by the EUTF.

Medicare Part B Reimbursement

Anyone enrolled in an active employee medical plan that is also enrolled in Medicare Part B does not receive reimbursement from the EUTF for their premiums. Only retirees and their spouses, who are enrolled in an EUTF retiree medical plan, are eligible for the Part B reimbursement. If you are an active employee and enrolled in Medicare Part B but covered by the EUTF retiree plan through your spouse, your spouse is entitled to Medicare Part B reimbursement for you. Domestic partners of retirees are not eligible for Part B reimbursement.

Change of Coverage

To change your coverage, you should contact your human resource representative and complete an EC-1 form. You are eligible to change your coverage outside the Open Enrollment period only under the following circumstances:

1. You marry and want to enroll your spouse and newly eligible dependent children.
2. You need to enroll a newborn or newly adopted child. In order to add a newly adopted child to your coverage, you must provide court documents verifying the adoption in order to have the application accepted.
3. You have a change in family status involving the loss of eligibility of a family member (e.g., separation, divorce, death, child marries, no longer lives with you, or turns age 19 or 24 for student).
4. Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
5. You move out of your plan's service area.

Effective Dates of Coverage

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

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

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

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

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

Transfer of Employment

If you transfer from one EUTF employer to another, including transfers within State and/or County employment, coverage will be continued provided that you are still covered by the EUTF (COBRA coverage excluded) when you begin in your new position. If you transfer employment within 90 calendar days of the last day of employment with the previous employer, you will not be subject to sections 87A-35 and 87A-36, Hawaii Revised Statutes. These paragraphs define the manner in which an employee's years of service are to be computed to determine the employer contributions for retiree benefits.

End of Coverage

Coverage for you and your dependents will end if:

1. You voluntarily terminate coverage.
2. Your employment terminates.
3. Your hours are reduced so you no longer qualify for coverage.
4. You do not make required premium payments.
5. You die except for certain exceptions.
6. Your employer ceases to participate in the EUTF.
7. The EUTF is discontinued.

Coverage for your dependents will end if:

1. Your dependent is no longer eligible for coverage.
2. Your enrolled dependent enters the uniformed services.

Effective Date of Termination

In general, coverage ends on the first day of the pay period after the event giving rise to the end of coverage. There may be certain instances in which the effective date is different such as a divorce, when coverage ends on the date the EUTF receives notification of the divorce. You may obtain additional information from your DPO or by referring to the EUTF Administrative Rules that are posted on the EUTF website, www.eutf.hawaii.gov.

Enrollment in EUTF benefit plans is contingent on meeting all eligibility criteria outlined on the previous pages and detailed in the Administrative Rules. Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

An enrollment application shall be rejected if:

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

Employee-beneficiaries will be notified of the rejection of any enrollment application.

Administrative Appeals

A person aggrieved by one of the following decisions by the EUTF may appeal to the board for relief from that decision:

1. A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the EUTF;

2. A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
3. A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF; or
4. A refusal to reinstate the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the EUTF.

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

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

If the aggrieved person is dissatisfied with the administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety days of its being filed in the EUTF's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the board. A written appeal to the board must be filed in duplicate in the EUTF's office. The written appeal need not be in any particular form but shall contain the following information:

1. The aggrieved person's name, address and telephone number;
2. A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;
3. A description of the decision with respect to which relief is requested, including, the date of the decision;

4. A complete statement of the relevant and material facts;
5. A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
6. A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

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

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

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

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

State of Hawaii Employees Only

By electing to participate in the Premium Conversion Plan (PCP), please note that:

1. Your authorization will automatically continue year-to-year for the duration of the plan until you change or cancel your participation in the PCP during the Open Enrollment period or as provided under number 2 below.
2. If you have an allowable change in status (marriage, birth or adoption of children, divorce, etc.), you must complete/file all the required PCP forms within 90 days of the event, to change or cancel your reduction in pay (otherwise, changes can be made only during the Open Enrollment

3. period). Please note that you must notify the EUTF within 30 days of the event in order to make the change in coverage.
4. Allowable changes/cancellations will generally take effect the month after you file, so to avoid the risk of losing money, you need to file the forms as soon as possible. Changes in pre-tax payroll deductions are always done after receipt of the PCP-2 form; never retroactively.
5. Your election, in the absence of an allowable change in status, cannot be changed for the current plan year.
6. If you change/cancel your health insurance plan coverage, but your PCP change/cancellation is not allowable, your PCP authorization will still remain in effect through the end of the plan year, and your payments will be forfeited, until PCP change/cancellation forms are filed and approved during the next Open Enrollment period.

EC-1

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

1. Event:
2. Event Date: (MM/DD/YY)

See Instructions on reverse side BEFORE completing this form. Refer to your reference guide or our website for plan details.

3a. Employee's Last Name, First, M.I.
3b. Social Security Number
3c. Mailing Address:
3d. City:
3e. Zip Code:
3f. Marital Status:
3g. Birth Date: (MM/DD/YY)
3h. Gender:
3i. Phone Number - Work
3j. Phone Number - Home
4. Social Security Number of Spouse or Domestic Partner
4a. State or County - Employee or Retiree
4b. Other - Private, Federal ,etc.

Sample Only

Table with 8 columns: 5a. Add, 5b. Delete, 6a. Dependents: First Name, M.I., Last Name (if different), 6b. Birth Date (MM/DD/YY), 6c. Social Security Number, 7. Relationship, 8. Gender. Contains 5 rows of dependent information.

9. Plan Selections, Changes or Cancellations - Make your selection by checking the box for the appropriate benefit plans below. Select either Self, Family or Cancel/Waive coverage. Choose only one box in each plan section.

Table for Plan Selections with columns: Plan Section, Carrier Selection, Self, Family, Cancel/Waive. Rows include Medical/Drug, Chiropractic; Dental; Vision; and AETNA Life Insurance Plan.

10. State Employees ONLY (Premium Conversion Plan) [] Enroll [] Do NOT Enroll [] Change amount [] Cancel PCP

11. Comments:

12. Certification (see instructions on back of this form)

Employee Signature: _____ Date: _____

13. DPO Signature: _____ Date: _____ DPO Phone: _____ DPO FAX: _____

14. Dept. ID# _____ 15a. Dept: _____ 15b. Division/School: _____ 16. Barg. Unit: _____

Sample Only

EC1

SUBMIT TO YOUR PERSONNEL OFFICE

Medical - PPO Plan



This summary is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Guide to Benefits, which may be obtained by calling HMSA or from the EUTF website, www.eutf.hawaii.gov, for complete information on benefits and provisions. In the case of a discrepancy between this comparison and the language contained within the Guide to Benefits, the latter will take precedence.

If you have questions, please contact HMSA at any of the following locations:

Oah	818 Keeaumoku Street Honolulu, HI 96814 Phone: (808) 948-6499	Hawaii	670 Ponahawai Street, Suite Hilo, HI 96720 Phone: (808) 935-5441	75-1029 Henry St., Suite 301 Kailua-Kona, HI 96740 Phone: (808) 329-5291
Kauai	4366 Kukui grove Street, Suite 103 Lihue, HI 96766 Phone: (808) 245-3393	Maui	33 Lono Avenue, Suite 350 Kahului, HI 96732 Phone: (808) 871-6295	

All member copayments shown are based on the eligible charge. The eligible charge is the amount that HMSA's participating providers have agreed to accept as payment in full for services rendered. Services received from a non-participating provider will likely result in significantly higher out-of-pocket expenses since the member is responsible for any difference between HMSA's eligible charge and the nonparticipating provider's actual charge.

Lifetime Maximum	\$2,000,000	
Maximum Annual Co-payment	\$1,500 per person	\$4,500 per family
Annual Deductible (nonparticipating providers only)	None	\$100 per person/\$300 per family
	Member Copayment	
	Participating Provider	Nonparticipating Provider Copayment amount after annual deductible met where noted (*)
Physician Services		
Physician Visits, Well Woman, Surgical Services, Maternity Care	10% of Eligible Charges	30% of Eligible Charges*
Well Child Care Exams—Limitations apply	None	30% of Eligible Charges
Immunizations including Hepatitis B	None	None
Testing, Laboratory and Radiology—Outpatient ⁽¹⁾		
Allergy Test, Diagnostic Test and Radiology, Tuberculin Skin Test, Pap Smear, PSA, RSVP Screening	10% of Eligible Charges	30% of Eligible Charges*
Screening Mammography	10% of Eligible Charges	30% of Eligible Charges

Note: ⁽¹⁾ HMSA may contract with certain laboratory and radiology groups to accept HMSA's payment as payment in full. Members may not have a copayment for services received as part of these types of contractual arrangements.

Medical - PPO Plan Continued



	Member Copayment	
	Participating Provider	Nonparticipating Provider
Organ and Tissue Transplants		
Corneal, Kindey, Small Bowel, Small Bowel/Liver Transplants	10% of Eligible Charges	30% of Eligible Charges*
Bone Marrow, Heart, Heart/Lung, Liver, Lung, Kidney/Pancreas Transplants or Transplant Evaluation ⁽²⁾	None	Not Covered
Note: ⁽²⁾ HMSA has contracted with certain providers for specific transplant services. You must receive services from a contracted provider for this benefit to apply.		
Chemotherapy and Radiation Therapy--Outpatient		
Chemotherapy, Radiation Therapy	10% of Eligible Charges	30% of Eligible Charges*
Hospital and Facility Services		
Emergency Room	10% of Eligible Charges	10% of Eligible Charges
Hospital Room, Skilled Nursing Facility, Ambulatory Surgical Center	10% of Eligible Charges	30% of Eligible Charges*
Behavioral Health - Mental Health ⁽³⁾ and Substance Abuse		
Inpatient Hospital/Facility Services, Physician Services	Regular Plan Benefits	Regular Plan Benefits
Psychological Testing – Inpatient or Outpatient	10% of Eligible Charges	30% of Eligible Charges*
Note: ⁽³⁾ Mental health benefits are limited to 30 inpatient days and 24 outpatient visits per calendar year. Limitations do not apply to serious mental illnesses in accord with Hawaii law. There is no limit for substance		
Special Benefits for Homebound, Terminal, or Long-term Care		
Home Health Care	None	30% of Eligible Charges*
Hospice Services	None	Not Covered
Other Medical Services and Supplies		
Ambulance, Appliances/Equipment, Blood, Dialysis, Injections, Physical Therapy, Occupational Therapy, or Speech Therapy	10% of Eligible Charges	30% of Eligible Charges*
Medical Foods	10% of Eligible Charges	20% of Eligible Charges
Special Benefits for Health Assessment, Health Education, and Disease Management		
HealthPass, Disease Management Programs, Health Appraisal ⁽⁴⁾	None	Not Covered
Physical Exam ⁽⁴⁾	Any amount exceeding HMSA's allowance of up to \$41.50 ages 6 – 12 years \$62 ages 13 – 18 years \$113.50 ages 19 – 39 years \$170.00 ages over 40 years	

Note: ⁽⁴⁾ Coverage includes benefits for either one Health Appraisal Program or one Physical Exam per calendar year.

Medical - PPO Plan Prescription Benefits



Prescription Drug-Only Plan Benefits

BENEFITS	MEMBER PAYS	
	Participating Pharmacy	Nonparticipating Pharmacy
RETAIL PRESCRIPTION PROGRAM (30 day supply)		
Generic	\$5 copayment	\$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Preferred Brand Name	\$15 copayment	\$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Brand Name	\$30 copayment	\$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Insulin		
Preferred Insulin	\$5 copayment	\$5 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Other Insulin	\$15 copayment	\$15 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	No copayment
Other Diabetic Supplies	\$15 copayment	\$15 copayment
Oral Contraceptives		
Preferred Oral Contraceptives	\$5 copayment	\$8 copayment
Other Oral Contraceptives (including generic contraceptives)	\$30 copayment	\$30 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
Diaphragms		
Preferred Diaphragms	\$10 copayment	\$12 copayment
Other Diaphragms	\$20 copayment	\$20 copayment, plus any charges exceeding HMSA's payment of 80% of Eligible Charge
MAIL ORDER PRESCRIPTION PROGRAM (90 day supply)	HMSA Vendor	Non-HMSA Vendor
Generic	\$10 copayment	Not a benefit
Preferred Brand Name	\$35 copayment	Not a benefit
Other Brand Name	\$60 copayment	Not a benefit
Insulin		
Preferred Insulin	\$10 copayment	Not a benefit
Other Insulin	\$35 copayment	Not a benefit
Diabetic Supplies		
Preferred Diabetic Supplies	No copayment	Not a benefit
Other Diabetic Supplies	\$35 copayment	Not a benefit

Medical - HMO Plan



This is only a summary. It does not fully describe your benefit coverage. For details on your benefit coverage, exclusions, and plan terms, please refer to your employer's applicable Face Sheet, Group Medical and Hospital Service Agreement, Benefit Schedule, and Riders (collectively known as "Service Agreement"). The Service Agreement is the legal binding document between Health Plan and its members.

You are covered for medically necessary services, within the Hawaii service area, at Kaiser Permanente facilities, and which are provided or arranged by a Kaiser Permanente physician. All care and services need to be coordinated by a Kaiser Permanente physician. For specific questions about coverage, please call the Customer Service Center at (808) 432-5955 (Oahu) or 1-(800) 966-5955 (Neighbor Islands). You may also obtain information from the Kaiser website, www.kaiserpermanente.org.

Except for certain situations outlined in the Service Agreement, all claims, disputes, or causes of action arising out of or related to the 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 causes of action subject to binding arbitration, all parties give up the right to jury or court trial. For a complete description of arbitration information, please see the Service Agreement.

Benefits		You pay
	Deductible	None
	Lifetime Maximum	None
	Annual supplemental charges maximum per calendar year	\$1,500 per member \$4,500 per family unit (3 or more members)
Preventive services	Well-baby visits	\$12 office visit copayment per visit
	Immunizations	No charge for most immunizations (some have a 50% copayment)
	Physicals, routine and school	\$12 office visit copayment per visit
Outpatient services	Office visits, doctors' & other health professionals'	\$12 office visit copayment per visit
	Laboratory procedures, prescribed imaging, and diagnostic services	No charge
	Outpatient surgery and procedures	\$12 office visit copayment per visit
	Routine obstetrical care (prenatal, delivery, and mother's care in the hospital following delivery)	No charge upon confirmation of pregnancy
	Abortions, elective or medically indicated	\$12 per visit (elective abortions limited to two per lifetime)
	Administered drugs	No charge for most drugs that require skilled administration by medical personnel. Members must pay their office visit charge for the visit.
	FDA-Approved contraceptive drugs and services	50% of applicable charges

Medical - HMO Plan Continued



Benefits		You pay
Inpatient services	Hospital (room and board)	No charge
	Doctors' medical and surgical services	No charge
	Anesthesia services	No charge
	Lab, X-ray, and diagnostic testing	No charge
	Administered drugs	No charge for most drugs administered during a covered hospital stay
	Skilled nursing care	No charge up to 100 days per benefit period
Mental health services (B rider)	Outpatient up to 24 visits/calendar year	\$12 office visit copayment per visit
	Inpatient up to 30 days/calendar year	No charge
Chemical dependency services	Outpatient	\$12 office visit copayment per visit
	Inpatient	No charge
Emergency services (for initial treatment only) & ambulance services	At a facility <u>within</u> the Hawaii service area	\$25 per visit, plus other applicable plan charges
	At a facility <u>outside</u> the Hawaii service area	20% of R & C*, plus other applicable plan charges
	Ambulance services	20% of R & C*, plus other applicable plan charges
Additional Services	Prescription drugs – drug 10	\$10 for each prescription not exceeding a 30 consecutive day supply (excludes contraceptive drugs and devices)
	Prescription drug mail order incentive	Members may purchase mail order refills for most maintenance drugs for a 90 consecutive day supply upon payment of two drug copayments. The mail order program does not apply to certain drugs and mailing is limited to addresses inside the State of Hawaii.
Internal/ External prosthesis	Durable medical equipment	20% of applicable charges

You must retain your receipts for the charges you have paid, and when the maximum amount has been PAID, you must present these receipts to our Business Office at Moanalua Medical Center, Honolulu Clinic or to the cashier at other clinics. After verification that the Supplemental Charges Maximum has been PAID, you will be given a card which indicates that no additional Supplemental Charges for covered Basic Health Services will be collected for the remainder of the calendar year. You need to show this card at your visits to get your Supplemental Charges waived.

All payments are credited toward the calendar year in which the services were received.

Once you have met the Supplemental Charges Maximum, please submit your proof of payment as soon as reasonably possible. All receipts must be submitted no later than February 28 of the year following the one in which the services were received.

Dual-Coverage Medical Benefits

Active Employees who have medical coverage through private sector or federal government plans have the option to select a dual-coverage medical plan as a supplement. Active employees have a choice between dual-coverage benefits offered by HMSA and the Royal State National Insurance Company Limited. Summaries of the benefits offered by each carrier follow.

HMSA Dual-Coverage Medical and Prescription Benefits



This summary is intended to provide a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Guide to Benefits, which may be obtained by calling HMSA or from the EUTF website, www.eutf.hawaii.gov, for complete information on benefits and provisions. In the case of a discrepancy between this comparison and the language contained within the Guide to Benefits, the latter will take precedence.

If you have questions, please contact HMSA at any of the following locations:

Oahu	818 Keeaumoku Street Honolulu, HI 96814 Phone: (808) 948-6499	Hawaii	670 Ponahawai Street, Suite 121 Hilo, HI 96720 Phone: (808) 935-5441	75-1029 Henry St., Suite 301 Kailua-Kona, HI 96740 Phone: (808) 329-5291
Kauai	4366 Kukui grove Street, Suite 103 Lihue, HI 96766 Phone: (808) 245-3393	Maui	33 Lono Avenue, Suite 350 Kahului, HI 96732 Phone: (808) 871-6295	

All member copayments shown are based on the eligible charge. The eligible charge is the amount that HMSA's participating providers have agreed to accept as payment in full for services rendered. Services received from a non-participating provider will likely result in significantly higher out-of-pocket expenses since the member is responsible for any difference between HMSA's eligible charge and the nonparticipating provider's actual charge.

Lifetime Maximum	\$1,000,000	
Maximum Annual Co-payment	\$10,000 per person	
	Member Copayment	
	Participating Provider	Nonparticipating Provider
Physician Services		
Physician Visits, Surgical Services, Maternity Care	50% of Eligible Charges	50% of Eligible Charges
Well Woman, Well Child Care Exams—Limitations apply	None	50% of Eligible Charges
Immunizations (Standard)	50% of Eligible Charges	50% of Eligible Charges
Immunizations (Well Child Care)	None	None
Testing, Laboratory and Radiology—Outpatient ⁽¹⁾		
Allergy Test, Diagnostic Test and Radiology, Tuberculin Skin Test	50% of Eligible Charges	50% of Eligible Charges

HMSA Dual-Coverage Medical and Prescription Benefits



	Member Copayment	
	Participating Provider	Nonparticipating Provider
Screening Mammography, Pap Smear, PSA, RSVP Screening	None	50% of Eligible Charges
Note: ⁽¹⁾ HMSA may contract with certain laboratory and radiology groups to accept HMSA's payment as payment in full. Members may not have a copayment for services received as part of these types of contractual arrangements.		
Organ and Tissue Transplants		
Corneal, Kidney, Small Bowel, Small Bowel/Liver Transplants	50% of Eligible Charges	50% of Eligible Charges
Bone Marrow, Heart, Heart/Lung, Liver, Lung, Kidney/Pancreas Transplants or Transplant Evaluation ⁽²⁾	None	Not Covered
Note: ⁽²⁾ HMSA has contracted with certain providers for specific transplant services. You must receive services from a contracted provider for this benefit to apply.		
Chemotherapy and Radiation Therapy--Outpatient		
Chemotherapy, Radiation Therapy	50% of Eligible Charges	50% of Eligible Charges
Hospital and Facility Services		
Emergency Room	50% of Eligible Charges	50% of Eligible Charges
Hospital Room, Skilled Nursing Facility, Ambulatory Surgical Center	50% of Eligible Charges	50% of Eligible Charges
Behavioral Health - Mental Health ⁽³⁾ and Substance Abuse		
Inpatient Hospital/Facility Services, Physician Services	Regular Plan Benefits	Regular Plan Benefits
Psychological Testing – Inpatient or Outpatient	50% of Eligible Charges	50% of Eligible Charges
Note: ⁽³⁾ Mental health benefits are limited to 30 inpatient days and 24 outpatient visits per calendar year. Limitations do not apply to serious mental illnesses in accord with Hawaii law. There is no limit for substance abuse services.		
Special Benefits for Homebound, Terminal, or Long-term Care		
Home Health Care	50% of Eligible Charges	50% of Eligible Charges
Hospice Services	None	Not Covered
Other Medical Services and Supplies		
Ambulance, Appliances/Equipment, Blood, Dialysis, Injections, Physical Therapy, Occupational Therapy, or Speech Therapy	50% of Eligible Charges	50% of Eligible Charges
Medical Foods	20% of Eligible Charges	20% of Eligible Charges
Special Benefits for Health Assessment, Health Education, and Disease Management		
HealthPass, Disease Management Programs, Health Appraisal ⁽⁴⁾	None	Not Covered

HMSA Dual-Coverage Prescription Benefits



The following summarizes HMSA’s dual coverage prescription drug benefits.

Benefits	Member Pays	
	Participating Pharmacy	Nonparticipating Pharmacy
Retail Pharmacy (30 day supply)		
Retail Pharmacy—Generic, Brand Name, Insulin, Diabetic Supplies, oral Contraceptives, diaphragms	Eligible charges exceeding plan payment of up to \$15	All charges exceeding plan payment of up to \$15
Mail Order Prescription Program (90 day supply)		
Mail-Order program—Generic, Brand Name, Insulin, Diabetic Supplies	Eligible charges exceeding plan payment of up to \$30	Not Covered

Royal State National Insurance Company, Limited Dual Coverage Benefits

The Royal State National dual-coverage benefits plan reimburses the member’s out-of-pocket costs paid for medical care up to the maximum amount per month shown below. Medical care means the diagnosis, cure, mitigation, treatment or prevention of disease, prescribed drugs, and treatments affecting any part or function of the body. Medical care must be primarily to alleviate or prevent a physical or mental defect or illness, and includes limited amounts paid for transportation to get medical care. Only expenses for medical care, which the member has paid, and which costs are not recoverable from any other person including any insurance policy, are eligible for reimbursement under the Royal State National dual-coverage benefits plan.

This summary describes plan highlights only. Please refer to Plan Certificate and Master Policy for benefit details, limitations and exclusions.

Plan Provisions	
Annual Deductible	Not Applicable
Annual Copayment Maximum	Not Applicable
Maximum Reimbursement Per Month	
Bargaining Units 01, 10, 20, 33, 61, 70 & 90	
Single Coverage	\$138.00*
Family Coverage	\$329.00*
*Benefit amount may change based on collective bargaining agreements.	
All Other Bargaining Units	
Single Coverage	\$40.00
Family Coverage	\$125.00

Medical Care Expenses Eligible for Reimbursement		
Acupuncture	Drug addiction treatment	Massage therapy
Ambulance	Eyeglasses	Medical services
Appliances/medical equipment	Eye surgery	Nutritional supplements
Birth control pills	Fertility enhancement	Prescription drugs
Chiropractic care	Hospital services	Surgical services
Contact lenses	Laboratory and x-ray	Weight-loss program
Dental services	Learning disabilities	

Carry forward Benefit. The maximum reimbursement amount is per month as described above. If the out-of-pocket expenses for medical care are less than the monthly maximum amount, the unused benefit amount will be carried forward to future (subsequent) months, but no further than to the end of the plan year (June 30) or the date the dual-coverage plan is terminated, whichever is earlier. If the member's out-of-pocket expenses for medical care are greater than the monthly maximum amount, additional reimbursement for the same out-of-pocket medical care expenses may be paid in future (subsequent) months, but no more will be paid than the allowable monthly maximum amount, and no further than to the end of the plan year (June 30) or the date the dual-coverage plan is terminated, whichever is earlier.

Claim Submission Requirements

1. You are responsible to collect and keep all receipts or statements that show that you have paid out-of-pocket medical care expenses incurred during the plan year.
2. You must fill out a claim form approved by Royal State National and attach copy of all receipts or statements as proof of your out-of-pocket paid expenses. The dates of service must be clearly itemized with your out-of-pocket expense indicated. Your reimbursement is based on the date of service, not when the service was paid for. For additional rules and requirements, you must follow the Company's claim form instructions.
3. All services for out-of-pocket reimbursement must be received or incurred during the plan year.
4. Royal State National must receive your claim by the last day of a month in order to be processed for that month. If your claim is received after the last day of the month, your claim will be processed the following month.

Timely Submission of Claims Royal State National must receive your claims before the end of the 90-day period after the end of the plan year or after your termination date, whichever is earlier. The Plan will not pay any claims received after this 90-day period.

Payment of Benefits Approved claims shall be paid on monthly basis and after the close of the month. All reimbursement payments are payable directly to you.

Plan Certificate and Claim Forms. The Company will mail you your plan certificate and claim form within 15 business days from the date the Company receives your enrollment information from the Hawaii Employer-Union Health Benefits Trust Fund. A new claim form will be enclosed with every reimbursement benefit payment to you. For additional claim forms or questions, please contact Royal State National at (808) 539-1621 or toll free 1-800-890-9022.

This summary is intended to provide a condensed explanation of plan benefits. Please refer to the respective plan brochures and certificates for complete information on benefits, provisions, limitations or exclusions. In the case of a discrepancy between these descriptions or comparisons and the language contained within the respective plan certificates, the latter will govern.

Mutual Benefit Association of Hawaii



ChiroPlan Chiropractic Coverage

Mutual Benefit Association of Hawaii, through ChiroPlan Hawaii, Inc. is the provider of chiropractic benefits. The plan description provided in this summary of benefits shows highlights of the plan benefits. Please refer to the plan certificate for complete information on benefits, provisions, limitations and exclusions. In the errant case of a discrepancy between these descriptions and the provisions contained in the plan certificate, the latter will govern. A complete list of ChiroPlan doctors and plan information may be obtained from the EUTF website, www.eutf.hawaii.gov.

All three of the medical plan options (PPO, HMO or dual-coverage) described on the previous pages include these chiropractic benefits. In order to use these benefits you must use ChiroPlan doctors. ChiroPlan may be contacted at:

ChiroPlan Hawaii, Inc.
 711 Kilani Avenue, Suite 3
 Wahiawa, HI 96786
 Telephone: 808-621-4774
 Toll-free: 800-414-8845 (Neighbor Islands)
 Fax: 808-621-0006
 Website: www.chiroplanhawaii.com

	ChiroPlan Provider	Non-ChiroPlan Provider
Maximum # of Office Visits Per Year	20	Not Covered
Office Visit Copay	\$15.00	Not Covered
Therapy Modalities*	No Charge	Not Covered
X-Ray**	No Charge	Not Covered
Lab	Not Covered	Not Covered
Chiropractic Appliances	Not Covered	Not Covered
Emergency/Urgent Care	Not Covered	Not Covered
Out-of-Network	Not Covered	Not Covered
Alternative Medical Services***	Not Covered	Not Covered

* Therapy Modalities Include: Ultrasound, Ice Packs, Heat Packs, Electrical Muscle Stimulation and other approved therapies.

** Routine x-rays: Two (2) views per body region, per calendar year (when performed in a ChiroPlan doctor's office).

*** Alternative Medical Services Includes: Hypnotherapy, Acupuncture, Behavior Training, Sleep Therapy, etc.

HDS Dental Plan



Summarized below are the dental benefits provided through Hawaii Dental Service (HDS). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or the HDS Customer Service Department at (808) 529-9248 or toll-free from the neighbor islands and continental U.S. at 1-800-232-2533 extension 248. You may also obtain information from the HDS website, www.deltadentalhi.org.

Benefit	Plan Coverage
Maximum Benefit Amount Per Calendar Year	\$2,000/ person
Deductible Per Calendar Year (does not apply to benefits covered at 100%)	\$25/ person
Diagnostic	
Examinations (twice per calendar year)	100%
Bitewing x-rays (twice per calendar year)	100%
Other x-rays (full mouth x-rays limited to once every three years)	100%
Preventive	
Prophylaxes (cleanings - twice per calendar year)	100%
Stannous fluoride (once per calendar year through age 19)	100%
Space maintainers (through age 17)	100%
Sealants (through age 18)	100%
One treatment application, once per lifetime only to permanent posterior molar teeth with no cavities and no occlusal restorations, regardless of the number of surfaces involved.	
Restorative	
Amalgam (silver-colored) fillings	80%
Composite (white-colored) fillings, limited to anterior (front) teeth	80%
Note: Composite restorations on posterior (back) teeth will be processed as the alternate benefit of an amalgam and the patient will be responsible for the cost difference up to the dentist's charged fee.	
Crowns and Gold Restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings)	60%
Note: Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent and the patient will be responsible for the cost difference up to the dentist's charged fee.	
Endodontics	
Pulpal Therapy	80%
Root canal treatment, retreatment, apexification, apicoectomy	80%
Periodontics	
Periodontal scaling and root planing – once every two years	80%
Gingivectomy, flap curettage and osseous surgery - - once every three years	80%
Periodontal maintenance – twice per calendar year	80%
Prosthetics	
Fixed Bridges (once every 5 years; ages 16 and older)	60%
Removable dentures (complete & partial – once every 5 years; ages 16 & older)	60%
Repairs, adjustments, relines and rebase	60%
Oral Surgery	
Extractions and other oral surgery procedures to supplement medical care plan	80%
Adjunctive General Services	
Consultations by Specialist not performing services	80%
Office visits (injury related)	80%
Sedation General and IV – Oral Surgery Only	80%
Palliative (Emergency) treatment (for relief of pain but not to cure)	100%

HDS Dental Plan continued

Benefit	Plan Coverage
<p>Orthodontics</p> <p>Maximum amount payable by HDS for an eligible patient shall be \$1,000 lifetime per case paid in 8 quarterly payments of \$125. If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue. If the group removes the orthodontic benefit, coverage will end on the last day of the benefit change month.</p>	<p>50%</p>

Shaded areas indicate coverage after 12 months of continuous enrollment.

Benefit Exclusions

Your HDS plan does not cover the following services:

- Services for injuries and conditions that are covered under Workers' Compensation or Employer's Liability Laws; services provided by any federal or state government agency or those provided without cost to the eligible person by the government or any agency or instrumentality of the government.
- Congenital malformations, medically related problems, cosmetic surgery or dentistry for cosmetic reasons.
- Procedures, appliances or restorations other than those for replacement of structure loss from cavities that are necessary to alter, restore or maintain occlusion.
- Vertical dimension, occlusal adjustment, equilibration, periodontal splinting, restoration of tooth structure lost from wearing away, restoration for tooth malalignment, jaw movement recordings and treatment of disturbances of the temporomandibular joint (TMJ).
- Orthodontic services if services were started prior to the date the patient became eligible under this group plan.
- Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to subscriber by a dentist.
- All other services not specified in the Schedule of Benefits, which is available from your employer.

Multi-state Coverage

If you or your family reside or travel outside Hawaii and need dental care, your HDS plan will provide you coverage. HDS is a member of Delta Dental Plans Association, the largest dental benefits provider in the nation. So if your job takes you out of state or your son or daughter attends school on the Mainland, the charges of participating dentists would be capped by their respective state's eligible fees for covered services.

While on the Mainland, you can maximize your benefits by selecting a dentist who participates with Delta Dental. To obtain a list of participating Delta dentists in that zip code, visit the Delta Dental web site at www.deltadental.com and use the 'Dentist Search' capability. Or you may call our Customer Service Department toll-free at (800) 232-2533 ext. 248 and we will send you a list of participating dentists in your area.

Visiting a Participating Delta Dentist

If the dentist you have selected is a participating HDS or Delta (on the Mainland) dentist, he/she will submit the claim directly to HDS for you. Be sure he/she obtains HDS's mailing address from the back of your member identification card. HDS's payment will be based upon the participating dentist's eligible fees in his/her state. (HDS uses the National Provider File to obtain these fees.) Your share will be limited to the difference between the participating dentist's eligible fee and HDS's payment amount.

Visiting a Non-Participating Dentist

When you visit a non-participating dentist, in most cases you will need to pay in full at the time of service. On your first visit to a non-participating dentist, advise the dentist that you have an HDS dental plan and present your HDS member identification card. Your dentist will render services and may send you the completed claim form (universal ADA claim form) to file with HDS. Mail the completed claim form to the following address for processing:

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

HDS will pay for services rendered up to your benefits coverage amount. Please be aware that your non-participating dentist's fees may be higher than a participating dentist's fees, and the fees used to calculate your benefit are lower than participating dentists' eligible fees. You are responsible for the difference between your non-participating dentist's fees and HDS's payment amount.

Dual Coverage Dental Plan

As with the medical plan, you have the option to elect the Dual Coverage Dental plan if you have primary dental coverage from the private sector or federal government. This plan is also offered by HDS. Please refer to page 25 for contact information for HDS.

Benefit	Plan Coverage
Maximum Benefit Amount Per Calendar Year	\$800/ person
Diagnostic Examinations (twice per calendar year) Bitewing x-rays (twice per calendar year) Other x-rays (full mouth x-rays limited to once every three years)	50% 50% 50%
Preventive Prophylaxes (cleanings - twice per calendar year) Stannous fluoride (once per calendar year through age 19) Space maintainers (through age 17) Sealants (through age 18) One treatment application, once per lifetime only to permanent posterior molar teeth with no cavities and no occlusal restorations, regardless of the number of surfaces involved.	50% 50% 50% 50%
Restorative Amalgam (silver-colored) fillings Composite (white-colored) fillings, limited to anterior (front) teeth Note: Composite restorations on posterior (back) teeth will be processed as the alternate benefit of an amalgam and the patient will be responsible for the cost difference up to the dentist's charged fee. Crowns and Gold Restorations (once every 5 years when teeth cannot be restored with amalgam or composite fillings) Note: Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent and the patient will be responsible for the cost difference up to the dentist's charged fee.	40% 40% 30%
Endodontics Pulpal Therapy Root canal treatment, retreatment, apexification, apicoectomy	40% 40%
Periodontics Periodontal scaling and root planing – once every two years Gingivectomy, flap curettage and osseous surgery - - once every three years Periodontal maintenance – twice per calendar year	40% 40% 40%
Prosthodontics Fixed Bridges (once every 5 years; ages 16 and older) Removable dentures (complete & partial – once every 5 years; ages 16 & older) Repairs, adjustments, relines and rebase	30% 30% 30%
Oral Surgery Extractions and other oral surgery procedures to supplement medical care plan	40%
Adjunctive General Services Consultations by Specialist not performing services Office visits (injury related) Sedation General and IV – Oral Surgery Only Palliative (Emergency) treatment (for relief of pain but not to cure)	40% 40% 40% 50%

VSP Vision Plan



Summarized below are the vision benefits provided through Vision Service Plan (VSP). For a full description of the benefits and how to access them, refer to the EUTF website, www.eutf.hawaii.gov, or call VSP's Customer Service Department, Hawaii Office: 808-532-1600 or toll-free from the neighbor islands at 800-522-5162; Customer Call Center (mainland US): 800-877-7195. You may also obtain information from the VSP website, www.vsp.com.

	<i>VSP Doctor</i>	<i>Out-of-Network Reimbursement</i>
Eye Exam	\$10 Co-payment	After Co-pay
Every 12 Months*	No Charge	Up to \$40
Materials (lenses and/or frame)	\$25 Co-payment	Not Applicable
Every 12 Months*		
Single Vision	No Charge ¹	Up to \$40
Bifocals	No Charge ¹	Up to \$60
Trifocals	No Charge ¹	Up to \$60
UV Coating	No Charge	No Additional Benefit
Frames		
Every 24 Months*	Covered up to \$105 Allowance ²	Up to \$40
Contacts (in lieu of glasses)		
Every 12 Months*	Covered up to \$100 Allowance ³	Up to \$100

* Based on your last date of service.

¹ Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at VSP's member preferred pricing.

² If you choose a frame valued at more than your allowance, you'll save 20% on your out-of-pocket cost for frames.

³ Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15% discount off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

Dual Coverage Vision Plan

As with the medical and dental plans, you have the option to elect the Dual Coverage Vision plan if you have primary vision coverage under another vision plan. This plan is also offered by VSP.

Eye Exam	Plan Pays
Every 12 Months*	Up to \$10 Benefit
Materials (lenses and/or frame)	
Lenses of Frames	Up to \$75 per year

* Based on your last date of service.



Life insurance benefits are underwritten by Aetna Life Insurance Company. This is a summary of the plan benefits. For complete information and provisions, please refer to your certificate provided by Aetna, contact Aetna Customer Service at 1-866-227-9954 or visit their website, www.aetna.com.

Submit claims to: Aetna Inc. Life Service Center
 151 Farmington Avenue – RE52
 Hartford, CT 06156-3007
 Fax Number for Claim Submission: 1-800-238-6239

In the event of your death, the life insurance company will pay your beneficiary the applicable amount of life insurance benefits as shown below:

Classification	Benefit Amount
Under age 65	\$26,000
Age 65 through 69	\$16,900
Age 70 through 74	\$11,700
Age 75 through 79	\$7,800
Age 80 and over	\$5,200

The death benefit amount will be reduced by any amount previously paid under the Accelerated Death Benefit provision, described below.

Designation of Beneficiary Form

Please download the form from the EUTF website at www.eutf.hawaii.gov or call the EUTF to have it sent to you.

Classification Change Date

Any change in your life insurance classification will become effective on the date of your 65th, 70th, 75th, and 80th birthday. When you retire from active employment, your benefit amount will change. Refer to the Retiree Reference Guide for specific information.

Accelerated Death Benefit

If, while covered under this life insurance plan you become terminally ill, you may request that the life insurance company pay an Accelerated Death Benefit. Your physician must certify that you suffer from a terminal illness and have a life expectancy of 12 months or less. Upon approval of your request, the insurance company will pay up to 75% of your life insurance benefits, with a minimum payment of \$5,000. A nominal amount of interest is charged for the accelerated payment, as defined in your life insurance certificate. The Accelerated Death Benefit payment will be reduced by an interest discount to account for the early payment.

Life Insurance Conversion

If your life insurance ceases because of termination of employment or is reduced due to age, you may convert to an individual policy. You must apply within 31 days of the following events:

- ▶ Your insurance ends because you are no longer eligible, you may convert to an amount of life insurance equal to the amount of insurance you had prior to your termination.
- ▶ When you reach age 65, 70, 75, and 80 as an active employee and at retirement, you may convert to the amount being reduced.

If you die within the 31-day conversion period, and before the individual policy goes into effect, the amount payable is the maximum amount you could have converted. This amount applies even if you had not applied for or paid the first premium on the individual policy.

Important Notices

Many federal and state laws guide the administration of all health benefits insurance plans. While official insurance contracts actually govern your rights and benefits under each plan in which you are enrolled, the following information is provided to help you understand your statutory rights and benefits. If any discrepancy exists between the information provided in this section and your official insurance documents, the official insurance documents will prevail.

If you have any questions about this section, please call the Hawaii Employer-Union Health Benefits Trust Fund (the EUTF) at 808-586-7390.

Women's Health & Cancer Rights Act

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

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

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

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

Newborns' & Mothers' Health Protection Act

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

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

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

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the

plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the Plan may still require pre-certification of any hospital admission in connection with childbirth, in order for you to obtain the maximum level of benefits available under the Plan.

Qualified Medical Child Support Order

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

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

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

National Medical Support Notices

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

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

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

If you are not enrolled and there is more than one coverage option available, the EUTF will inform the state agency of the coverage options from which you may elect coverage. In this event, the EUTF will also

notify your employer, who will determine whether federal or state withholding rules permit withholding from your salary or wages the amount required to provide coverage to the child(ren) under the terms of the health insurance plan, and, if so, to withhold the required amounts from your pay for such coverage and remit these amounts withheld to the EUTF.

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

Continuation of Group Health Coverage Under COBRA: Initial Notice

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

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

Qualifying Events

Employees

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

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

Covered Spouses

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

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

Covered Children

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

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

When Is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other initial Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must provide the Plan Administrator with notice of the Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date of the loss of coverage under the Plan.

You must provide this notice in writing by appropriately completing the attached "Notice of a COBRA-Related Event." For detailed instructions on completing this Notice, the documentation required to accompany the Notice and the procedures for submitting the Notice, see the EUTF's website or contact the Plan Administrator. If you do not follow these procedures or if you fail to provide written notice to the Plan Administrator within the 60-day notice period, **YOU AND ANY OTHER FAMILY MEMBERS WHO WOULD OTHERWISE BE QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHTS UNDER COBRA, INCLUDING THE RIGHT TO ELECT COBRA CONTINUATION COVERAGE..**

Cost of Coverage

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

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

You may pay for COBRA coverage on a monthly basis. Your first payment will cover the period from the date your former coverage terminated to the date you elect COBRA coverage — and is due within 45 days of your COBRA election date. The EUTF will give you specific cost information at that time. For subsequent premium payments, you have a grace period of 30 days for payment of the regularly scheduled premium. If you fail to pay the full monthly premium amount when due, your COBRA coverage will be terminated for non-payment. If this happens, you will not be allowed to reinstate your COBRA coverage.

How Long Does COBRA Continuation Coverage Last?

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

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

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

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

Disability extension of 18-month period of continuation coverage

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

procedures for providing the notice of disability and the cost of COBRA coverage during any disability extension period, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

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

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

Medicare extension for a spouse and dependent children

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

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

A child born to or adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage is considered to be a Qualified Beneficiary provided that, if the covered employee is a Qualified Beneficiary, the covered employee has elected COBRA continuation coverage for himself or

herself. For more information regarding a newly acquired dependent child's COBRA, refer to the "COBRA Notice" on the EUTF's website or contact the Plan Administrator.

Alternate Recipients under QMCSOs

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

Hawaii Employer-Union Health Benefits Trust Fund

P.O. Box 2121

Honolulu, HI 96805-2121

Telephone: (808) 586-7390

Toll Free: (800) 295-0089

Rights and Benefits

COBRA participants in a health insurance plan have the same rights and benefits as active participants in the

plan. Any changes made to the plan for active participants will also apply to COBRA participants.

HIPAA Initial Notice: Notice of Privacy Rules

Effective date of this notice is March 1, 2005.

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

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

This notice describes the EUTF's privacy practices and your rights regarding the uses and disclosures of your medical information.

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

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

By law, the EUTF MUST:

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

HIPAA also requires the EUTF to tell you about: The EUTF's uses and disclosures of your medical information,

- ◆ Your privacy rights with respect to your medical information,

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

How the EUTF May Use and Disclose Your Medical Information

The following categories describe the different ways the EUTF may use and disclose your medical information. Some uses and disclosures of your medical information require your authorization or the opportunity to agree or object to the use or disclosure. Other uses and disclosures do not. This notice clearly identifies whether or not the use or disclosure of your medical information requires your authorization or the opportunity to agree or object. Each category contains an explanation of what is meant by the "use and disclosure" of your medical information, and some examples. Not every use or disclosure in a category will be listed. However, all of the ways the EUTF is allowed to use and disclose your medical information will fall into one of the categories listed.

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

For Treatment: the EUTF may use or disclose your medical information to help you get medical treatment or services through the EUTF. The EUTF may disclose your medical information to health care providers, including doctors, nurses, technicians, medical students, or other health care professionals who are providing you with services covered under the your insurance plan. For example, the EUTF might disclose the name of your child's dentist to your child's orthodontist so that the orthodontist may ask the dentist for your child's dental X-rays.

For Payment: the EUTF may use and disclose your medical information in the process of determining your eligibility for benefits under the EUTF, to facilitate payment to health care providers for the treatment or services you have received from them, to determine benefit responsibility under the EUTF, and to facilitate reviews for medical necessity/appropriateness of your care. For example, the EUTF may tell your doctor whether you are eligible for coverage under the EUTF, or what percentage of the bill may be paid by the EUTF. Likewise, the EUTF may share your medical information with another entity to assist with the adjudication or subrogation of your claims or to another health plan to coordinate benefit payments.

For EUTF Operations: the EUTF may use and disclose your medical information for health care operations and other EUTF operations. These uses

and disclosures are necessary to administer the EUTF benefit plans. For example, the EUTF may use and disclose your medical information to conduct or facilitate quality assessments, improvement activities, performance and compliance reviews, auditing, fraud and abuse detection, underwriting, premium rating and other activities related to creating, renewing or replacing insurance contracts or benefit plans, claims review and appeals, legal functions and services, business planning and development, and other activities related to business management and administration. In connection with the foregoing, the EUTF may disclose your medical information to third parties who perform various health care operations or EUTF operations on its behalf.

As Required By Law: the EUTF will disclose your medical information when required to do so by federal, state or local law. For example, the EUTF may disclose your medical information when required to do so by a court order in a civil proceeding such as a malpractice lawsuit. Or, the Secretary of the Department of Health and Human Services might require the use and disclosure of your medical information to investigate or determine the EUTF's compliance with federal privacy regulations (this notice).

To Avert a Serious Threat to Health or Safety: the EUTF may use and disclose your medical information when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. However, any such disclosure would be made only to a person able to help prevent the threat. For example, the EUTF may disclose your medical information in a legal proceeding regarding the licensure of a doctor.

Special Situations

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

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

Plan, Hawaii Dental Service, Vision Service Plans, ChiroPlan Hawaii or Royal State Insurance in order to verify your eligibility for benefits or services.

Disclosure to the Plan Sponsor and Its

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

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

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

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

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

Health Oversight Activities: the EUTF may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities can include audits, investigations, inspections,

and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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

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

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

Coroners, Medical Examiners and Funeral

Directors: the EUTF may release your medical information to a coroner or medical examiner. This might be necessary, for example, to identify a deceased person or determine the cause of death.

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

The following category **REQUIRES** the EUTF to obtain your written authorization for the use or disclosure.

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

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

Family or Friends Involvement: the EUTF may disclose your medical information to family members, other relatives, or your friends if:

- ◆ The medical information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- ◆ You have either agreed to the disclosure or have been given the opportunity to object to the disclosure and have not objected.

Your Rights Regarding Your Medical Information

You have the following rights regarding your medical information maintained by the EUTF:

Right to Inspect and Copy Your Medical Information:

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

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

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

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

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

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

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

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

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

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

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

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

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

To request this list of disclosures, you must submit a written request to the EUTF Privacy Officer. Your request must state a time period for which you are requesting the list of disclosures. This period may not be longer than six years and may not include dates

before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within any 12-month period will be provided free of charge. For additional lists, the EUTF may charge you for the costs of providing the list. The EUTF will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any costs.

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

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

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

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

In your request, you must indicate:

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

Right to Request Confidential Communications:

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

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

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may

ask the EUTF to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to request a paper copy of this notice.

To obtain a paper copy of this notice, submit a written request to the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

A Note about Personal Representatives

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

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

The EUTF may decide to deny a personal representative access to medical information of a person if it thinks this will protect the person represented from abuse or neglect. This also applies to personal representatives of minors.

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

Changes to This Notice

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

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, your rights, the duties of the EUTF or other privacy practices stated in this notice.

Minimum Necessary Standard

When the EUTF uses or discloses your medical information, or requests your medical information

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

However, the minimum necessary standard will not apply to:

- ◆ Disclosures to or requests by a health care provider for treatment,
- ◆ Uses by you or disclosures to you of your own medical information,
- ◆ Disclosures made to the Secretary of the Department of Health and Human Services,
- ◆ Uses or disclosures that may be required by law,
- ◆ Uses or disclosures that are required by the EUTF's compliance with legal regulations, and
- ◆ Uses and disclosures for which the EUTF has obtained your authorization.

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

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

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the EUTF Privacy Officer, whose address is provided at the end of this HIPAA notice.

You may also file a complaint with the Secretary of the Department of Health and Human Services at:

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

You must submit any complaints in writing. The EUTF will not penalize or retaliate against you for filing a complaint.

Other Uses and Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the EUTF will be made only with your written authorization. If you provide the EUTF with authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the EUTF will no longer use or disclose your medical information for the reasons covered by your written authorization. You should understand that the EUTF is unable to take back any disclosures that have already been made with your authorization, and that the EUTF is required to retain any records regarding any care or services provided to you.

Questions?

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

Governing Law

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

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

CONTACT INFORMATION

Mailing Address: P.O. Box 2121
Honolulu, HI 96805-2121

Location Address: 201 Merchant Street #1520
City Financial Tower
Honolulu, Hawaii

Telephone Numbers

Local Number: (808) 586-7390

Toll-Free Number 1-800-295-0089

Fax Number: (808) 586-2161

Email Address: eutf@hawaii.gov

Website Address: www.eutf.hawaii.gov